REPORT TO THE EMCDDA
by the Reitox National Focal Point

"ITALY"
DRUG SITUATION 2002

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SUMMARY

MAIN TRENDS AND DEVELOPMENTS

During 2002 the major developments within Italy reported in the last National Report were consolidated. The Government signalled its intention to give high priority to the problems associated with drug misuse. In particular it indicated a desire to strengthen the capacity of law enforcement agencies to respond to drug and drug related offending and to re-focus demand reduction interventions on primary prevention and treatment aimed at achieving abstinence and re-insertion into employment. In February 2002 the Government approved the first National Drugs Plan produced in Italy. This plan concentrated on issues of drug demand reduction and gave clear expression to the primary prevention and abstinence oriented policies favoured by the Government. In June 2002, a Ministerial Decree from the Minister of Health in association with the Minister of Welfare, sought to improve accessibility to private socio-rehabilitative services by allowing direct access to services without the necessity of the Ser.T. (Servizio Tossicodipendenze) being directly involved. This decree was subsequently annulled by the Constitutional Court. The guidance for use of the National Drugs Fund gave priority to activities, which would implement either at national or local levels the priority areas of the National Drugs Plan. At the Regional level, the process of devolving greater autonomy to the Regions from central Government continued. Regions took responsibility for the planning, organisation and delivery of health and social care within broad guidance from the Ministry of Health. Legislation was also introduced and began the Parliamentary process to transfer the maximum possible responsibility to the Regions. These changes will lead to greater variations in responses and service delivery as individual Regions determine their own priorities.

Epidemiology

In 2001 the first general population survey of drug use was undertaken. This involved a postal survey and followed earlier trials of different methodological approaches. The age range for the survey was 15 – 44. Cannabis was identified as the most prevalent drug with most other drugs having very low prevalence rates. The lifetime prevalence of hypnotics/sedatives is relatively high, especially in the female population, but last 12 month and last 30 day prevalence is low. The highest prevalence rates are found in the 15 – 24 age range. During 2002 further analysis of the data was undertaken, especially with regard to patterns of alcohol use. The ESPAD Italia study shows a general reduction in listed drug use with the exception of cannabis use. It also shows a reduction in combined alcohol and drug use. The notable developments appear to be changing patterns of alcohol use, with increased drunkenness and a small but noticeable increase in use of drugs by injection. Data from the Ministry of Defence shows a changing situation, which seems to be related to the ending of conscription. Those now within the armed forces are predominantly volunteers who have chosen it as a career not conscripts and may be less likely to have an involvement in illicit drug use. Estimates of problematic drug use, based on four different indicators, suggest that there is still a substantial number of heroin users outside the treatment system and that around 8% of the population in the 15 to 54 age range has tried heroin.

Treatment demand has continued to increase. However, the proportion of existing to new patients has also increased suggesting that there may be a blockage in the availability of treatment for newer users. There is some evidence that there has been a reduction in heroin use and heroin injecting and that new users are increasingly likely to use heroin by sniffing or smoking.

In terms of morbidity and mortality, there was a further substantial decrease in the number of direct drug related deaths. The percentage of all clients of the Ser.T. found HIV positive has continued to decline. However, the level of testing for any of the drug related infectious diseases has also been falling and there are very substantial differences in testing practice between Regions. The downward trend in HBV infection has remained although there was a slight increase in the percentage of all clients testing positive for HBV. There has been an increase in the percentage of all clients testing positive for HCV infection and the level now almost matches that for 1998. New clients of the Ser.T. are much less likely to test positive for drug related infectious diseases but the percentage tested for these diseases is much lower than for existing clients.

Drug availability remains relatively high and whilst there has been a slight decrease in average street purity for most drugs, street prices in 2002 were in real terms lower than for 1999. The quantity of heroin seized rose again in 2002, as did the quantity of cocaine. For the latter over a four year period the average street purity has hardly changed whilst the street price has fallen, suggesting that there is a continuing increase in availability and use. The quantity of cannabis seized fell in 2002 and there has been a downward trend in the quantity of cannabis seized over recent years. There was an increase in amphetamine and amphetamine analogue seizures with an upward trend in the quantity seized since the mid '90s. No data on the number of seizures is available. It is difficult, therefore, to ascertain what trends there might be in supply or availability.
The pattern of referrals to the Prefect for unlawful possession shows a continuing sharp decline. The number of referrals to the Judicial Authority for drug law offences has remained stable. The number of drug dependents in the prison system has continued to fall, although prisoners assessed as drug dependent represent a significant proportion of the prison population. It is noticeable that the percentage of non-Italian prisoners, both drug dependent and non-drug dependent, has been rising steadily for several years. This has implications for prevention and treatment interventions. It also suggests that illicit supply systems are increasingly using highly vulnerable populations to act as couriers and low-level deliverers of drugs. This trend and its implications will need to be monitored further.

Drug Demand Reduction
The clear statement of intent arising from speeches by Ministers and confirmed in the National Drugs Plan has resulted in an increased focus on primary prevention. This can be seen not only in the projects and activities supported by the Ministry of Education but also through the prevention plans being produced at the local health authority and Regional levels. There are graduated prevention approaches based on primary prevention within the educational environment, especially the elementary and lower secondary schools and varying levels of secondary prevention in specific settings such as discotheques, bars and through street work.
The internet is increasingly being used to provide information about various aspects of drug demand reduction. Although there has been a continued expansion of the sites available, many are relatively static and are up-dated very infrequently. At the same time, a small number of sites have been developed as interactive youth oriented sites in which drug prevention is integrated with broader information about events, activities, games, etc.
There has been a policy move away from harm reduction as a goal in itself in favour of low threshold services and early interventions to reduce the likelihood of drug problems developing or to bring drug users rapidly within a therapeutic environment. There are substantial variations in practice around the country and no single modality or approach can be found. Rather, there appears to be a mix of service by tradition, new initiatives and, increasingly, adaptation of treatment to match identified client needs. In practice, many Ser.T. and socio-rehabilitative organisations are multi-modality and multi-service providers.
There has been a continued reduction in the number of people in residential treatment and an increase in the number attending outpatient services, although the total number of people attending socio-rehabilitative services has remained stable.
The use of pharmacological treatments by the Ser.T. has declined but there has been a continuing increase in the percentage of clients who receive long term (over 6 months) methadone. The reduction is not correlated with a reduction in the number of people with primary heroin use and suggests that there has been a conscious move towards the use of symptomatic and psychosocial interventions.
The number of drug users passing through the criminal justice system has declined, as has the overall prison population. Drugs users represent 29% of all new prisoners. Over time, the percentage of new, drug using prisoners from Italy has fallen by one-third whilst the percentage of new non-Italian drug using prisoners has risen by 80%. Following the assumption of responsibility for the health care of prisoners, the Ser.T. have seen an increase in the percentage of clients in prison. Treatment remains primarily psychosocial but there has been an increase in pharmacological treatments. This may reflect work with existing clients, with drug users who are awaiting trial or who are in preparation for an alternative measure. 26% of all assignments to the Probation Service are of drug using offenders.

Quality assurance approaches have continued to develop with a major publication on this issue. A number of drug services have now obtained the ISO 2000 certificate and there increased interest in this area.

Consistency between sections

There is broad consistency between the sections of the report and between data from different sources. For instance, the general population survey, the ESPAD data and the data from the Ministry of Defence all show common trends in terms of the development of substance use, patterns of substance use and the drugs most frequently used. The data from the Ministry of Health on problem drug users in contact with the Ser.T for treatment is consistent with local data reported in published papers or in papers presented at regional and national conferences. It also confirms, given the time lapse between drug use and the first approach for treatment, a gradual move away from injection of drugs and a wider pattern of drug use with heroin use declining but use of other drugs increasing. The law enforcement data also seems to confirm these trends, with cocaine and ecstasy seizures being substantial. Seizures of heroin have risen but there is no data available on the type of heroin being seized. Cannabis seizures have consistently represented the largest quantity of listed drugs seized. The data on referrals for unlawful possession of listed drugs is not, however, consistent with the other indicators. This may reflect the fact that possession of a listed drug is an administrative offence with low enforcement priority. Discovery of a listed drug may occur in the course of other policing operations and not be the focus of the policing operation. The greatest difficulty rests in interpreting data from local sources concerned with drug use by young people. Where well-sampled studies have been undertaken, these appear to confirm data from the general population and school surveys. They also provide more in depth and qualitative data, which can assist in the development of local responses and better understanding of geographical variations. Studies of randomly selected populations, however, may provide significantly different results and are easily misinterpreted. At the same time, they can provide valuable insights into very specific situations, which, whilst not capable of being generalised, can provide a focus for intervention and evaluation of the impact of different interventions.

Implications for policy and interventions

Improvements in both the quantity and quality of data arising from the work of the OIDT and of projects undertaken by individual Ministries and Departments has already provided valuable information for targeting both policy and interventions. It has already had an influence on policy in that the data identified priorities for the first stage of the National Drugs Plan and gaps in data, such as qualitative studies, evaluations of interventions etc. As the experimental data collection systems being developed are finalised and fully implemented, along with improvements in existing data systems and completion of the evaluations of the effectiveness of treatment, these are also likely to provide a basis for further developing policy, strategy and interventions.

PART 1

NATIONAL STRATEGIES: INSTITUTIONAL & LEGAL FRAMEWORK

1. Developments in Drug Policy and Responses

1.1 Political framework in the drug field

During 2002 and 2003 there has been considerable discussion on drug policy and on the legal framework for the implementation of policy. The intentions for the development of drug policy have been clearly stated by both the Prime Minister, Silvio Berlusconi [1] and the Deputy Prime Minister, Gianfranco Fini [2]. The Extraordinary Commissioner, Prefetto Pietro Soggiu has also emphasised the need to adjust policy in the outline national drugs plan which was approved in early 2002.

The intentions behind the proposed new policy are to emphasise approaches, which support prevention of drug use and promote recovery from drug use. To this end, harm reduction initiatives, which are not designed to lead away from drug use, are to be discouraged.

As has been reported previously, the outline of a national drugs plan was approved by the Council of Ministers in February 2002. Since then work has focussed on developing a new legislative framework for the outline national drugs plan. It was initially planned that the draft legislation should be published in June 2003. However, to facilitate further consultation publication was delayed until November 2003. The draft law will now be considered by Parliament and will be the subject of considerable discussion in both political and professional circles. In the meantime, there have been no changes to the co-ordination arrangements which were reported in the last National Report.

1.2 Legal framework

The basic framework for the demand reduction field has remained stable during the period. Private social organisations providing residential, semi-residential or ambulatory services are required to be registered with the Region. Most Regions now have in place their basic requirements in terms of minimum standards and reporting requirements, which apply to all drug demand reduction services whether provided by public or private organisations. Treatment with substitute drugs is usually undertaken by the national health service managed Ser.T. (drug treatment services) although general medical practitioners may also provide this service and in some areas, such as Trieste, are major providers of substitution treatment. The Ministry of Health regulates the way in which drugs are prescribed and provides guidelines on best practice.

As reported in the last National Report, a Ministerial Decree by the Minister of Health was published in the Official Gazette No. 147 of 25 June 2002. The purpose of this Decree was to change arrangements for the admission of people with drug problems into residential treatment provided by private social organisations. The aim was to allow such organisations to admit people directly rather than via the Ser.T. and to receive payment from the Ser.T. for the treatment provided. The Decree also intended that such treatment could be provided at any facility and need not be confined to services with which the relevant Ser.T. had an agreement. However, this Decree was challenged in the Constitutional Court on the grounds that responsibility for health and social care had been devolved to the Regions and that the central administration did not have the legal authority, therefore, to determine the mechanism for service delivery. The Constitutional Court upheld the challenge to the Decree, which was in consequence revoked. The challenge was essentially concerned with the question of the balance of authority between central and regional administrations in matters of health and social care and some Regions, for example Piemonte, have introduced Regional Legislation which effectively implements the decree at the local level.

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[1] For example, in an interview with Gianni di Capua of Il Tempo on 11\10\2002

[2] For example, in his speech to the Ministerial Segment of the 46th Session of the Commission on Narcotic Drugs, 2003

The draft law which was presented to the Council of Ministers in November 2004 proposes significant changes in terms of national co-ordination arrangements, the regulations concerned with the provision of drug treatment and the legal consequences of possessing or supplying controlled drugs. However, as has been noted, this law will be subject to detailed examination and until it has been reviewed by the Chamber of Deputies and the Senate it is not possible to say what the final contents will be.

At the local level, but with potentially national significance, in March 2002 the Tribunal of Venice ordered the local health authority of S.Donà di Piave to provide cannabis at no charge to a women with cancer. Although it was noted that there were no drugs containing derivatives of cannabis authorised for use in Italy, the Health Minister accepted the possibility that additional therapeutic options, properly tested, could provide additional benefits to some patients.

1.3 Laws implementation

There have been no formal changes in the implementation of the drug law during the reporting year. Those found in possession of controlled drugs without lawful authority (Article 75 of the Drug Law) are referred to the prefecture where they may be warned about the dangers of drugs and advised not to use them again or may be referred for counselling and treatment. Those in breach of the criminal offences listed in the Drug Law are investigated and if the investigating magistrate / supervising judge considers there is sufficient evidence, they are sent for trial.

There has been no change in prosecution policy. Drug law offenders are prosecuted where there is sufficient evidence to proceed. If the offender is a drug user and alternatives to imprisonment are available, policy remains to encourage the drug user into treatment. The National Drugs Plan has emphasised the importance of providing treatment to drug dependent offenders with the objective of achieving long tem abstinence on release from prison. To this end it has encouraged an increased role for services providing drug free treatment and, as reported above, has proposed additional mechanisms to assist drug dependent prisoners achieve abstinence.

Again, the draft drug law proposes re-instating specific quantity limits to determine possession for personal use and enforcement of strict penalties for trafficking offences balanced by increased treatment provision for drug dependent offenders. However, until the law is approved, there has been no change in implementation arrangements.

1.4 Developments in public attitudes and debates

The outline National Drugs Plan, the proposed changes to the drug laws and the high profile given to drug policy through speeches and interviews given by the Prime Minister, Deputy Prime Minister, other Ministers and the National Drugs Co-ordinator have all served to increase discussion about drug policy and priorities in responding to drug misuse and drug related problems. To some extent there has been a polarisation in the debate, although several strands can be identified.

There is a lively professional discussion about the most effective ways for the delivery of drug services, the balance of service provision and the contents of treatment programmes. This has occasionally been characterised as a battle between drug-free and medically assisted treatment services. Such a representation is, however, an over-simplification. Rather, the debate has been concerned with the purpose of drug treatment and to what extent treatment services should press drug users to achieve abstinence. Within this debate the role of methadone as a component of drug treatment has been questioned, especially in so far as the use of methadone for long term maintenance has increased and an increasing number of clients are remaining in treatment for an extended period of time. Thus, the professional debate concerns the balance of treatments and provision in order that those with drug related problems might be moved as quickly as possible away from drug use and into a position where they can be fully re-integrated into society drug-free.

A second strand of the public debate has been about the role of the law as a mechanism for directing drug users into treatment and enforcing treatment compliance. Although the drug law which is currently in force can require engagement in treatment following either a referral to the Prefect for drug possession or as an alternative to prison or continued imprisonment,

many drug dependent offenders do not receive treatment or do not continue in treatment for sufficient time. The national drugs plan proposes that the law should be used more effectively to press drug users into treatment and to retain them within treatment and that it should be enforced where a drug user fails to keep to the terms of a treatment order. At the same time it is proposed that greater provision of drug treatment should be made available within the prison system. The debate has thus been about whether treatment should be purely voluntary or whether an element of compulsion, properly enforced, should be used to ensure treatment compliance. Within this strand there is also debate about whether supply reduction and demand reduction should be separate processes or whether they should be part of a continuum.

A further strand concerns the purpose of interventions in the drugs field. This is most clearly seen in the debate between those who favour harm reduction as the primary purpose and those who see prevention of drug use and the achievement of long term abstinence as the proper goal. Within Italy such a debate is further complicated because of the presence over many years of a significant anti-prohibitionist lobby which has argued in favour of legalisation and regulation rather than prohibition.

The National Drugs Plan and its elaboration through speeches and the preparation of the draft legislation has thus given high profile to discussion about responses to drug problems and has allowed an informed debate to be carried out both within professional and political circles and within the media.

The EURISPES Report (2003) details some aspects of attitudes towards drugs and drug use. It reports that in a public opinion survey of 2,000 people, 30.8% favoured the legalisation of 'soft' drugs whilst 58.3% felt that use of such drugs should be punished and 10.9% had no opinion or did not respond. By contrast, 79.1% favoured therapeutic use of these drugs whilst only 14.3% were opposed. This is also in line with resolutions passed by four Regions – Friuli Venezia Giulia, Lombardia, Sardinia and Umbria – calling for cannabis to be made available for therapeutic use. In terms of controlled distribution of drugs to addicts, 43.7% of respondents considered this useful, 25.7% not useful and 15.6% considered it damaging. When responses were examined in more detail, those who favoured legalisation were predominantly in the 18 – 24 age range. 40.3% of this group favoured legalisation. Those who felt use of 'soft' drugs should be punished were primarily in the 45 and over age group. When the data was examined by occupational and educational status, students (47.8%) and traders (45.7%) were most in favour of legalisation whilst housewives were most opposed (70.1%). Those with a full university degree were more in favour of legalisation (42%) whilst those with no educational qualification or just the elementary certificate were least in favour (10%). Support for making 'soft' drugs available for therapeutic use was evenly distributed across all professional groups, with managers, teachers, professionals and students all recording over 80% in favour (range 83% - 87.4%), whilst housewives, manual workers, unemployed and retired people were least in favour (71%, 69.8%, 71.4% and 72.5% respectively). With regard to the controlled distribution of drugs to drug dependents, there was general consensus amongst all those interviewed, with men having higher support for this approach than women and those with degrees and/or professional positions being more in favour than other groups.

1.5 Budget and funding arrangements

The only dedicated funding for drug related activities relates to the National Drugs Fund. As in previous years, 75% of these funds are allocated to the Regions and Autonomous Provinces whilst 25% is available for national projects proposed by Ministries.

In 2002, the total amount allocated from the Fund was € 122,606,717.15, of which € 91,955,000.15 was allocated to Regions and € 30,615,717.00 was allocated to Ministries and the Directorate General. The table below shows the allocation to Ministries over the period since the Fund was reinstated under law 45/99.

At the Regional level, only very incomplete data is available, with many Regions not in a position to identify the resources used in responding to drug misuse. The table below shows the dedicated funds identified by Regions allocated for activity on drug misuse in 2001. The amount listed under the National Drugs Fund heading refers to the expenditure committed in that year from Fund allocation to a Region. For most Regions

Number of Projects Funded by Year and Ministry / Department

Ministry / Department	Financing Period								Total	
	1997-1998-1999		2000		2001		2002			
	No.	Amount (€ x 100)	No.	Amount (€ x 100)	No.	Amount (€ x 100)	No.	Amount (€ x 100)	No.	Amount (€ x 100)
Social Affairs	0		5	44560	17	105166	-	-	22	149726
Defence	4	27595	5	4886	3	1283	0	0	12	33764
Justice	15	187029	8	41270	5	28147	4	41780	28	298226
Interior	13	31052	18	28464	19	26929	15	21073	50	107518
Employment	9	55391	3	12076	7	30946	13	108156	19	206568
Education	8	243179	7	43930	4	56810	1	103730	19	447649
Health	40	146338	9	64580	6	54305	5	31779	55	297003
TOTAL	89	690584	55	239765	61	303588	38	306517	205	1540454

Table 1

Source: OIDT

specific arrangements have to be put in place to regulate the criteria for the submission of applications, selection, monitoring and evaluation criteria and any other necessary arrangements. In consequence, although funds may have been allocated to a Region in one year, the majority of project approvals will occur in the following calendar year and will not be shown. It is probable that expenditure from the Fund listed in 2002 actually relates to project approvals for applications made in respect of the 2001 National Drugs Fund allocation.

As can be seen from the table, many Regions are not in a position to provide the data requested on expenditure for drug related problems. This may in part be because the data is requested before any audit of Regional expenditure. However, it is also the case that a significant number of Regions report that they are not in a position to identify drug related expenditure separate from their general health and social care expenditure.

Expenditure on Demand Reduction by Regions 2001 and 2002 (€ x 100)

	Ser.T.		Therapeutic Communities		National Drugs Fund		TOTAL	
REGION	***2001***	**2002**	***2001***	**2002**	***2001***	**2002**	***2001***	**2002**
Piemonte	*38,139.2*	38,139.2	*11,508.4*	11,508.4	*9,908.2*	n.a.	*59,555.8*	49,647.6
Valle d'Aosta	*1,312.1*	1,032.6	*927.9*	1,087.2	*223.8*	n.a.	*2,463.8*	2,119.8
Lombardia	*6,757.7*	62.256. 4	*22,547.5*	24,520.0	*19,674.8*	14,023.8	*48,980.0*	100,800.2
Trentino A.A.	*6,539. 5*	7,467.9	*4,842.4*	4,851.5	*1,332.4*	1,304.8	*12,714.3*	13,624.2
P.A. Bolzano	*3,994.7*	4,884.9	*3,253.9*	3,239.2	*722.2*	722.2	*7,970.8*	8,846.3
P.A. Trento	*2,544.8*	2,583.0	*1,588.5*	1,612.3	*610.2*	582.6	*4,743.5*	4,777.9
Veneto	*47,987.0*	n.a.	*15,493.7*	15,506.0	*4,866.5*	5,970.9	*68,347.2*	21,476.9
Friuli V.G.	*n.a.*	n.a.	*1,196.0*	n.a.	*n.a.*	5,095.4	*1,196.0*	5,095.4
Liguria	*15,617.0*	15,803.8	*6,896.0*	6,576.0	*2,813.5*	2,817.0	*25,326.5*	25,196.8
Emilia Romagna	*n.a.*	41,052.1	*10,725.8*	10,415.9	*6,385.2*	11,227.6	*17,111.0*	62,695.6
Toscana	*48,837.7*	24,585.0	*10,329.1*	12,268.0	*6,023.0*	3,942.1	*65,189.8*	40,795.1
Umbria	*n.a.*	n.a.	*n.a.*	n.a.	*1,518.1*	n.a.	*1,518.1*	n.a.
Marche	*14,311.5*	8,720.2	*1,910.9*	5,350.1	*2,048.7*	1,422.0	*18,271.1*	15,492.3
Lazio	*n.a.*	n.a.	*n.a.*	n.a.	*6,697.7*	n.a.	*6,697.7*	n.a.
Abruzzo	*n.a.*	n.a.	*n.a.*	4,283.5	*1,950.7*	1,953.1	*1,950.7*	6,236.6
Molise	*n.a.*	n.a.	*n.a.*	n.a.	*n.a.*	n.a.	*n.a.*	n.a.
Campania	*14,999.9*	19,350.6	*8,272.7*	8,430.5	*3,758.7*	2,180.0	*27,031.3*	29,961.1
Puglia	*n.a.*	n.a.	*n.a.*	n.a.	*n.a.*	n.a.	*n.a.*	n.a.
Basilicata	*2,259.8*	2,300.6	*430.4*	309.6	*548.8*	820.5	*3,239.0*	3,430.7
Calabria	*n.a.*	n.a.	*n.a.*	n.a.	*n.a.*	n.a.	*n.a.*	n.a.
Sicilia	*n.a.*	n.a.	*n.a.*	3,223.3	*n.a.*	n.a.	*n.a.*	3,223.3
Sardegna	*n.a.*	10,471.4	*3,098.7*	3,443.2	*2,470.7*	2.8	*5,569.4*	13,917.4
ITALY	*196,761.4*	231,179.8	*98,179.5*	111,773.2	*70,220.2*	50,760.0	*365,161.7*	393,713.0

Table 2

Source: OIDT

As has been reported in previous years no data is available on dedicated funding for law enforcement activity related to drug supply or to the prosecution and punishment of drug law offending. At the national level, the funding forms part of overall law enforcement costs of the Ministry of the Interior and the Ministry of Justice and there is no separate budget for direct drug related activity.

Table 2 above gives some indication of the funds expended on social and health care by Regions. However, detailed data is not available. The costs of the Ser.T., for instance, include costs for non-care activities, such as research. Moreover, funds for social and health care may come from a range of other sources including Provinces, Communes and private sources. There is no information available at either the national or local level on the true level of dedicated expenditure on drug related social and health care activities. The Ministry of Justice has estimated the cost of assistance to drug dependent prisoners in 2002 as €15.487.510 but no other Ministry or Region has completed or published the results of such an exercise.

As with other areas, there is limited data available on the amount of funds allocated for research. At the national level an analysis of projects approved in 2001 for support from the National Drugs Fund shows that € 34,852,577 was for research or for experimental projects which included research and evaluation as part of their activity.

There is no nationally available data on basic or clinical research conducted in university departments or through local health services. In consequence, it is not possible to state the amount expended on research. It is likely, however, that projects funded by the National Drugs Fund will include many experimental projects with research and evaluation as part of their remit. Unfortunately, it is not certain that the results of research or evaluations will be disseminated.

Italy is the major donor to UNDCP and through its international co-operation programme has financed projects, which include assistance in drug control, alternative development and drug demand reduction. Between 1991 and 2001 approximately €129,114,225 has been contributed to UNDCP by Italy. In both 2000 and 2001 the Italian contribution has been €12,200,000, representing about one sixth of the total expenditure of that organisation. To provide stability for UNDCP, since the early 1990s 35% has been for the general expenditure of UNDCP and 65% has been for projects agreed with Italy and based on geographical and thematic criteria and priorities. Additionally, three bilateral projects have been undertaken, two in Peru and one in the Maldives and alternative development projects have been funded in Columbia, Ecuador and Bolivia.

No data is available on funds allocated for national strategy and co-ordination. This is considered part of the proper activities of individual Ministries in respect of their own areas of responsibility and a function of the Prime Minister's Office with regard to co-ordination between Ministries and Departments. As such, there is no specifically identified budget for this area of activity. However, as one of the priority tasks being undertaken by the National Department for Anti-Drug Policies of the Extraordinary Commissioner has been a study to identify the cost of drug use to the country. This study is currently underway and no publication is yet available. However, it is anticipated that it will eventually provide important information on costs which is presently unavailable.

PART 2

EPIDEMIOLOGICAL SITUATION

2. Prevalence, Patterns and Developments in Drug Use

2.1 Main developments and emerging trends

In terms of drug use, surveys suggest that use of alcohol, tobacco and cannabis remains common. There has been a continuing increase in the percentage of young people reporting more frequent episodes of drunkenness. It seems that this represents a move towards increasing use of socially acceptable intoxicants but with changing drinking patterns. There is no indication that the use of synthetic drugs has increased and some suggestion that it has declined. At the same time, use of cocaine and heroin has shown an increase in general population use.

From a national project conducted by the National Institute of Health as part of the Italian contribution to the early warning system, a number of emerging trends have been noted. The use of drugs with effects on the cardio-circulatory system has been observed. Checks made on pharmaceutical drugs which were leaking into the illicit market have shown them to be Xantinolo nicotinato (a pharmaceutical product sold in Italy under the name Complamin). The most consistent reports have come from central and north east Italy. Two hypotheses have been put forward for this situation. The first, that it is an attempt to counter the negative effects of stimulant abuse, is plausible given the recorded increase in cocaine and stimulant use. The second hypothesis relates to the vasodilatory properties of the substance with action on the cardiovascular system. This links to the habit, reported by users, of "preparing themselves" for drug use by preparing the body to absorb greater quantities than the normal dose. Another report, coming from Tuscany, concerns the practice of long absorption into a normal tobacco cigarette of cocaine chloride. Analysis carried out on the first finds has revealed the presence of 10 milligrams of cocaine chloride in each individual cigarette. In various parts of Italy, such as Piemonte, Lazio, Toscana and Emilia Romagna, the use of Salvia divinorum and of Salvinorin A (its metabolite with hallucinogenic actions greater than those of LSD) is no longer sporadic and one factor in its rapid diffusion has been the availability of reassurances about the drug published through the internet. A trend towards the use of drugs with more hallucinogenic rather than stimulant properties can be observed and this may represent a further change in the drug sub-culture.

Estimates of problematic drug use, based on four different indicators, suggest that there is still a substantial number of heroin users outside the treatment system and that around 8% of the population in the 15 to 54 age range has tried heroin.

In terms of treatment demand, this has continued to increase. However, the proportion of existing to new patients has also increased. This suggests that existing clients of the Ser.T. are being retained in treatment for longer. It is possible, therefore, that the reduction in new clients seeking treatment reflects a blockage in treatment availability for newer users. There is also some evidence that there has been a reduction in heroin use and heroin injecting and that new users are increasingly likely to use heroin by sniffing or smoking or to be using other drugs. In the latter case there is some suggestion that they do not consider the Ser.T. to be in a position to help them.

In terms of morbidity and mortality, there was a substantial decrease in the number of direct drug related deaths. The percentage of all clients of the Ser.T. found HIV positive has continued to decline. However, the level of testing for any of the drug related infectious diseases has also been falling and there are very substantial differences in testing practice between Regions. The downward trend in HBV infection has remained and there has also been a decrease in the percentage of all clients testing positive for HCV. New clients of the Ser.T. are much less likely to test positive for drug related infectious diseases but the percentage tested for these diseases is much lower than for existing clients..

Drug availability remains relatively high. Seizures of both heroin and cocaine rose in 2002. The quantity of cannabis seized fell in 2002, continuing the downward trend over recent years. There was an increase in the quantity of amphetamines (including ecstasy) seized

with an upward trend in recent years. Data on the number of seizures is not available. It is known that a small number of seizures account for a large percentage of the total amount seized for any drug, but it is not known whether the remaining seizures are at wholesale, distributor or street level.

The pattern of referrals to the Prefect for unlawful possession shows a continuing sharp decline. The number of referrals to the Judicial Authority for drug law offences fell slightly and the number of drug dependents in the prison system is about the same as for 2001. It is noticeable that the percentage of non-Italian prisoners, both drug dependent and non-drug dependent, has been rising steadily for several years. This has implications for prevention and treatment interventions. It also suggests that illicit supply systems are increasingly using highly vulnerable populations to act as couriers and low-level deliverers of drugs. This trend and its implications will need to be monitored further.

Few new or emerging trends have been reported or noted during the year. The levels of cocaine use in general surveys continued to be higher than the use of heroin but treatment demand remains primarily from those using heroin. However, in absolute numbers, treatment demand for cocaine has almost doubled in the last four years. This would suggest that there is an increasing population on non-opiate problem drug users for whom treatment might be required. There is no estimate of the level of problematic cocaine use but together with use of amphetamine and amphetamine analogues the emerging data suggests that there could be a sizeable population, which might require some treatment intervention.

There is a possibility that the reduced levels of infectious disease testing is masking an increase in drug related infections. The evidence shows that new clients of the Ser.T. are less likely to be tested for drug related infections than those already in treatment with the Ser.T. This may not be a problem with regard to Hepatitis B since the introduction at the start of the 1990s of compulsory vaccination at age 12. It is also possible that testing of new clients of the Ser.T. is lower because of much lower levels of injecting. However, data is currently not available on different injecting rates between new clients and those already in treatment with the Ser.T.

Treatment demand is continuing to rise. However, there is little comparable data available from outreach work which would allow an assessment of the likely level of demand for service intervention or which could identify a focus for early intervention. This is a gap in knowledge that needs to be remedied.

The demographic changes in Italy are similar to that of many other European countries. The percentage of the population in the older age groups has been rising whilst the birth rate for Italy is the lowest in Europe. The gradual aging of the drug using population does, therefore, to some extent reflect the general shift in the age balance of the general population.

There are some indications that there has been a gradual move towards more frequent episodes of intoxication with alcohol and that patterns of alcohol use amongst the younger population have been changing. At the same time, there are indications that the overall use of listed drugs within the younger population may be declining. This would suggest increased use of socially acceptable drugs but no change in the desire to achieve mood or perception changes through the use of psychoactive substances. There is evidence from the EPSAD Italia survey of increased approval ratings for trying almost any of the listed drugs once or twice, but approval for regular use is limited to use of alcohol, tobacco and cannabis. These changes can be linked to the higher level of treatment demand related to cannabis and some indications of higher treatment demand for alcohol problems from the younger population (29 or under).

There is no other readily available data to compare drug trends with trends in the wider social context.

2.2 Drug use in the population

General Population Survey

As was reported in the last National Report, the first general population survey on drug use was carried out in 2001. No further survey has been conducted in the general population but further analysis of the 2001 survey has been carried out.

The survey was based on a postal questionnaire sent to 12,000 people selected through stratified random sampling of the resident population. There was a response rate of

Responses by sex and age group

	Male		Female		Total	
	Replies %	Population %	Replies %	Population %	Replies %	Population %
15 – 19	13.1	12.6	13.5	12.3	13.3	12.4
20 – 24	12.5	14.6	13.7	14.5	13.1	14.6
25 – 29	16.3	18.0	18.1	18.0	17.2	18.0
30 – 34	18.8	19.2	18.4	19.2	18.6	19.2
35 – 39	18.4	19.0	19.0	19.2	18.7	19.1
40 – 44	20.9	16.6	17.3	16.9	19.0	16.8

Table 3 *Source: IPSAD and ISTAT*

48.2% to the questionnaire which rose to 56.8% when postcards acknowledging receipt were returned but no questionnaire was completed. The age range of the sample was 15 to 44 years, and the national population in this age range was estimated by the National Institute of Statistics (ISTAT) as 24,437,177 for 2001. Table 3 shows the response rate by age group and sex whilst Table 4 shows the geographical distribution of responses. In

Responses by sex and geographical distribution

	Male		Female		Total	
	Replies %	Population %	Replies %	Population %	Replies %	Population %
North West	15.9	25.8	15.3	25.3	15.6	25.5
North East	28.1	18.3	29.2	17.9	28.7	18.1
Centre	29.2	18.6	29.2	18.8	29.2	18.7
South	17.0	25.4	16.2	25.9	16.6	25.6
Islands	9.8	11.9	10.1	12.2	10.0	12.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

Table 4 *Source: IPSAD and ISTAT*

total just under 60% of respondents were from large urban areas but there was a difference by age group in the percentage of respondents. For those in the 15 – 24 age range 54.5% of replies came from large urban areas whilst for the 25 – 34 and 35 – 44 age ranges the replies from these areas were 61.9% and 61.0% respectively. There may, therefore, be a slight bias in the overall responses with better response rates from females compared to males, a concentration of replies from the north east and central Regions and better response rates from the younger age groups in non-metropolitan areas. However, a comparison with other research reporting on young people's experience of drug use suggests that any bias which may have occurred in not significant.

The survey provides data on cigarette and alcohol consumption which is important given the relationship which appears to exist between early use of these substances and the likely use of controlled drugs in the future. 44.2% of respondents reported never having smoked of whom 58.3% were females. 31.1% of respondents reported smoking, with prevalence highest in the over 25s and in men. Men were also more likely to be heavier smokers, with twice as many men as women smoking 20 or more cigarettes a day. The data also shows that there is a broad transition over time with young people (15 – 24) being occasional smokers whilst the older age group (35 – 44) are more likely to be regular smokers.

For alcohol consumption, 79.7% of all respondents reported drinking during the last month, with men more likely to have used alcohol (88.6%) compared to women (72%). As with tobacco, the likelihood of consuming alcohol increases with age although the increase is much less – 76.3% in the 15 – 24 age range rising to 81.6% in the 35 – 44

age range. In terms of frequency of use, data is available by type of alcoholic product. Table 5 shows frequency of consumption by product and sex whilst Table 6 shows consumption by product and age group.

Frequency of alcohol consumption by product and sex

	Wine			Beer			Spirits (Superalcohol)		
	M	F	*Total*	M	F	*Total*	M	F	*Total*
Never	42.2	57.8	*15.0*	35.5	64.5	*25.5*	41.9	58.1	*44.6*
Once in the month	38.5	61.5	*17.2*	43.1	56.9	*21.8*	50.9	49.1	*25.1*
2-3 times in the month	46.7	53.3	*29.7*	56.8	43.2	*31.2*	62.3	37.7	*22.2*
1-3 times in the week	64.0	36.0	*19.9*	71.7	28.3	*17.7*	77.2	22.8	*6.8*
4 or more times a week	66.8	33.2	*18.2*	77.6	22.4	*3.9*	89.5	10.5	*1.3*
Total	*51.7*	*48.3*	*100*	*51.8*	*48.2*	*100*	*51.7*	*48.3*	*100*

Table 5 *Source: OIDT*

As can be seen from this data men are much more likely to be regular drinkers, with twice as many men drinking wine 4 or more times a week than women rising to eight times as many men drinking spirits 4 or more times a week than women. At the same time, it is noticeable that for beer and spirits, regular use is low whilst it is much higher for wine. The implication is that there still remains a traditional pattern of wine consumption associated with eating and that spirits are infrequently taken. However, the age group

Frequency of alcohol consumption by product and age group

	Wine				Beer				Spirits (Superalcohol)			
	15-24	25-34	35-44	*Total*	15-24	25-34	35-44	*Total*	15-24	25-34	35-44	*Total*
Never	46.0	31.0	23.0	*15.0*	26.1	34.0	39.8	*25.5*	22.3	34.8	42.9	*44.6*
1 / month	31.8	38.3	29.9	*17.2*	25.1	34.6	40.3	*21.8*	26.1	37.7	36.2	*25.1*
2-3 / month	25.3	41.4	33.4	*29.7*	25.2	37.3	37.5	*31.2*	29.2	38.3	32.5	*22.2*
1-3 / week	19.0	39.5	41.5	*19.9*	25.0	38.7	36.2	*17.7*	30.2	38.1	31.7	*6.8*
4 or more / week	8.5	26.8	64.8	*18.2*	24.1	37.9	37.9	*3.9*	15.8	15.8	68.4	*1.3*
Total	*25.2*	*36.3*	*38.5*	*100*	*25.3*	*36.2*	*38.5*	*100*	*25.2*	*36.3*	*38.5*	*100*

Table 6 *Source: OIDT*

breakdown may suggest a different pattern is developing. Amongst the youngest age group wine consumption is relatively low whereas beer consumption is more evenly spread and consumption of spirits is also relatively high. When respondents were asked about the context of alcohol consumption 18.9% of respondents reported drinking other than with a meal with 38% of both the 15 – 24 and 25 – 34 age groups reporting this, compared to only 23.1% in the 35 – 44 age group. This pattern of drinking was also predominantly male (75%). When the age groups are examined in greater detail, young women in the 15 – 19 group are more likely to have consumed alcohol in the last 30 days than young men (51.3% women to 48.7% men) whilst men are more likely to have drunk alcohol when they are in the 40 – 44 age group (57.3% men to 42.7% women). However, the frequency of consumption for young women is low whilst for older men ii is relatively high.

There is some data on the use of pharmaceutical products. 22.5% of respondents reported use of sedatives and/or tranquillisers. Of these, 81.4% stated that the drugs had been medically prescribed and had been used as directed. 9.3% reported having obtained these drugs both with and without a prescription, 60% of this group being women and 44.6% being in the 25 – 34 age group.

The data on other drug use was reported in the last National Report and there is no additional information. As might be expected, it shows that the percentage reporting use of a controlled drug at least once in their life is significantly higher than use in the last year or last month. It is noticeable, however, that lifetime prevalence is highest for the 25

– 34 age group and lowest for the 35 – 44 age group, but for last year and last month prevalence, the highest percentage of use is amongst the 15 – 24 age group. Table 7 shows prevalence for any unlawful use of a controlled drug by age group. As can be seen from this, current drug use is predominantly in the younger population and is predominantly a masculine activity.

Prevalence of use of any controlled drug in the general population

	15 – 24			25 – 34			35 - 44		
	Ever	L.Year	L.Month	Ever	L.Year	L.Month	Ever	L.Year	L.Month
Male	27.5	15.4	12.2	35.9	11.1	7.9	22.5	1.9	1.0
Female	19.1	8.9	6.8	17.9	5.1	3.0	14.0	1.1	1.0
TOTAL	22.8	11.8	9.2	26.0	7.8	5.2	18.2	1.5	1.0

Table 7 *Source: OIDT*

This pattern applies across all drugs with the exception of last month prevalence of ecstasy and cocaine use. None of the male respondents in the 15 – 24 age group reported ecstasy use whilst 0.7% of males in the 25 – 34 age group reported such use. By contrast, 0.3% of females in the 15 – 24 group reported use but no females in the 25 – 35 age group. For cocaine, 1.4% of males in the 15 – 24 age group reported use whilst 1.6% of males in the 25 – 34 group reported use. This suggests that there may be some difficulty in interpreting some of the details of reported unlawful drug use given that local surveys and research which have previously been reported suggest that use of ecstasy or of substances sold as ecstasy is found in both age groups.

Drug Use in the School Age Population – ESPAD Italia

The ESPAD Italia survey has now been conducted for four consecutive years. Additionally, data from the first survey, carried out in 1995 is also available although its information is not always comparable with the recent series. The data includes information on alcohol, tobacco and other drug use and has two elements. The first is concerned with attitudes to the use of the different substances, the second is concerned with the experience of personal use of these substances.

Attitudes to use and perceptions of risk from using once or twice

	Approve				Disapprove				No Risk				Don't Know			
	1999	2000	2001	2002	1999	2000	2001	2002	1999	2000	2001	2002	1999	2000	2001	2002
LSD	11	10	13	11	84	86	83	84	2	2	1	2	5	4	4	5
Cocaine	10	11	12	12	87	86	84	84	2	2	2	2	3	3	4	4
Amph.	10	10	11	10	85	86	84	85	3	2	2	2	5	4	5	5
Ecstasy	10	9	11	11	86	87	85	85	2	2	1	2	4	4	4	4
Sed/Tranqu	9	10	11	11	85	83	83	83	-	-	-	-	6	7	6	6
Crack	7	8	10	10	89	88	85	86	2	2	2	2	4	4	5	5
Heroin	6	7	9	9	90	89	87	87	-	-	-	-	4	4	4	4

Table 8 *Source: OIDT*

Table 8 shows attitudes to use and perceptions of risk from using different drugs once or twice and the changes which have occurred over time. As can be seen from this data, between 1999 and 2002 there has been a rise in the percent of young people approving of use of all the drugs listed with the exception of LSD and amphetamines. For LSD, after a rise in use approval rating in 2001, it has returned to the 1999 level. With amphetamines the use approval rating has remained constant throughout the period. The approval rating for trying heroin shows a very noticeable increase from 6% in 1999 to 9% in 2002, as does that for crack cocaine from 7% to 10% in the same period. The reason for these changes is not entirely clear and there may be several different factors at work. The reported lifetime prevalence of heroin and crack use amongst this population has also risen over this period, especially smoked heroin. More people may therefore know of someone who has tried heroin or crack cocaine and they may be disinclined to express disapproval of the behaviour of their peers. At the same time, the

perception of risk from using any of the drugs listed has remained constant over time and this itself may be a protective factor for the majority of students. Table 9 shows information on the use of different substances reported by young people. There has been a steady increase in reported use of alcohol over the four year period, although there has been a slight reduction in reports of having been intoxicated. The reported use of

Percentage of young people reporting use in their life of:

	1999	2000	2001	2002		1999	2000	2001	2002
Alcohol	86.5	89.4	87.4	89.0	LSD	3.4	2.7	2.2	2.3
Tabacco	70.4	67.9	67.8	68.1	Amphetamine	3.1	1.5	2.0	2.0
Been intoxicated	52.7	55	55.2	54.6	Ecstasy	3.1	3.1	2.6	2.7
Cannabis	33.3	30.9	32.7	33.5	Heroin (smoked)	3.1	4.2	2.0	3.8
Alcohol and cannabis	32	30.9	22.1	21.6	Hallucinogenic mushrooms	1.6	1.4	1.4	2.1
Sedatives and tranquillisers	7.4	7.5	6.5	6.0	Heroin other than by smoking	0.8	0.8	0.9	0.7
Inhalants	6.4	6.1	5.1	6.6	Anabolic steroids	0.7	1.1	0.6	0.7
Cocaine	4.8	4.2	4.1	5.1	Crack	0.7	0.9	0.6	1.4
Alcohol together with pills	3.9	2.5	2.0	2.4	Drugs by injection	0.2	0.3	0.4	0.5

Table 9

Source: ESPAD Italian data

cannabis has also shown an increase from a low of 30.9% in 2000 to 33.5% in 2002, but the reported use of alcohol in combination with cannabis or with pills has significantly declined. There are some developments of note, specifically a continued increase in reported use of cocaine and/or crack cocaine, of hallucinogenic mushrooms and of smoked heroin. There has also been a continued increase in the lifetime prevalence of injecting drugs. Although the percentage for this latter group is small, it is nevertheless a matter for some concern.

Table 10 shows data on last 12 months prevalence for the substances most used by young people. As can be seen from this data, it broadly confirms the trends identified in

The Spread of Drug Use: Comparative Analysis	ESPAD				
	1995 %	1999 %	2000 %	2001 %	2002 %
Consumption of alcohol in the last 12 months	76	79	82	79	83
Being drunk in the last 12 months	36	39	41	42	41
Smoked cigarettes - ever	66	70	68	68	68
Smoked at least one cigarette a day in the last 30 days	n.a.	30	28	28	27
Used cannabis - ever	25	33	30	33	34
Used cannabis in the last 12 months	n.a.	27	25	27	27
Used tranquillisers / sedatives - ever	10	7	7	7	6
Used alcohol and pills - ever	5	4	3	2	2.4

Table 10

Source: ESPAD Italian data

the lifetime prevalence data. Alcohol consumption and experience of being drunk in the last 12 months has shown a steady increase whilst the prevalence of tobacco use has declined. Lifetime prevalence of cannabis use appears to have stabilised with just over one in every three students reporting use on at least one occasion. Of those who have used cannabis at least once, the vast majority have used it in the last 12 months.

Table 11 shows the age of first use of a range of drugs. The patterns which have been reported in previous years appear to be confirmed from this data. Wine, and to a slightly lesser extent beer, are the first substances used by the majority of young people, commonly when 11 or younger. This is almost certainly under adult supervision and most probably in the context of a family celebration. Students first drink spirits between the ages of 13 and 14 and again this is likely to be in the context of a family celebration. The first experience of being drunk, however, is much more likely to occur aged 15 or over, suggesting that this occurs within the peer group as part of adolescent testing out. Cigarettes are first tried between the ages of 13 and 14 but regular smoking begins most commonly aged 15 or over. The illicit use of controlled drugs is relatively rare and in

Age of First Use (Percent)	11 or less				12				13				14				15				16 or more			
	99	00	*01*	02	*99*	00	*01*	02	*99*	00	*01*	02	*99*	00	*01*	02	*99*	00	*01*	02	*99*	00	*01*	02
Drank beer	*18*	18	*23*	18	*14*	14	*16*	14	*16*	15	*14*	16	*17*	18	*16*	17	*10*	12	*10*	10	*8*	8	*7*	9
Drank wine	*23*	25	*25*	21	*11*	11	*12*	11	*12*	12	*11*	13	*12*	14	*12*	12	*8*	8	*10*	8	*7*	7	*7*	8
Drank spirits	*5*	5	*8*	6	*7*	6	*8*	6	*10*	10	*13*	11	*15*	19	*15*	17	*14*	15	*14*	15	*14*	14	*13*	15
Being drunk	*1*	1	*2*	2	*2*	2	*2*	2	*5*	6	*5*	5	*12*	13	*12*	13	*14*	14	*14*	13	*18*	19	*19*	19
Smoked first cigarette	*7*	6	*9*	7	*11*	10	*9*	8	*13*	13	*13*	13	*17*	18	*16*	18	*12*	12	*12*	11	*10*	10	*9*	9
Smoked daily	*1*	-	*1*	1	*2*	2	*1*	1	*4*	4	*3*	4	*10*	8	*7*	9	*9*	10	*10*	9	*12*	12	*11*	12
Tried amphetamines	-	-	-	-	-	-	-	-	-	-	-	-	*1*	-	*1*	1	*1*	1	*1*	-	*1*	1	*1*	2
Tried sedatives / tranquillisers	-	-	*1*	-	-	-	-	-	*1*	1	*1*	1	*1*	1	*1*	1	*1*	1	*1*	1	*1*	2	*1*	2
Tried cannabis	-	-	*1*	-	*1*	1	*1*	1	*2*	2	*2*	2	*7*	6	*7*	6	*9*	8	*7*	8	*10*	10	*13*	11
Tried LSD / hallucinogens	-	-	-	-	-	-	-	-	-	-	-	-	*1*	-	-	1	*1*	1	*1*	1	*2*	2	*14*	2
Tried crack	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Tried cocaine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	*1*	-	*1*	1	*1*	1	*3*	3	*2*	4
Tried ecstasy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	*2*	2	*1*	2
Tried heroin	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	*1*	1	*1*	1
Tried alcohol with pills	-	-	-	-	-	-	-	-	-	-	-	-	*1*	-	-	1	*1*	1	-	1	*1*	1	*1*	1

Table 11

Source: ESPAD Italian data

general occurs aged 16 or older. First use of cannabis, however, tends to occur at a slightly earlier age, probably related to its relatively greater availability, less disapproval of us and the lower risks perceived in using this drug once of twice.

Drug Use in the Armed Services

The other national data available on drug use within a general population relates to reported drug use by members of the armed services. Table 12 shows the number of people and the percentage this number represents of the total reported cases. For all the data from the services, a significant change can be observed between the years 2000 and 2001. This coincides with the ending of conscription of young males and a likely difference between the population which has chosen the armed services as a career and the wider male population. Although there has been a change, the trend of the data has

Drugs most used within the armed services

Type of Drug	*Number*						*%*					
	1996	*1998*	*1999*	*2000*	*2001*	*2002*	*1996*	*1998*	*1999*	*2000*	*2001*	*2002*
Heroin / 0ther opiates	112	288	185	126	64	55	5.9	9.9	7.4	7.1	7.3	6.7
Alcohol	2	61	63				0.1	2.1	2.5			
Barbiturates		1	0	1	1			0.0	0.0	0.06	0.1	
Hypnotic sedatives		7	2	1	0			0.2	0.1	0.06	0	
Amphetamine / Ecstasy	5	89	49	52	19	3	0.3	3.2	1.9	2.6	2.2	0.4
Cocaine / Crack	13	206	221	117	56	70	0.7	7.2	8.8	6.6	6.3	8.5
Marijuana/Hashish	1,749	2,097	1,968	1423	691	690	92.8	73.5	78.7	79.9	77.9	83.6
Hallucinogens	1	20	12	8	2		0.05	0.7	0.5	0.5	0.2	
Inhalants	1	1	0	2	0		0.05	0.0	0.0	0.1	0	
Other drugs		82	3	50	54	7		2.9	0.1	2.8	6.1	0.8
Total	***1,884***	***2,852***	***2,503***	***1780***	***887***	***825***	***100***	***100***	***100***	***100***	***100***	***100***

Table 12

Source: Ministry of Defence

remained broadly consistent over time. A specific caveat needs to be entered on some of the data, especially drugs used, where in 2001 and 2002 data is only available for less than half of those reported for drug use. In terms of the drugs most commonly used, cannabis has continued to be predominant with over 80% of cases where data was known related to cannabis use. Use of heroin or other opiates and of amphetamines or ecstasy has declined over time but use of cocaine has shown a continued increase. These patterns are broadly similar to those found in both the general population and student population surveys.

Data on frequency of use, time of first use and motivation for use is shown in Tables 13 to 15. Frequency of use patterns changes between 2000 and 2001 with those reporting daily use falling by over half and several times a week use almost halving. Although the

Distribution of users by frequency of use

Frequency of use	***Number***					***%***				
	1998	*1999*	*2000*	*2001*	*2002*	*1998*	*1999*	*2000*	*2001*	*2002*
Several times a year	537	520	327	180	456	18.9	17.4	21.5	11.4	28.9
Several times a month	735	741	539	293	294	25.9	24.8	35.4	18.6	18.6
Several times a week	647	640	434	235	219	22.8	21.4	28.5	14.9	13.9
Daily	298	266	168	76	67	10.5	8.9	11	4.8	4.2
Not known	635	825	56	793	543	21.9	27.5	3.7	50.3	34.4
Total	***2,852***	***2,990***	***1,524***	***1,577***	***1,579***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***

Table 13 *Source: Ministry of Defence*

Distribution of users by occasion of first use

Period	***Number***					***%***				
	1998	*1999*	*2000*	*2001*	*2002*	*1998*	*1999*	*2000*	*2001*	*2002*
Before enlistment	402	432	325	1,069	1,187	14.2	14.4	15.9	67.8	75.2
After enlistment	2,003	2,257	1633	297	309	70.6	75.5	80	18.8	19.6
Not known	433	301	83	211	83	15.3	10.1	4.1	13.4	5.2
Total	***2,838***	***2,990***	***2041***	***1,577***	***1,579***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***

Table 14 *Source: Ministry of Defence*

Distribution of users by motivation for use

Motive	***Number***					***%***				
	1998	*1999*	*2000*	*2001*	*2002*	*1998*	*1999*	*2000*	*2001*	*2002*
Group pressure	121	123	136	173	558	30.1	28.4	37.8	11.0	35.3
Psychological pressures	14	19	8	3	5	3.5	4.4	2.2	0.2	0.3
Curiosity	164	213	154	128	139	40.8	49.4	42.8	8.1	8.8
Meeting a dealer	5	2	1	1	1	1.2	0.5	0.3	0.1	0.1
Personal problems	66	55	40	28	17	16.4	12.7	11.1	1.8	1.1
Other	32	20	21	1244	859	8.0	4.6	5.8	78.9	54.4
Total	***402***	***432***	***360***	***1,577***	***1,579***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***

Table 15 *Source: Ministry of Defence*

percentage of cases where frequency of use was not known rose to half of all cases in 2001 and over one third of cases in 2002, it is likely that use was infrequent and non-dependent. Period of first use shows a major change between 2000 and 2001. Whereas in the earlier period use most commonly occurred after enlistment, in the later period use most commonly occurred prior to enlistment. The implication is that when conscription

was operating there was a spectrum of the male population who were susceptible to the peer pressure of a large group of relatively young men and who would also have their fair share of personal problems. By contrast, those who entered the services post the end of conscription were less likely to be drug users and those who did use drugs were in all probability maintaining a form of recreational behaviour which had developed prior to enlistment. Such an interpretation gains some confirmation from the data on motivation for use. Whilst peer pressure has remained broadly consistent (the large reduction in this in 2001 appears to have been a statistical anomaly) curiosity has fallen sharply as a motivation and "other" reasons dominate. There is some difficulty in fuller analysis of the data because the way in which data is recorded is dependent upon individual interpretations which may vary from one person to another, and also upon the reason the information came to light – a personal / health problem or a disciplinary offence. Nevertheless, over time the data has had consistency with the patterns identified in more general population surveys suggesting that it is still a useful marker to confirm general trends in illicit drug use.

Combination Survey

A study carried out in the Veneto Region by the Health Service Epidemiology and Rsearch Section based in the Institute of Clinical Physiology of the National Research Council combined the general population and school survey methodologies, along with data on referrals for drug possession and from both public and private treatment services. The total population under consideration was 1.9 million people in the age range 15 to 44. From this work, in terms of drug use within the general population (including the school population): 84,852 people, representing 4.3% of the population, had been drunk ten or more times during 2000; 128,841 (6.6%) had used cannabis ten or more times during the year; 19,834 (1.04%) had used other controlled drugs three or more times during the year. Further local studies are being carried out by the section but results have not yet been published.

2.3 Problem drug use

National and local estimates

Table 16 reports on estimates of heroin use by different methodologies over time. It was noted last year that this data suggested that after a continuing increase in the estimates

Estimates of heroin use (Absolute values of estimates and range of the estimates).

Year	Extrapolation from Ministry of the Interior data	Extrapolation from treatment demand data	Capture-recapture method	Multivariate indicator method	Back calculation HIV/ AIDS multiplier method	Range between the estimates
1996	172,000	299,000	274,000	248,672	326,000	172,000 - 326,000
1999	281,273	276,746	297,711	302,829	406,176	276,746 - 406,176
2000	272,513	292,196	309,850	319,447	437,983	272,513 - 437,983
2001	251,864	279,820	268,660	233,075	470,378	233,075 - 470,378
2002	306,653	270,096	281,844	314,002	n.a.	270,096 – 314,002

Table 16 *Source: OIDT*

between 1996 and 2000, in 2001 there had been a consistent reduction in the estimates arising from the four different methodologies which had been employed. This could suggest that the steady increase in problematic drug use which had been noted during the second half of the 1990s had peaked but data from 2002 was required to confirm if this was the case. As can be seen from the table, in 2002 for three of the four methodologies used there has been an increase in the estimates of heroin use. The exception is extrapolation from treatment demand data, although this might be influenced by under-reporting of treatment data from some Regions. Figure 1 provides a graphic presentation of the estimates data excluding the back calculation method. This suggests that, setting aside the 2001, the estimates for recent years have remained constant although this results in a slight reduction in the estimate of the number of users per 10,000 population in the 15 – 64 age range. For 2000 the maximum, minimum and median estimates of heroin use per 100,000 population were respectively 81.9, 69.9 and 76.5 whilst for 2002 the corresponding figures were 80.8, 69.5 and 75.4.

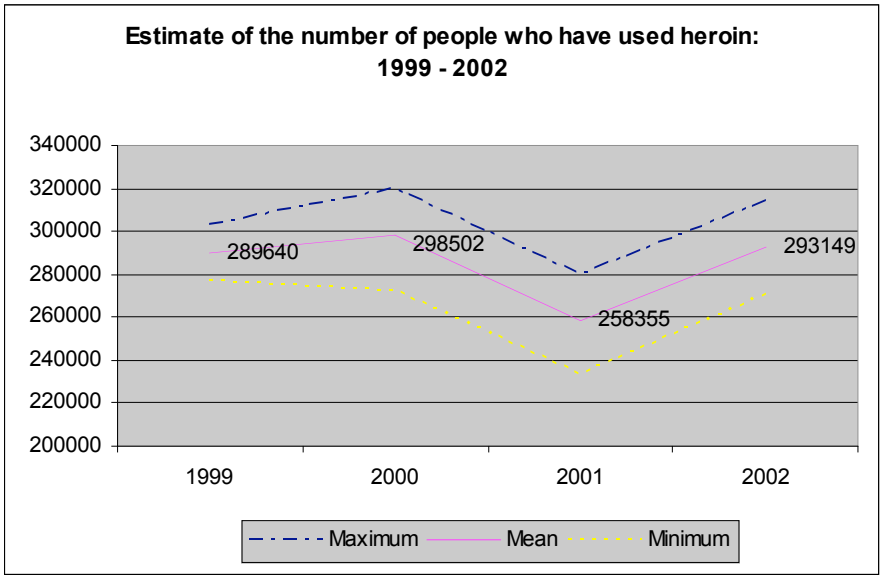


Figure 1

Source: OIDT

There is little data available on local estimates of problematic drug use although there is substantial data available on socio-demographic characteristics of those in contact with treatment services (public and private). Most of this data comes from local observatories in the north and central Regions of Italy, with less data available from local sources in the southern Regions. Discussion on this data is included in later sections of this report.

The study conducted in the Veneto Region (see earlier reference) estimated that there were 16,500 problem drug users in the Region, with 10,057 already in treatment with a public or private service. This is interesting data in itself because it suggests that just under 61% of those considered to be in need of treatment were receiving it. If this is the case it is a relatively high proportion considered against other reported data on the ratio of treatment provision to treatment need. At present it is not possible to say if this result is representative of Italy or only for the Veneto Region and when data from the other studies starts to become available it will be possible to make a fuller judgement on the proportion of problem drug users in contact with treatment services.

Risk behaviours and trends

There is limited data available on risk behaviours and trends in such behaviour. Heroin remains the most widely used drug amongst those presenting to services with drug problems and it is most commonly injected. Over the last four years, the percentage of those attending the Ser.T. who use heroin by injection has gradually fallen from 77.4% in 1998 to 69.7% in 2002. There has also been a reduction in the percentage of all clients of the Ser.T. testing positive for HIV infection in the same period. However, there was an increase in the percentage of clients testing positive for both Hepatitis B and Hepatitis C between 2000 and 2001, suggesting that risk behaviours which might lead to infections have continued at a significant level.

There has been a marked reduction in the number of direct drug-related deaths which has maintained the general downward trend over recent years, again suggesting reduced risk behaviours in relation to overdose. Although there remains substantial numbers using more than one drug, the data suggests that this is not leading to increased mortality. The evidence available from the treatment demand data shows that there has been a further reduction in primary use of heroin and that use of heroin by methods other than injection has increased. This has been confirmed by reports emanating from a national project aimed to identify new trends in drug use.
At the national level there is no additional information readily available on more specific risk behaviours and the available data at Regional or more local level does not, in general, provide detailed analysis of risk behaviours. Rather, it reports on indicators which are already used at the national level. A search of documents and web sites in Italy has produced no additional data on trends in injection equipment sharing, on unsafe sexual practices or on other drug-related risk behaviours.

3. Health Consequences

3.1 Drug treatment demand

Characteristics of clients
Figure 2 shows the treatment demand for Italy as a whole. In 2002 there was a further increase in the number of clients already in treatment with the Ser.T. to 126,063 and a slight decrease in the number of new clients to the Ser.T. to 32,802. However, this decrease is so small that it can readily explained by under-reporting from a small number of Ser.T.s. What is clear from the data is that whilst new treatment demand has remained constant over time, the number of people continuing in treatment has continued to rise each year. As can be seen from this figure, all treatment demand has risen throughout Italy and this is largely due to a continuing rise in demand from males. Whilst there has been an increase in females receiving treatment the ratio of males to females has continued to increase.

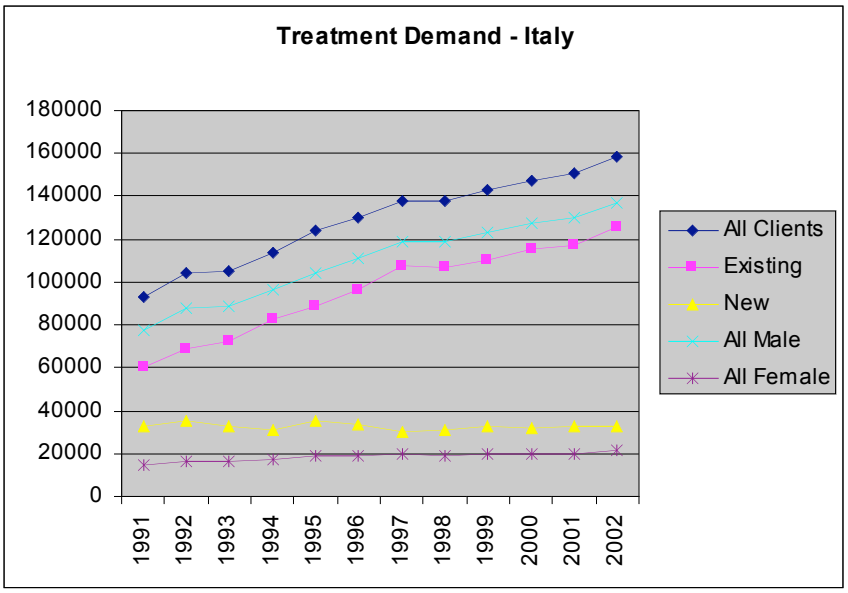
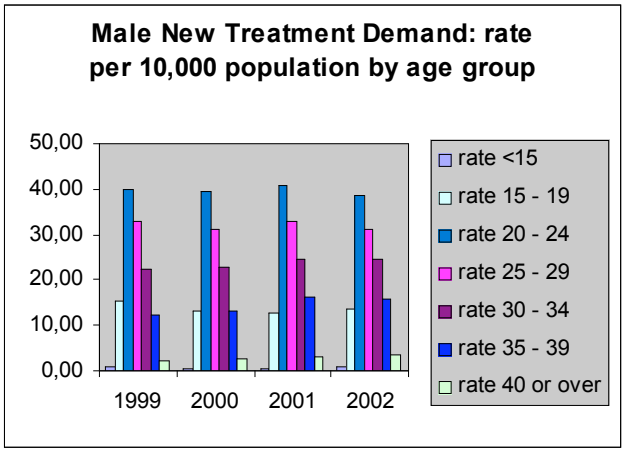
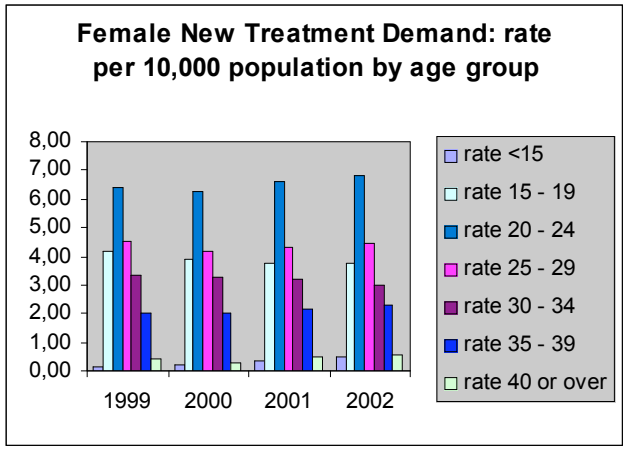
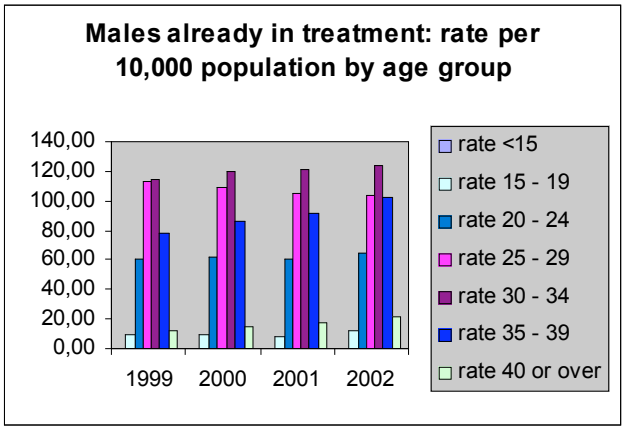


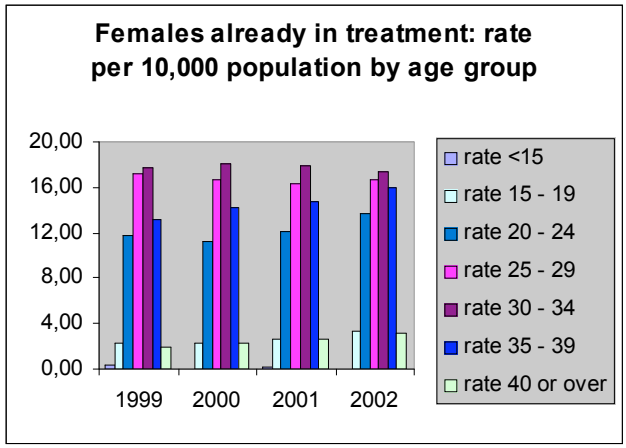
Figure 2

Source: Ministry of Health









Figures 3 - 6

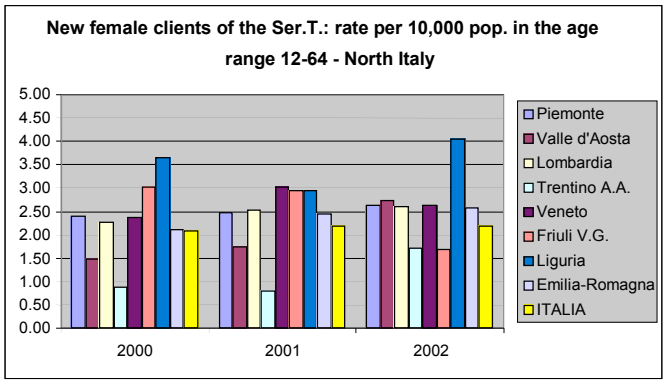
Source: Ministry of Health and ISTAT

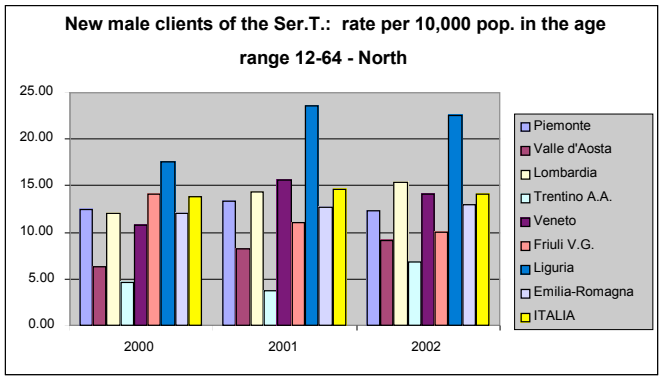
Figures 3 – 6 show the treatment demand rate per 10,000 population. For new male clients, the rate has remained at about the same level as for 2001, as has the rate for new female clients. For both male and female new clients, there has been a continuing increase in treatment demand from the 40 or older age group. It is noticeable that females appear to seek treatment earlier than males and this may also have an impact on the male : female ratio in treatment in that earlier entry into treatment might also result in earlier completion. Unfortunately there is no research data currently available which could provide fuller understanding of treatment patterns in terms of sex and age group. By contrast, the treatment demand rate from clients continuing in treatment has increased for both male and female clients and for almost every age group – the exceptions are males aged 25 – 29 and females aged under 15 or in the age group 30 – 34. In all instances the reduction is small.

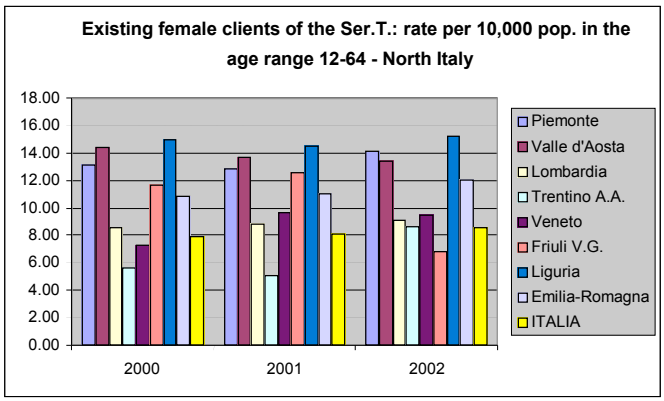
Figures 7 to 18 show the treatment demand rate per 10,000 population by Region of Italy by sex and by new and existing treatment demand. The rate for Italy as a whole has been included for reference in each figure. As can be seen from the data, there are considerable variations between Regions and between areas of Italy. Although there are some instances of large rate changes from one year to the next in some Regions, this is largely accounted for by under-reporting in a single year, corrected in a succeeding year.

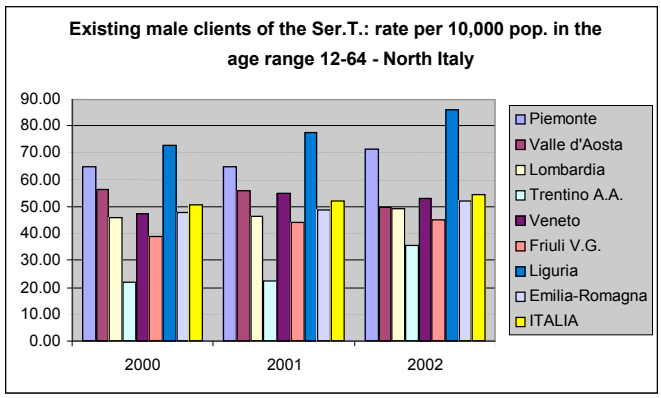
In general the data shows that treatment demand is greatest in the more densely populated Regions and in larger urban areas. It also shows that the treatment demand rate from females is higher in the northern and the central Regions than in southern Regions. This difference in male and female treatment demand between the north and south has been noted in previous reports. There are broad similarities in male treatment demand from both new and existing clients throughout Italy, with the southern Regions overall having a slightly higher rate per 10,000 population than the north and south. For female treatment demand, however, the southern Regions in general show a much lower rate than either the central or northern Regions. Looking at individual Regions, Liguria and Umbria continue to show the highest treatment demand rates overall and have the

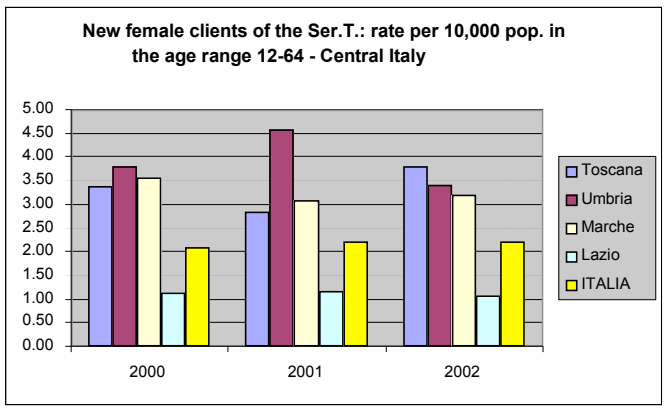
highest rates in almost all categories. Some Regions, such as Abruzzo and Calabria, have shown increased rates for particular groups of clients, for instance new and existing female clients. It is not clear at present whether this reflects a real change in treatment demand or a change in treatment practice which has resulted in more female drug users coming forward for assistance. At present it is not possible to identify the primary drug

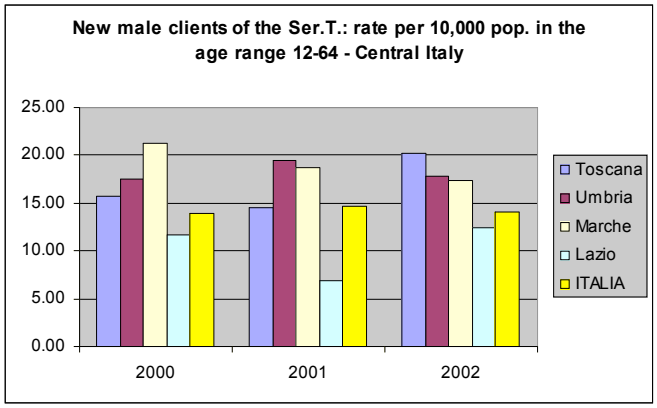


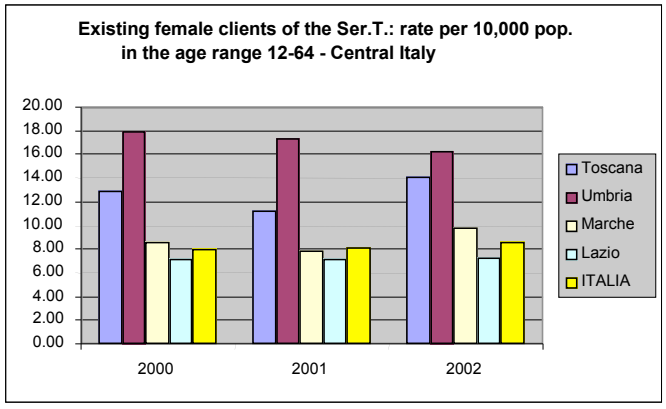


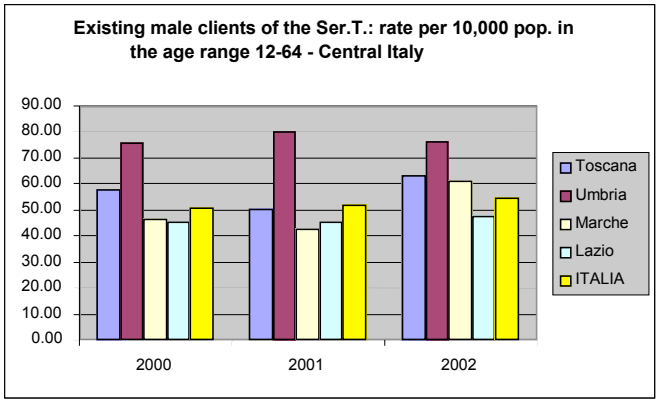


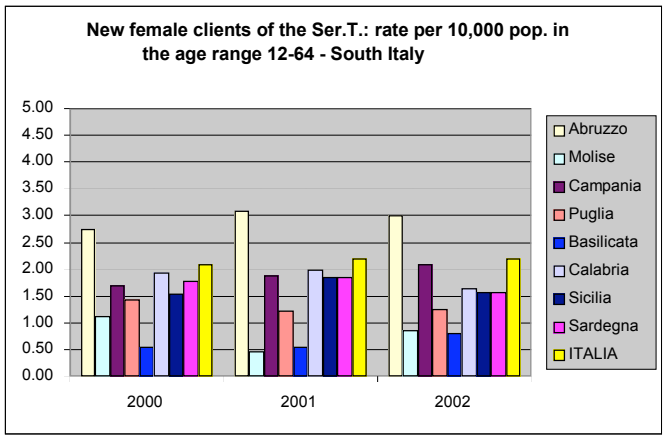


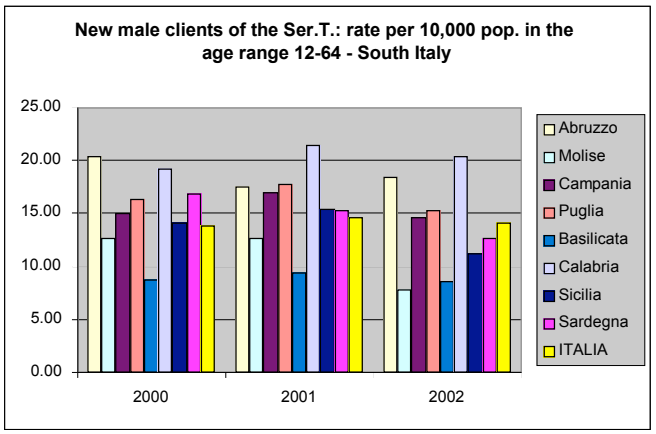


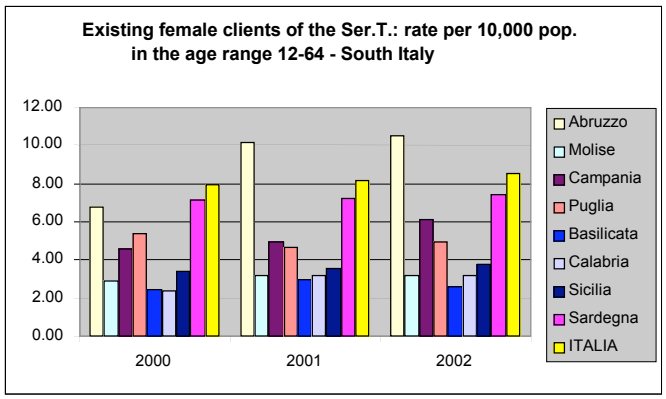


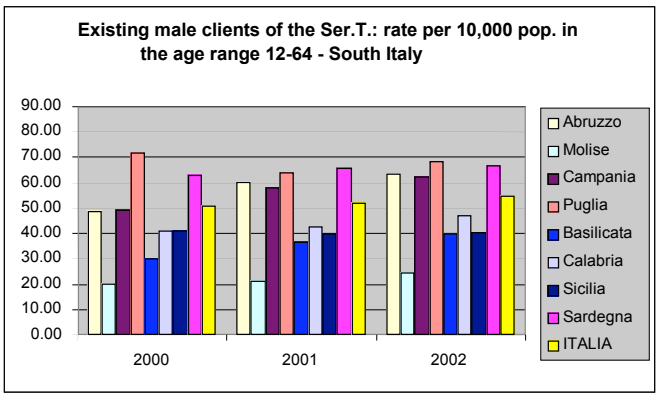












Figures 7 - 18

Sources: Ministry of Health and ISTAT

use of new clients as opposed to that of all clients or by sex. It may be that the primary drug use of females is different to that of men and that the primary drug use of new female clients is different from that of existing female clients. Overall the data suggests that treatment demand may be stabilising in terms of new treatment demand. It is also possible that the continuing increase in those remaining in treatment makes it more difficult for new clients to be accepted, although there have been no specific reports of demand for treatment exceeding available capacity.

Figure 19 shows the location of treatment provided to drug users in contact with the Ser.T. There has been a continuing slow decrease in the percentage of clients treated directly within the Ser.T., the percentage treated within a socio-rehabilitation service has remained broadly stable and the largest increase has been in the treatment of drug users within the prison system. This does not indicate necessarily a higher number of drug users requiring treatment coming into the prison system. It is more likely to reflect the responsibility for prison health care being transferred to the national health system with drug treatment being one of the first areas to be transferred.

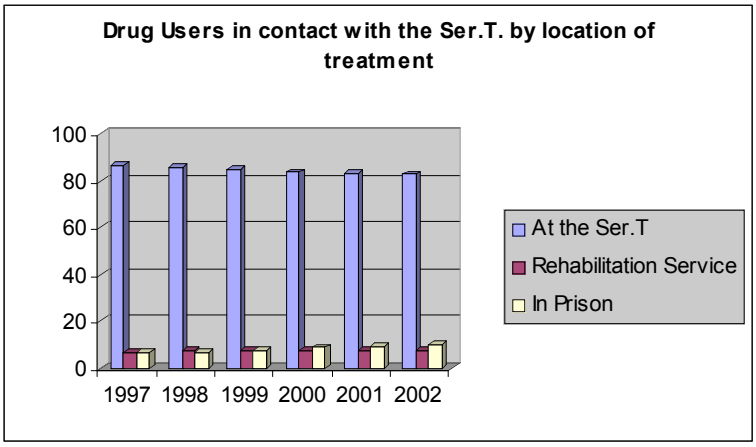


Figure 19

Source: Ministry of Health

In terms of primary drug use the data (Figure 20) shows that whilst heroin is the most widely used drug, with 79.5% of all treatment demand arising from primary heroin use,

there has been a continuing fall in primary use of heroin and of use of heroin by injection. At the same time, there have been increases in the primary use of cocaine and cannabis. In terms of secondary drug use (Figure 21) the use of heroin is relatively uncommon, although there has been a slight upward trend over time from 1.3% in 1991 to 3% in 2002. The secondary use

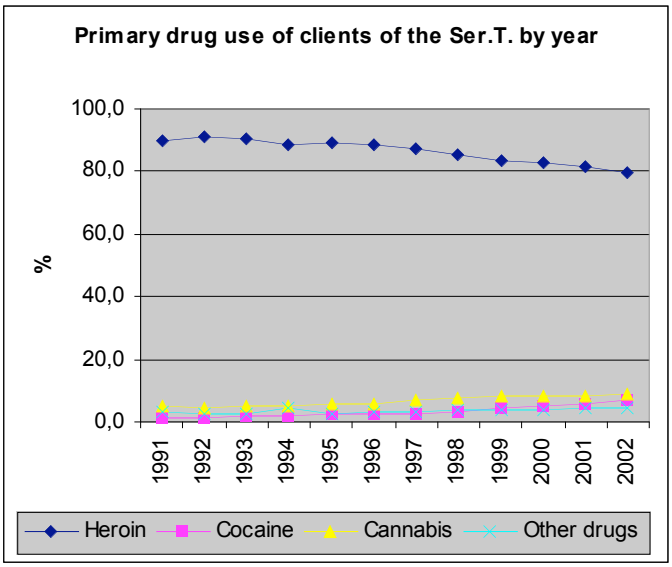


Figure 20

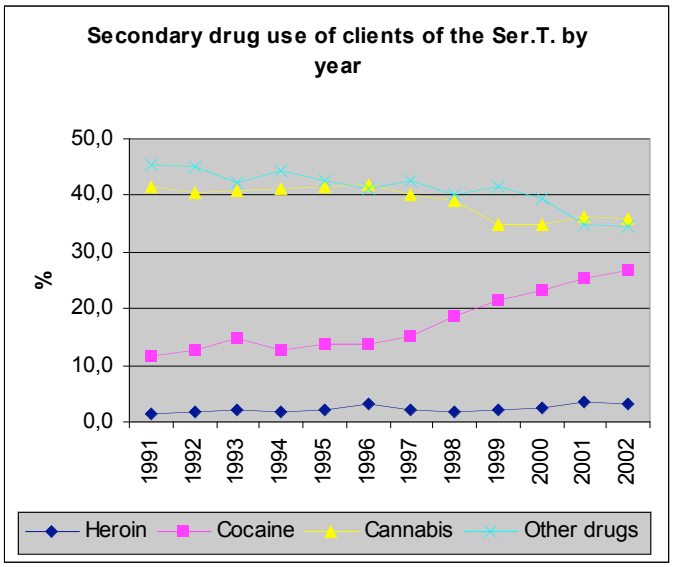


Figure 21

Source: Ministry of Health

of cannabis and of other drugs has shown a slight downward trend over the same period. Secondary use of cocaine, however, has shown a steady increase from 11.8% in 1991 to 26.6% in 2002. This data confirms a trend which has been noted in previous reports for a steady reduction in heroin use and in heroin injection with increasing diversity in the range of drugs being used and a significant increase in the use of cocaine specifically. From the data it is clear that poly-drug use is common. What is less clear is whether this is use of a cocktail of drugs in search of specific effects or if different substances are used independently for their specific properties. Data from an unpublished report on a national research project suggests that there is a definite trend towards the use of drug combinations to enhance the effects of a particular substance or to counter anticipated adverse effects.

There is limited data available on the characteristics of drug users seeking treatment for a drug problem. The regional drug observatories which provide more extensive client profiles than those available from the nationally collected statistics have not yet published annual reports covering 2002 data. The 2001 data from, for instance, Emilia Romagna was provided in the last National Report and no update is available. The local observatories of Modena and Bologna Metropolitan area have published reports for 2002 and have provided data on the educational level of the clients of the Ser.T. (Table 17). As can be seen from this, the majority of clients did not progress beyond compulsory schooling. It is also noticeable that female clients were more likely to have higher educational attainment

Educational attainments of clients of the Ser.T. – Modena & Bologna	Modena		Bologna	
	Female	Male	In treatment	New clients
No qualification	0.5	0.8	0.3	-
Elementary school certificate	10.2	17	8.8	6.2
Lower middle school certificate	61.8	63.6	60.3	54.6
Vocational qualification	14	8	8.3	7.3
Upper middle school certificate	10.9	9.9	18.3	23.5
Short degree course	1.1	0.3	0.5	0.5
Higher degree course	1.6	0.5	2.0	3.5
Not known			1.5	6.5

Table 17

Sources: Bologna Metropolitan & Modena Observatories for Pathological Dependencies

than male clients. The Modena Observatory also correlated educational attainment with primary drug use. This showed an association between higher educational qualifications and the use of cocaine, particularly amongst females. Data from this report also confirmed the national trend for longer retention in treatment of drug users and a reduction in the number of new clients. Using an index of 100 for 1991, the index rose to 159 for all clients in treatment by 2002 but declined to 73 for new clients to treatment with the Ser.T. There is additional data available from the Bologna Metropolitan area observatory. This largely supports the national data and that provided from Modena. It shows that whilst incidence has remained stable over the last three years, the prevalence of problematic drug use amongst the 'at risk' population (15 – 45 age group) has risen. It also indicates the marital status, accommodation and employment of clients (Table 18). It is difficult to make any definitive analysis of this data because the percentage of 'Not known' information for new clients is very high for marital status and high for employment. However, it is noticeable that whilst almost three-quarters of all clients are single only 15.5% live alone. It is also noticeable that the percentage of clients who were unemployed is much higher for new clients and that this situation would not be effected even if information for the 'Not known' group was added.

Marital Status			**Accommodation**		
	Old	New		Old	New
Single	75.2	72.2	With parents	36.9	34.6
Married	11.6	12.3	With partner	22.4	27.5
Separated	6.4	4.2	Alone	15.5	15.2
Divorced	2.3	3.2	Homeless	3.8	19.7
Widowed	0.7	0.6	Institution	13.1	12.6
Not Known	3.8	33.7	Prison	4.2	4.9
Employment			Other	3.8	7.8
Employed	56.2	53.4	Not known	0.3	3.9
Casual	5.5	11.3			
Unemployed	28.7	38.2			
Student	1.9	7.4			
Non professional	3.2	0.6			
Other	2.8	0.3			
Not known	1.7	14.9			

Table 18

Source: Bologna Metropolitan Area Observatory for Pathological Dependencies

3.2 *Drug-related mortality*

The total number of direct drug related deaths recorded in the Special Register has continued to fall and in 2002, at 516, was the lowest recorded in the last decade. The last two years has seen the number of deaths almost halve as can be seen from Figure 22. The fall has been across all age groups but the trend appears to be for a greater number of deaths in the older age groups rather than in the younger age groups. This trend is confirmed when the data is considered by sex and age group (Figures 23 – 24). As can be seen from these figures, the percentage of deaths in the 40 or over age group has risen over time for both men and women whilst the percentage of deaths in the younger age groups has generally shown a steady decline. The exception is in women under 25 where there has been a slight upward trend in recent years. The reason for this is not clear. Data from the General Mortality Register maintained by the National Statistics Institute (ISTAT) is available to 2000.

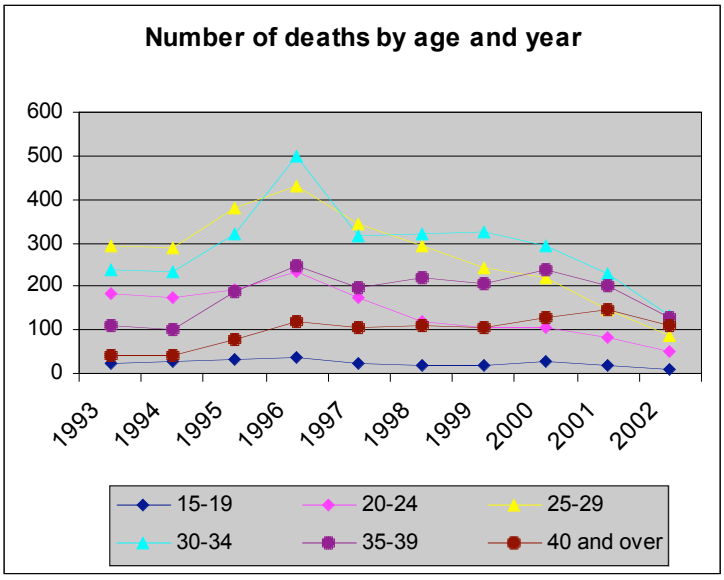


Figure 22

Source: Ministry of the Interior. DCSA

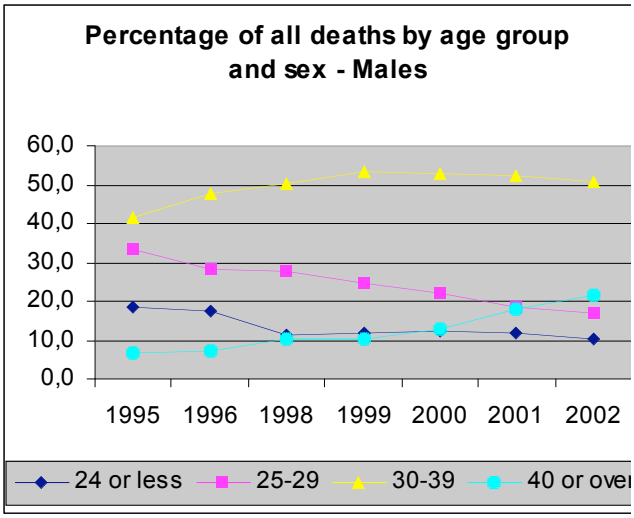


Figure 23

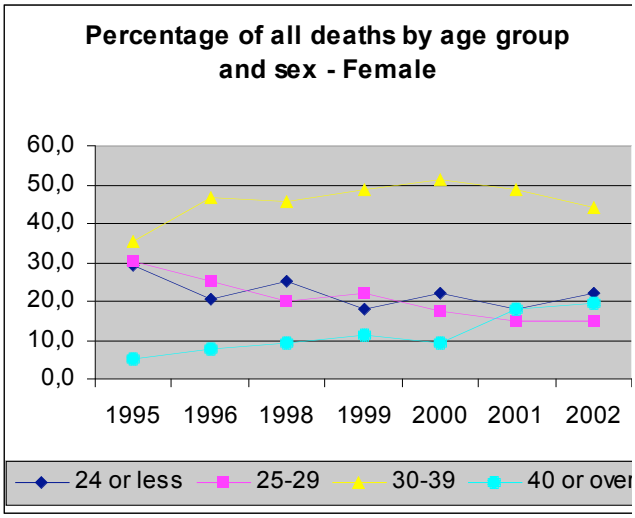


Figure 24

Source: Ministry of the Interior, DSA

This parallels the data from the Special Register maintained by the Central Directorate for Anti-Drug Services (DCSA) of the Ministry of the Interior and suggests that the downward trend is an accurate reflection of the situation in Italy. On the basis of a regression line using the two data sources, since 1996 the median annual reduction in deaths has been 114, equivalent to an 8% reduction per year. The male to female ratio in 2002 was 12 : 1 for all deaths but fell to 5 : 1 for the under 20 age group. This appears to suggest that amongst the younger population, where occasional rather than dependent drug use is more common, lack of drug tolerance and inexperience in terms of drugs and effects may contribute to accidental overdoses. The ratio of deaths in the older population more reflects the ratio of those in treatment with the Ser.T. and is therefore in line with expectations.

The overall reduction in deaths is reflected also in the number of deaths by Region. The exceptions were Lazio and Campania which both recorded an increase in drug-related deaths of 5.4% and 6.3% respectively. Campania has in fact provided an increasing percentage of all drug-related deaths, rising from 10.3% in 1999 to 16.3% in 2002. Campania (18%), along with Umbria (24%) and Sicily (20%) also had a higher percentage of deaths among the under 25 age group than the national percentage (11%).

Data on the drug or drugs implicated in a death is only collected as a result of a request from the magistrate for this to be established. There is, therefore, limited data available. The Italian Group of Forensic Toxicologists has, however, collected data on drug related deaths since 1999 and for 2002 provided data on 348 direct drug related deaths. Whereas the data from the DCSA shows that for almost two-thirds (65.3%) of cases, the drug involved was not established and shows cocaine and amphetamines to be relatively rare, the data from the Forensic Toxicologists indicates that, whilst opiates were a major cause of death, cocaine overdose was also an increasingly important cause. In the period 1991 – 96 2.8% of deaths were cocaine related. By 1999 this had risen to 7.9% and in 2002 it accounted for 13.8% of deaths. It should be emphasised that the data from the Forensic Toxicologists is based on a strict legal definition, established by toxicological test, of a direct cause of death. The data from the DCSA relates to a presumption of death by overdose without conforming to the strict legal test. It should also be noted that the data from the Forensic Toxicologists, whilst having national coverage, is not exhaustive and only relates to data directly available to the Forensic Toxicology Group. Nevertheless, the median age range of 32 for males and 31 for females confirms the DCSA data of the majority of deaths occurring in the 30 – 34 age group. The data from the two sources diverges substantially, however, with regard to the male female ratio. Where the former has a male to female ratio of 11.6 : 1, the latter has a ration of 6.6 : 1. It is not clear why there should be such a significant difference. One possible reason is

that given the much higher male to female ratio in the dug dependent population, there is a greater likelihood of the magistrate requesting a determination of the cause of death. This would then create some distortion in the male to female ratio. What is clear from both data sets, however, is the increasing role of cocaine in drug-related deaths. This confirms the trends noted in both treatment and seizure data for increasing availability and both dependent and casual use of cocaine.

Two research reports on drug related deaths have been published in the reporting period. Pavarin (2003) reports on drug related deaths amongst people referred to the N.O.T. (Nucleo Operativo Tossicodipendenze) by the Prefecture of Bologna. The people referred were those found in unlawful possession of a controlled drug and for whom an assessment of treatment need was sought from the N.O.T. From the introduction into force of DPR 309/90 in 1990 to the end of December 2000 5,946 people were referred, 92% male and 91% of Italian nationality. Half of all referrals related to people found in possession within the city of Bologna and 20% of those referred were resident in Bologna. 75% of referrals were for 'soft' drugs, with cannabis the most common and most of the referrals were unknown to the Ser.T. The study was concerned with the 2,908 people referred in the Province of Bologna between 1990 and 2000 who were resident in the Province when they were referred. ICD-9 was used to classify cause of death. The study is detailed and provides data on educational, employment, civil status, previous referrals and imprisonment as well as on drug use. During the follow-up period, there were 91 deaths, 82 male and 9 female. 24 deaths (23 m, 1 f) were amongst 'soft' drug users, 59 (52 m, 7 f) amongst 'hard' drug users and in 10 cases the drug involved was not recorded. For males and females, overdose was the most common cause of death – 46% and 44% respectively. AIDS accounted for 21% of male and 33% of female deaths. In the group of traumatic deaths there were clear differences between men and women. Whilst for both males and females, 22% of deaths related to traumatic incidents, for males road accidents represented 55.5% of such deaths suicide 22.2% and homicide 5.5%. For females, of the 2 traumatic deaths, one was suicide and the exact cause of the other was not recorded. There was also a clear difference between deaths amongst 'soft' drug users and those amongst 'hard' drug users. For the former, 25% of deaths were from overdose whilst for the latter this accounted for 51% of deaths. AIDS accounted for 17% and road accidents 33% of deaths amongst 'soft' drug users whilst accounting for 27% and 2% of deaths amongst 'hard' drug users. Physical health conditions (tumours, circulatory problems, cirrhosis) accounted for 4% of deaths in 'soft' drug users and 21% of deaths in 'hard' drug users. Using the standard mortality rate, the death rate amongst the cohort was higher than amongst the general population and twice as high amongst women compared to men. When the SMR was calculated by type of drug use, the rate for 'soft' drug users was 3.2 (male) and 3.5 (female) and for 'hard' drug users it was 15.9 (male) and 25.2 (female). Other data arising from this study suggested that death rates were higher amongst those referred when over 35 years of age, both in 'hard' and 'soft' drug users. Other significant data suggests that the relative risk of death was higher amongst unemployed than employed people, amongst those who had previously been arrested or imprisoned and amongst opiate users compared to cannabis users. There were also indications that some of those who were referred for unlawful possession of 'soft' drugs were also 'hard' drug users.

Faggiano et al (2002) report on a study of opiate overdose deaths in Piemonte and Turin. Overdose deaths for the Piemonte Region for the 1981 – 1998 period were extracted from the national mortality register maintained by ISTAT using ICD-9. An analysis was then conducted on adults between the ages of 15 and 54 resident in the Region. Standardised mortality rates were established for the Region per age and 100,000 inhabitants over an 18 year period to provide a basis for comparison. In the study period there were 1,430 overdose deaths, the major concentration being between 1990 and 1996. Overdose deaths represented 3.5% of all deaths in the age range under study with a peak of 6.7% of deaths in Turin in 1995. Male deaths were much higher than female deaths, with female deaths representing only 12% of all overdose deaths. Females represented a larger percentage of all deaths in Turin (15.6%) than in the rest of the Region (11.7%). For males, the standardised rate per 100,000 population was twice as

high for Turin residents (9.63) as for the rest of the Region (4.80) and over three times as high for females (1.86 – Turin, 0.59 – rest of Region). The age group with the highest overdose death risk in the last triennial period examined (1996 – 98) was the 25 – 29 group where overdose deaths represented 15.9% of all causes of death in this age group. It was also noted that the older age group (45 – 54) had a lower death rate from overdose and fatal overdoses occurred in the later years of the study. Overall, the study showed the age of death from overdose to be rising in the last period and this in itself supports the national picture reported through both the DCSA and the Forensic Toxicologists Group data. The study made a specific examination of overdose deaths inTurin for a later period (1998 – 2001), where local data was available which was collected and codified at the Commune at the same time as it was sent to the National Mortality Register. In this period there were 204 deaths in Turin with 167 of these amongst people resident in the city. 96 (47.1%) of those who died were employed and 44 (21.6%) unemployed, with the remaining percentage shared between: awaiting first employment (9.3%), housewife (3.9%), student (4.4%), retired (1%) and other (12.8%). In terms of location of death, the majority (40.2%) occurred in the street, with 22.1% in a private home, 10.3% at the station, 5.9% in hospital, 4.9% in prison, 4.9% in a public open space and 3.4% in a car.
Overall, the data reported from these studies confirms the trends noted in the national data and provides more ethnographic data than is otherwise available. It confirms that deaths arising from overdose of opiates are more common than deaths from other controlled substances and that mortality rates amongst drug users from both overdose and from physical health conditions most commonly associated with drug use are much higher than can be found in the general population. The ratio of male to female deaths is largely in line with that for treatment demand. This may suggest that drug use amongst females is significantly lower in Italy than in some other countries. On the other hand, it may suggest different drug using patterns amongst females and there is some evidence to suggest that female drug users seek help earlier or are referred into treatment at an earlier stage in their drug using career.

3.3 Drug-related infectious diseases

Maps 1 – 5 show the percentage of all clients found HIV positive by year and Region. As can be seen from these, there has been a continued reduction in the percentage of all clients testing HIV positive for Italy as a whole, with greater variations year by year for individual Regions. For most Regions the general trend has been for a lower percentage of Ser.T. clients to test positive for HIV over time. There are, however, some exceptions. Liguria, Marche, Molise, Umbria and Veneto Regions have all shown an increase in the percentage of clients testing positive for HIV infection. Whilst some of these increases are small, they do represent a consistent trend upwards for several Regions, for instance, Liguria, Molise and Umbria which is also reflected in the percentage of clients testing positive for other drug-related infectious diseases. Other Regions, whilst remaining within the same broad percentage 'category' have shown slight variations year by year but with a generally downward trend in the percentage testing positive for HIV infection. There continues to be some difficulty in interpreting the data because for all the drug related infectious diseases there has been a reduction in the percentage of clients of

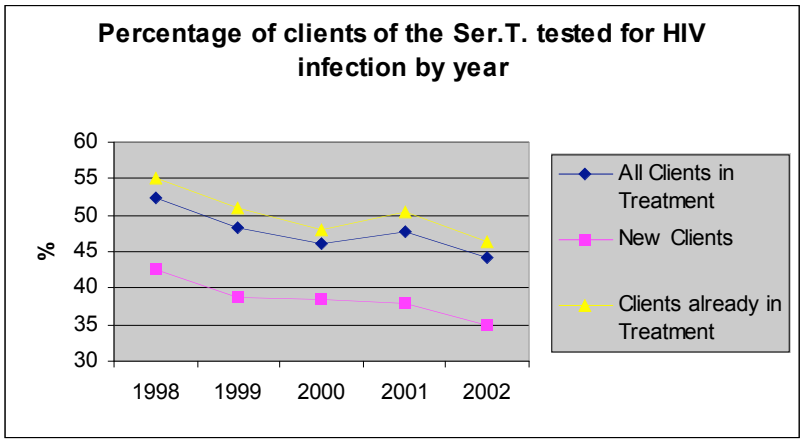
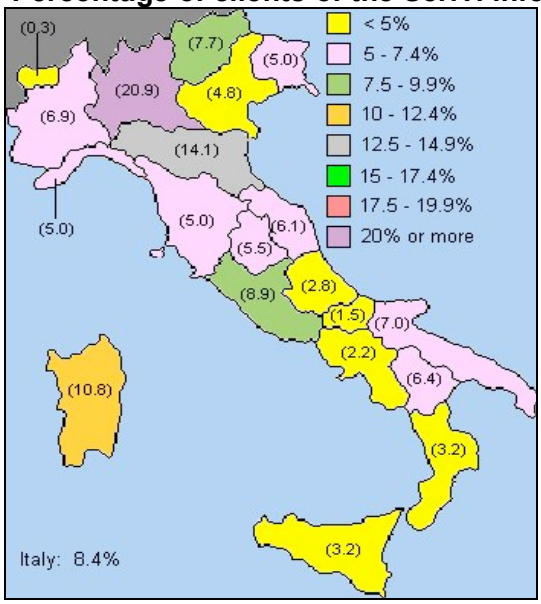


Figure 25

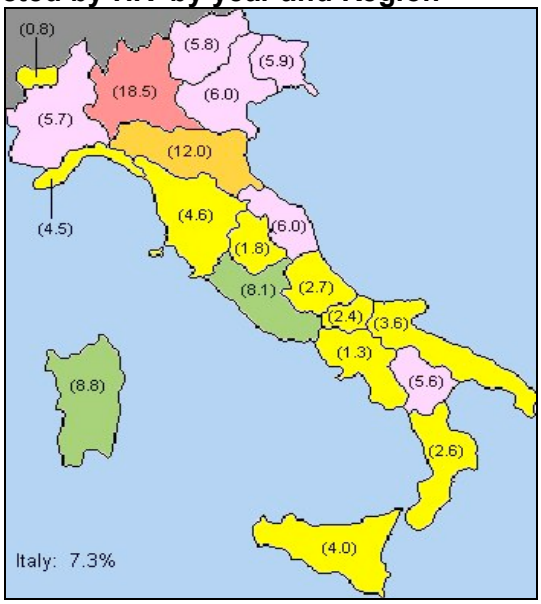
Source: Ministry of Health

the Ser.T. who have been tested, a reduction in the percentage of all clients testing negative and an increase in the number of people who have not been tested or for whom

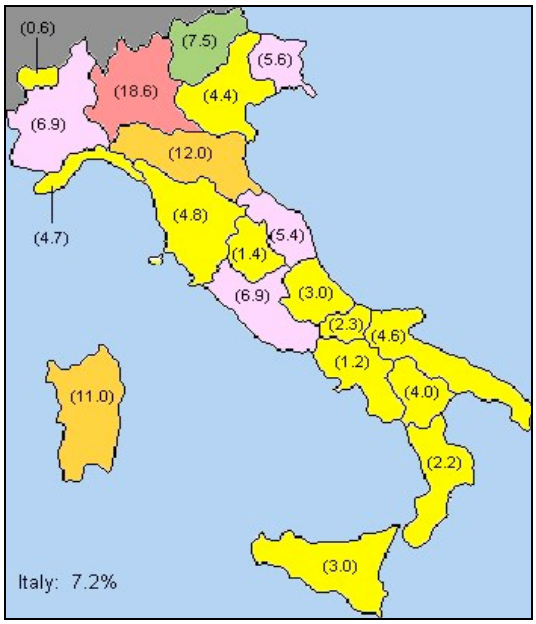
Percentage of clients of the Ser.T. infected by HIV by year and Region



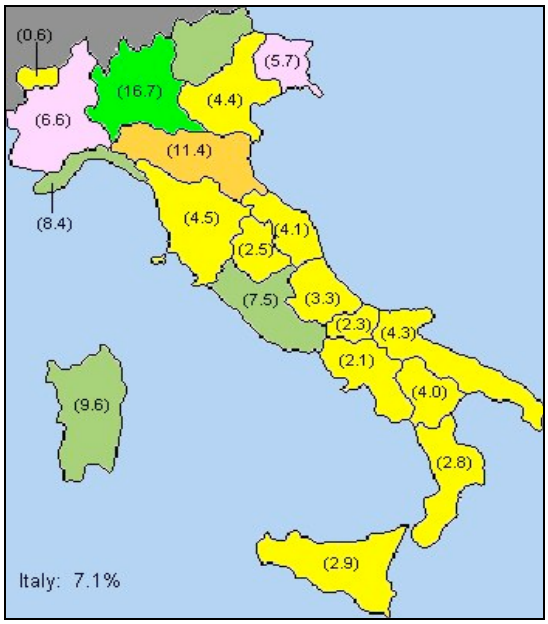
1998



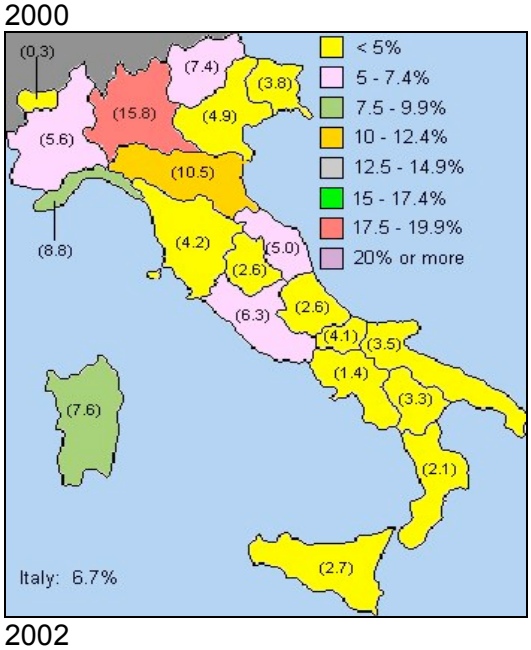
1999



2000



2001



2002

Maps 1 – 5

Source: Ministry of Health

there is no information. Figure 25 shows HIV testing of clients of the Ser.T. by year and by type of client. As can be seen from this, there has been a continuing downward trend in the percentage of all clients of the Ser.T. tested for HIV infection. At the same time, the percentage of clients who were not tested or for whom there is no data has continued to increase annually. There may be several reasons for this. In part it may reflect a reduction in the number of clients currently injecting drugs and this would be consistent with the data in an unpublished report on patterns and trends in drug use which suggests that there has been a reduction in injecting, especially amongst newer drug users. Whilst this might reflect the current situation, it does not fully explain why only 43% of new clients were tested in 1998. Other possible explanations include testing being targeted at those considered at highest risk to infection, financial constraints reducing the number of tests requested and reduced concern about HIV infection amongst both staff and clients in light of the substantial reductions in the level of infection in all groups perceived as having particularly high risk. In 1998, a median of 52.4% of all clients of the Ser.T. were tested for HIV infection with a range of 74.8% (Lombardia) to 30.3% (Liguria). In 2002 the comparable figures were a median of 44.1% with a range of 58.1% (Lombardia) to 29.7% (Sicily) and in only four Regions were more than 50% of clients tested for HIV.
Table 19 shows recorded cases of AIDS by risk factor. As can be seen from this there has been a continuing decline in the percentage of AIDS cases amongst drug users and a continuing increase in cases of AIDS where heterosexual contact was the risk factor.

Risk Exposure	<1993	1993/4	1995/6	1997/8	1999/ 2000	2001/2	Total	Male	Female
Homosexual/Bisexual	2691	1577	1572	917	718	528	**8003**	8003	0
%	*16.0*	*15.4*	*14.9*	*15.9*	*17.9*	*17.3*	***15.9***	*20.3*	*0.0*
Drug User	11348	6463	6343	2924	1646	1132	**29856**	23790	6066
%	*67.4*	*63.2*	*60.0*	*50.8*	*41.0*	*37.1*	***59.2***	*60.3*	*55.3*
Drug user/Homosexual	422	210	170	74	22	24	**922**	922	0
%	*2.5*	*2.1*	*1.6*	*1.3*	*0.5*	*0.8*	***1.8***	*2.3*	*0.0*
Haemophiliac	196	59	52	13	8	9	**337**	328	9
%	*1.2*	*0.6*	*0.5*	*0.2*	*0.2*	*0.3*	***0.7***	*0.8*	*0.1*
Blood transfusion	202	81	82	22	23	7	**417**	238	179
%	*1.2*	*0.8*	*0.8*	*0.4*	*0.6*	*0.2*	***0.8***	*0.6*	*1.6*
Heterosexual contact	1802	1654	2112	1296	1379	1161	**9404**	5146	4258
%	*10.7*	*16.2*	*20.0*	*22.5*	*34.4*	*38.0*	***18.6***	*13.0*	*38.8*
Other/Not known	168	181	240	507	218	193	**1507**	1046	461
%	*1.0*	*1.8*	*2.3*	*8.8*	*5.4*	*6.3*	***3.0***	*2.6*	*4.2*
Total	**16829**	**10225**	**10571**	**5753**	**4014**	**3054**	**50446**	**39473**	**10973**

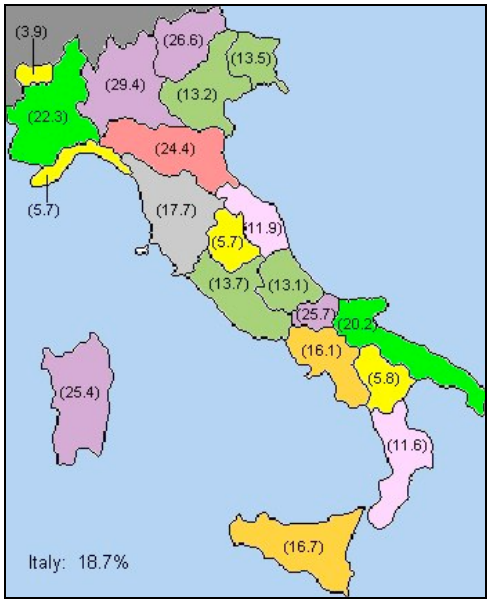
Table 19 *Source: National Health Institute*

Of these cases, 27.5% (2,589 people) had a drug using partner of whom 26.9% were male and 73.1% female. There was a slight increase in the percentage of AIDS cases from drug use in 2001/2 but this does not at present change the general trend. One factor which might affect the situation is the use of combination therapy. Data from the National Health Institute (ISS 2003) shows that over 50% of drug users with symptoms of AIDS received anti-retroviral therapies whilst only 23% of those infected through sexual transmission received such therapy. It is suggested that one reason for such a high percentage of drug users receiving these therapies prior to a diagnosis of AIDS is because of the high level of testing of drug users and a consequent improved knowledge of sero-positivity. It is possible that if the level of testing continues to fall, this treatment benefit for drug users might be lost.
The only other national data concerns prisoners and is maintained by the Prisons Administration of the Ministry of Justice. This shows that on 31 December 2002, 7.6% of prisoners assessed as drug dependent were HIV positive. This is broadly in line with the data from the Ser.T. if slightly higher than the national rate. Unfortunately it is not possible to provide separate information about rates in the male and female drug dependent population nor is it possible to provide information on health status – asymptomatic, symptomatic, with illnesses indicative of AIDS - by drug using status. However, 86.3% of male and 80.7% of female prisoners who are HIV positive are also drug dependent. It is

Percentage of clients of the Ser.T. infected by HBV by year and Region

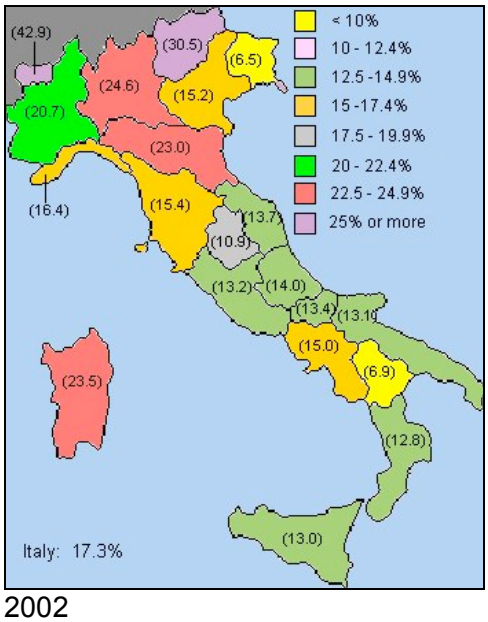
1998

1999



2000

2001



2002

Maps 6 – 10

Source: Ministry of Health

reasonable to assume, therefore, that these percentages will apply to health status. Of all known HIV positive prisoners, 62.4% of males and 69.7% of females were asymptomatic. 23.5% of males and 20.0% of females were symptomatic and 14.1% of males and 10.3% of females had illnesses indicative of AIDS.

Maps 6 – 10 show the percentage of all clients of the Ser.T. infected with Hepatitis B and maps 11 – 15 show the percentages for Hepatitis C infection. As with the data for HIV infection, there is some difficulty in interpretation because of changes in the level of testing over time. The situation with regard to Hepatitis B infection is more complicated because since 1990 vaccination against Hepatitis has been compulsory at age 12. In consequence around 10% of new clients to the Ser.T. should have been vaccinated before becoming involved in problematic drug use.

Figure 26 shows data on testing for Hepatitis B and Figure 27 shows the data on Hepatitis C testing. In 1999, the median percentage of Ser.T. clients tested for Hepatitis B infection was 44.5% with a range from 61.0% (Lombardia) to 23.6% (Umbria). By 2002, the median had fallen to 39.9% with a range from 83.2% (Valle d'Aosta) to 26.1% (Friuli). For Hepatitis C infection, the 1998 median was 52.7% with a range of 70.7% (Lombardia) to 28.6% (Liguria), whilst the 2001 media was 50.2% with a range of 83.8% (Valle d'Aosta) to 34.7% (Lazio).With these qualifications in mind, the data shows that the percentage of all clients of the Ser.T. testing positive for HBV or HCV fell slightly in 2002. This fall may be an illusion given the variable levels of testing and there is a correlation between reduced levels of testing and reduced positive results as was discussed in the last National Report It is worth noting that whilst the percentage of clients of the Ser.T. tested for either Hepatitis B or Hepatitis C infection has shown a downward trend, the percentage of clients testing positive has fallen only slightly. This may suggest either that the Ser.T. have been effective in identifying those clients whose risk behaviour makes them most prone to infection. Conversely, it may suggest that the level of infection is higher than that currently reported and is masked by the reduced level of testing. On this basis, the exact situation with regard to drug-related infections is somewhat unclear. Those Regions which have had a reasonably consistent level of testing over time do show either a small decrease or a stabilising in the level of infection. Where there has been a slight increase in the percentage of clients infected it almost always corresponds with an increase in the percentage of clients tested.

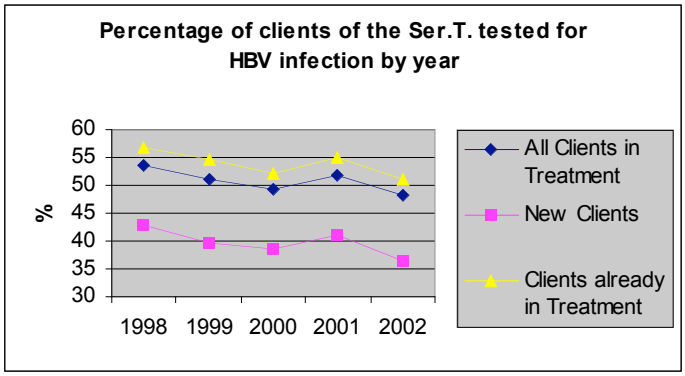


Figure 26 *Source: Ministry of Health*

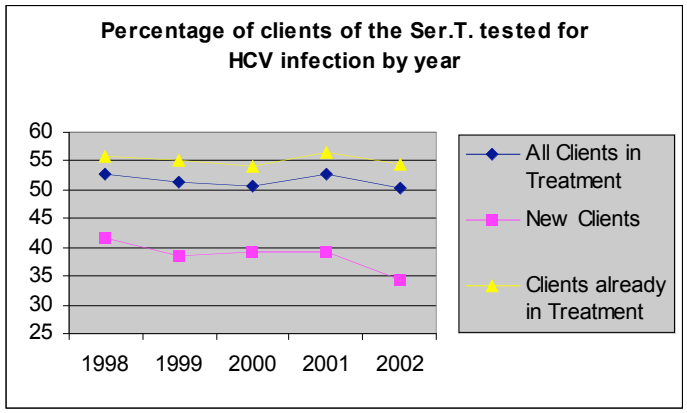
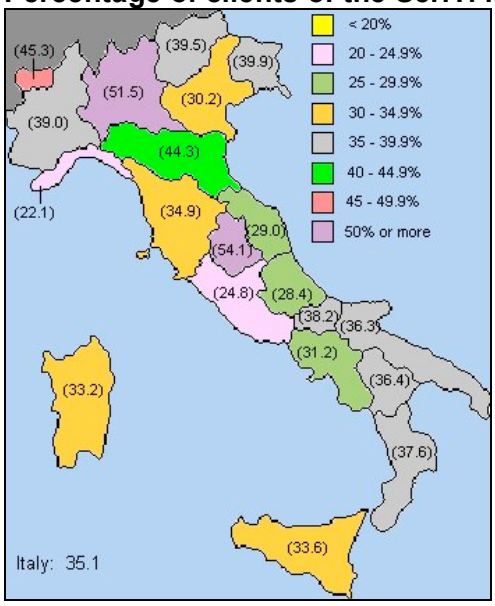


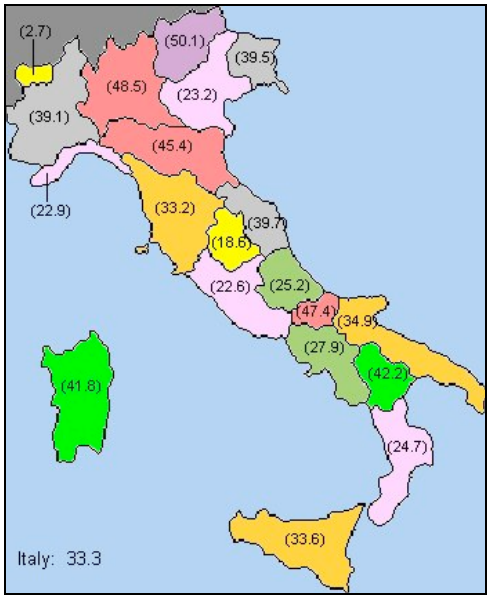
Figure 27 *Source: Ministry of Health*

Percentage of clients of the Ser.T. infected by HCV by year and Region



1998

1999



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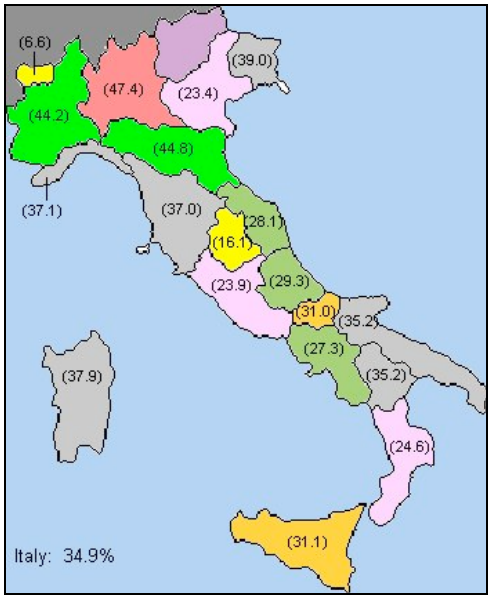

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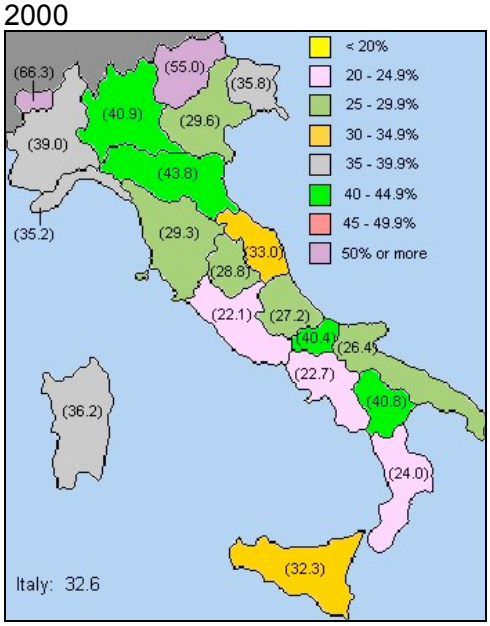

2002

Maps 11 – 15

Source: Ministry of Health

3.4 Other drug-related morbidity

There is limited data available on other drug-related morbidity. The Bologna Metropolitan Observatory for Pathological Dependencies has data on emergency interventions by the ambulance service. At the present time this appears to be the most comprehensive data on drug emergencies available in Italy and no other data source has yet been identified.

Table 20 shows data on these interventions between 1998 and 2002. As can be seen from this data, whilst the number of calls to the emergency service has risen over time, there has been a very substantial reduction in the number of calls for drug users. The data supports the information available on drug-related deaths and strongly suggests that there has been a substantial decline in drug overdoses in recent years. Information on the location of the overdose is available for 1998 – 2000. This shows that there has been a reduction in the number of calls to street locations and an increase in calls to home locations, with a slight increase in calls to "other" locations. The latter suggests that these might be to recreational settings and might relate to the use of synthetic drugs. There has also been a gradual reduction in the critical level of calls. In 1998, 30.4% were code yellow and 69.6% code red and by 2002 40.7% were code yellow and 56.4% code red. This is confirmed by the 2002 data which shows that in two thirds of cases (66.9%) the person was left where they were after a first aid intervention, 29.5% had a non-critical problem and only 3.6% had serious or critical problems. Data on sex, nationality and median age shows that there has been an increase over time in the percentage of males (71.5% - 1998 to 81.1% - 2002) and an increase in non-Italians (9.6% - 1998 to 13.4% - 2002). Italian and non-Italian males have accounted for an increasing percentage of incidents of overdose. The mean age for males has shown a steady increase from 29.7 years in 1998 to 33.2 years in 2002. For females, however, the mean age has hardly changed – 31.2 years in 1998 and 31.4 years in 2002. 80% of those for whom a 118 emergency intervention was required were unknown to the Ser.T.

	Bologna Province				
	1998	**1999**	**2000**	**2001**	**2002**
All emergency calls	72583	72566	76123	77394	78025
Calls for drug users (*)	3044	2294	1992	954	617
No. of drug users involved(**)	1129	957	873	330	254
Calls to drug users as a % of all calls	4.2	3.2	2.6	1.2	0.8
Individuals identified as a % of all calls to drug users	37.1	41.7	43.8	34.6	41.2

Source: Bologna Metropolitan Observatory

Table 20

* Criteria for inclusion: age 15 – 50. Calls to school, workplace or sports centre excluded
** Criteria for inclusion: a plausible name and surname and exclusion of repeats

Pavarin et al (2002) report on a study of drug dependents resident in Bologna who were hospitalised in 1997 and/or 1998. This retrospective study examined the computerised hosital records system to identify drug users known to the Ser.T. who received either in-patient or day hospital treatment. Of 2,243 clients known to the Ser.T. in 1997, 173 (7.7%) received hospital treatment and of 2,561 clients in 1998, 188 (7.3%) received hospital treatment in the year. There were 637 and 635 admissions in 1997 and 1998 respectively accounting for 5,660 hospital days in 1997 and 6,651 hospital days in 1998. The increase in the average time in hospital per client was accounted for by longer time in hospital per female client (34.3 days to 50.3 days) whilst there was a slight decrease in the length of hospitalisation per male client. This was also reflected in the average length of time in hospital per admission, with a reduction for male clients and an increase for female clients between 1997 and 1998. Compared to the general population in the 15 – 49 age group, the drug dependent admissions were in general hospital twice as long and in day hospital two and a half times as long for each admission. The drug dependent admissions represented 2.7% of all hospital admissions for the 15 –49 age group. The major causes of hospital

admission were HIV infection, mental illness, dual diagnosis and hepatitis. For almost all other causes of hospital admission, the percentage from the general population was higher than from the drug dependent population. This data clearly suggests that there are a number of specific conditions which are a direct result of drug misuse and that hospital recovery/treatment of drug dependents is more complex and requires longer admission with consequent costs to the public health system. No other data has been identified on other drug-related morbidity. There is limited published data on psychiatric co-morbidity, although this is an area of increasing interest within Italy. Discussion of this issue has, therefore been deferred to the key topic.

4. Social and Legal Correlates and Consequences

4.1 Social problems

No new information regarding social exclusion or public nuisance and community problems has come to light in the last year. The data provided in the last National Report under this heading and in the key topic and the data provided for the EMCDDA report on Social Reintegration in the European Union and Norway offers the most up to date information currently available to the Focal Point.

4.2 Drug offences and drug-related crime

Figure 28 shows the number of arrests[2] per year and drug involved. There has been a significant reduction in heroin related arrests between 1994 and 2002 whilst arrests for cannabis or cocaine related offences have more than doubled over the same period. Amphetamine arrests have remained relatively stable throughout the period, despite the high profile which has been given to the use of amphetamine analogues such as MDMA.

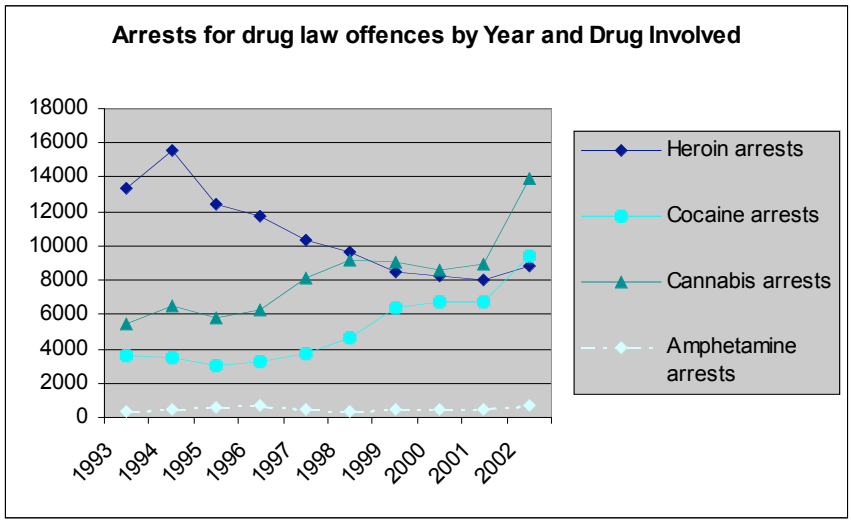

Figure 28 *Source: Ministry of the Interior, DCSA*

Looking at the number of arrests and comparing these with the quantity seized, there has been an upward trend in the quantity of heroin, cannabis and amphetamine seizures and a relatively even or slight downward trend in the quantity of cocaine and LSD seized. This might suggest that the law enforcement agencies have had some success in targeting larger supplies of illicit heroin.

Of the 33,106 people referred to the Judicial Authority, 70.3% were Italian of whom 10.3% were female and 89.7% male. 29.8% were non-Italian of whom 6.2% female 93.8% male. Compared to 2001, there has been a slight decrease in both absolute numbers (10,472 to 9,859) and in the percentage (30.9% to 29.8%) of non-Italian offenders in 2002.

Figure 29 shows the countries with the highest number of nationals referred to the Judicial Authority for a drug law offence. Moroccan, Tunisian, Algerian and Albanian nationals appear to be primarily involved in cannabis (resin and leaves) related offences. Nigerian nationals appear to be most often involved in heroin related offences. Spanish nationals

[2] Arrests here refers to people referred to the Judicial Authority for a drug law offence whether in custody, at liberty or absconded from justice

appear most often to be involved with cocaine related offences. In total, nationals from over 100 countries were referred to the Judicial Authorities in 2001.

The Region with the largest number of arrests in 2002 was Lombardia with 17.1% of all arrests, followed by Lazio (9.8%), Campania (8.0%) and Sicily (8.0%). This is not surprising as Lombardia is the most populous Region in Italy and around 50% of the referrals occurred within the Province of Milan which is relatively affluent, densely populated and a transport hub. For the three other Regions, the percentage of referrals does not reflect either their relative population or their relative levels of drug misuse. They may, therefore, more reflect trafficking rather than usage patterns. For example, Lazio and Campania (along with Lombardia) have the highest percentage of arrests involving cocaine, whilst Toscana, Lombardia and Lazio have the highest number of arrests involving heroin. Some of these concentrations appear to reflect trafficking routes rather than levels of usage in the Region of Province.

Unlawful possession of a listed drug is an administrative rather than a criminal offence in Italy. Someone found in unlawful possession is referred to

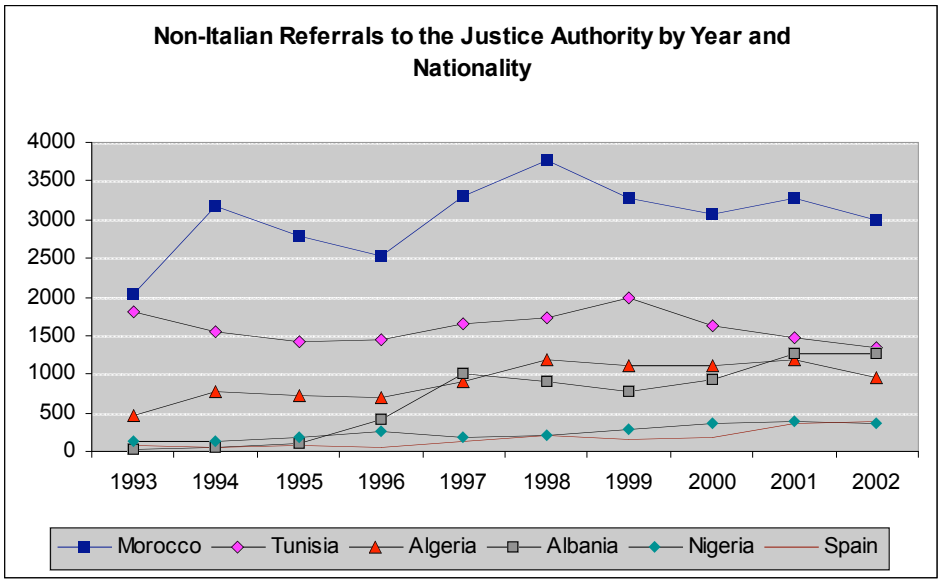

Figure 29 *Source: DCSA, Ministry of Interior*

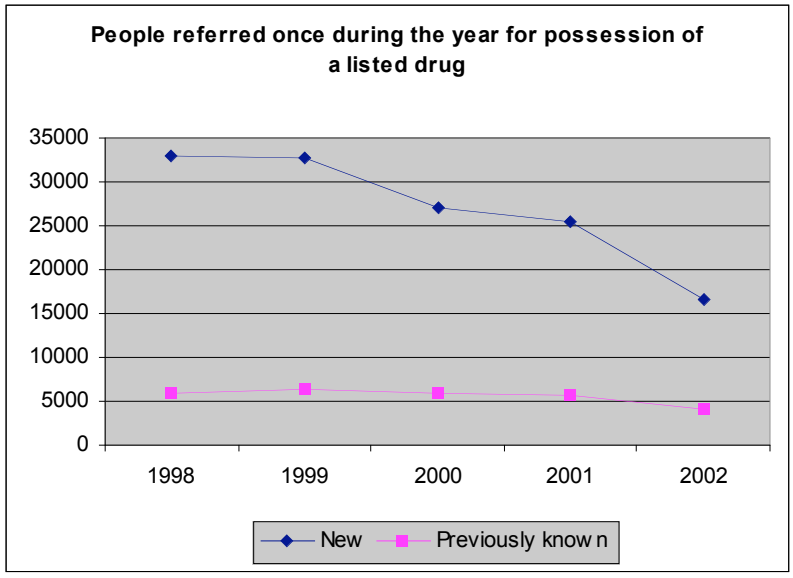

Figure 30 *Source: DCD, Ministry of Interior*

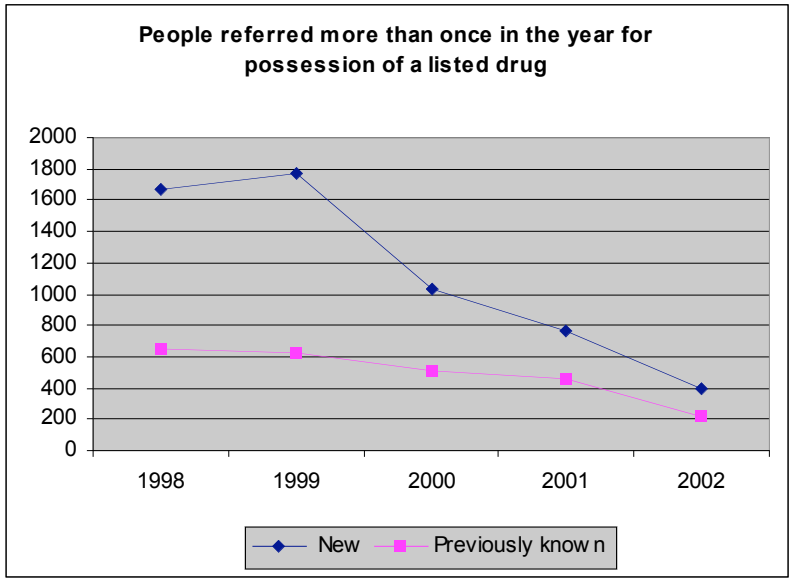

Figure 31 *Source: DCD, Ministry of Interior*

the Prefect where the offender may be advised of the dangers of drug use and warned not to continue use, or may be referred to the drug specialist team attached to the Prefecture or to a specialist service for treatment. Data on referrals to the Prefect is maintained by the Central Directorate for Documentation of the Ministry of the Interior. Figures 30 and 31 show referrals over time. There has been a very substantial reduction in the number of referrals over the five year period, with this reduction most marked in the referral of people for the first time. It is not clear why there has been this reduction. However, referrals for unlawful possession usually occur following a police intervention which is concerned with other offending behaviour and the discovery of drugs is not the primary purpose of the intervention. It is difficult, therefore, to draw conclusions about drug using patterns based on referrals for possession.

As can be seen the number of people referred more than once in the year has fallen more sharply than that for those referred on a single occasion. This might suggest that the process of referral, with a requirement to be assessed or referred to treatment if appropriate, has proved effective in reducing repeat offending.

93.6% of those referred were male, 8.2% of whom were juveniles whilst of the female referrals, 9.8% were juveniles. In 2002, 79% of males and 90.8% of females were first time referrals to the Prefect in that year. This compares to 79.8% of males and 89.9% of females in 2001. However, some caution must be given to this comparison because data on sex and age was missing for around one third of referrals in 2001. Figures 32 and 33 show the age groups and sex of referrals for 2002. As can be seen from these, new referrals are predominant amongst the younger age groups for both males and females whilst referrals occur increasingly amongst older age groups. This may suggest that new referrals are predominantly involved in irregular and/or non dependent drug use, primarily with cannabis and cocaine whilst re-referrals are predominantly involved in regular and/or dependent use, primarily with heroin, other opiates and cocaine. Such a hypothesis seems reasonable

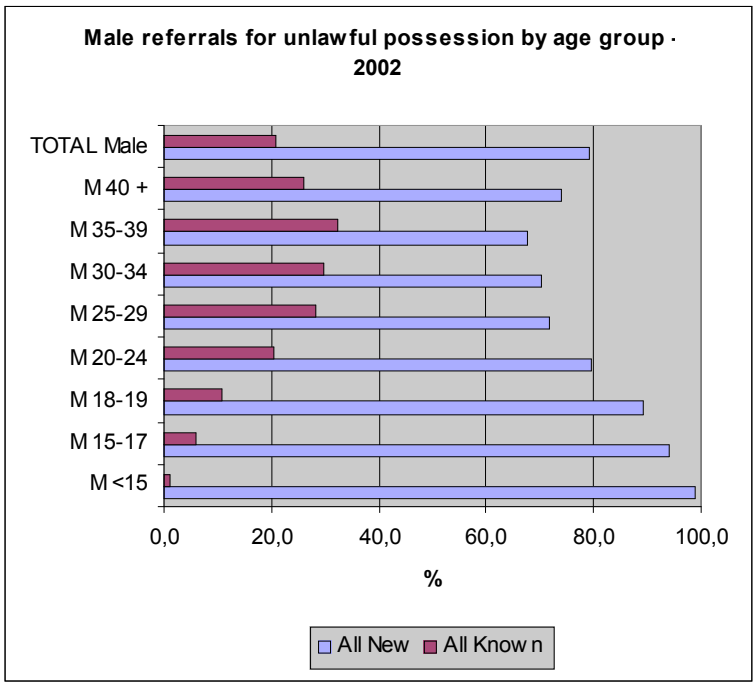

Figure 32 *Source: Ministry of the Interior, DCD*

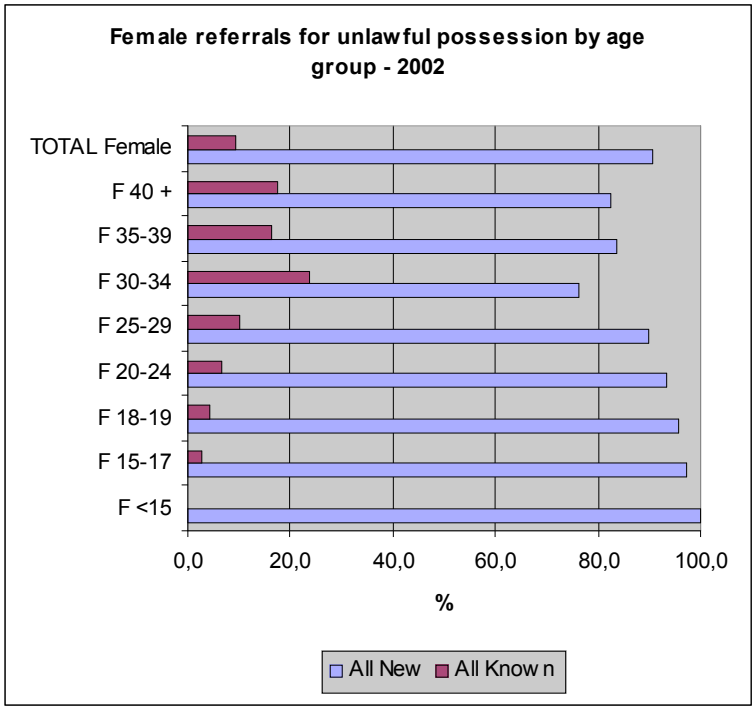

Figure 33 *Source: Ministry of the Interior, DCD*

and is consistent with other data from prevalence surveys and treatment data. However, at present it is not possible to analyse the data on the basis of sex, age group and primary drug use.

In terms of drugs for which referral was made, there has been a slight reduction in the percentage of referrals for unlawful possession of cannabis, from 83.1% of all referrals in 2001 to 80.7% in 2002, which is almost the same level as for 1999 (80.1%). Over a four year period there has been a reduction in opiate related referrals from 9.8% (1999) to 8.5% (2002) and an increase in cocaine referrals from 7..9% (1999) to 8.9% (2002). There is a clear distinction between the drugs involved for new referrals and for referrals of those previously referred and this distinction shows over the four year period. In 2002, 83% of new referrals were referred for unlawful possession of cannabis and 5.8% for possession of heroin. By contrast, only 71.3% of those already known were referred for cannabis whilst 15.9% were referred for heroin possession. This appears to support the hypothesis suggested above. For cocaine there was only a small difference in the percentage of referrals for both new and already known cases, with "known" having a slightly higher percentage. Ecstasy was found in only 1.2% of all referrals with no difference between new and known referrals.

From the data it appears that although the numbers are much smaller, women may be referred at an earlier age and perhaps for possession of more problematic drugs. The implication would seem to be that females are more likely to be referred to the Prefect because their drug use has been noticed where males are more likely to be referred following a police intervention for another law infringement.

Information from the Ministry of Justice provides data on the drug dependent prisoners and those imprisoned for drug law offences. In 2002 81,217 people were received into prison of whom 92.1% were male and 7.9% female. Of these detainees, 62.9% were Italian and 37.1% non-Italian (Figure 34). 35% of the Italian and 21% of the non-Italian detainees were assessed as drug dependent and in total 29.8% of all those received into prison in 2002 were assessed as drug dependent. Figures 35 and 36 show data on Italian and foreign new admissions to prison over time. As can be seen from these, there has been a reduction in the percentage of prisoners from

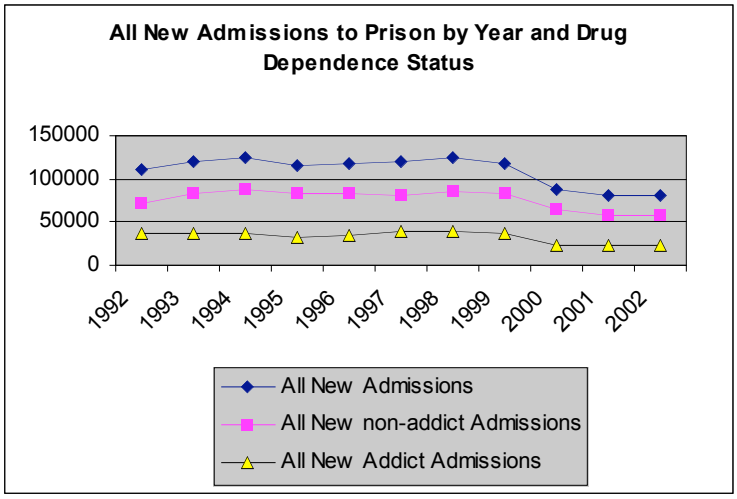

Figure 34 *Source: Ministry of Justice*

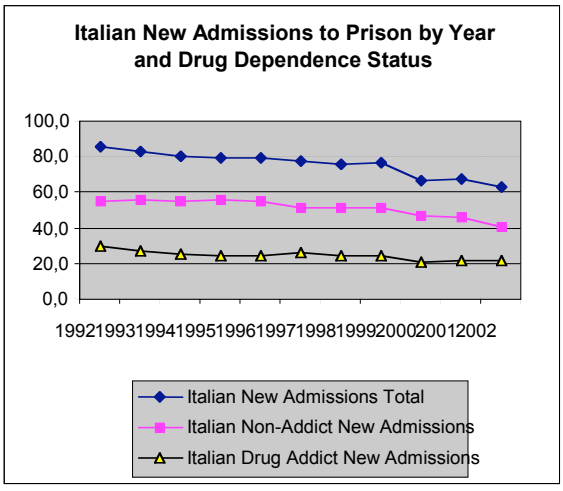

Figure 35 *Source: Ministry of Justice*

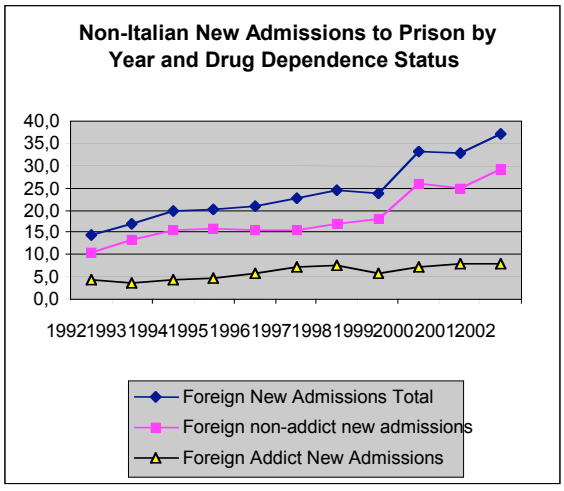

Figure 36 *Source: Ministry of Justice*

Italy and in the percentage of Italian non-addict new admissions. Italian addict new admissions have remained stable as a percentage of all new admissions. By contrast, there has been a substantial increase in the percentage of new admissions represented by non-Italians, largely as a result of non-addict new admissions, although there is a small upward trend in foreign addict new admissions.

Data on dependence status and category of offence is available for the first 6 months of 2002. This shows that of the 40.917 admissions into prison in this period, 31.4% were for offences against the drug law. 32.5% of prisoners detained for drug law offences were Italians assessed as drug dependent and 14.8% non-Italian whilst 17.4% of prisoners detained for other offences were Italians assessed as drug dependent and 4.3% were non-Italian. It is noticeable that in the case of non-drug dependent prisoners detained for drug law offences, there is an almost equal percentage of offences committed by Italians and non-Italians – 28.1% and 24.6% respectively of all drug law offences, whereas Italians predominate in offences committed by drug dependents and in other offences committed by non-drug dependents. This almost certainly reflects trafficking offences involving people with no residency or fixed accommodation in Italy and matches to a fair extent the data from the DCSA.

Data on young offenders is available from both the DCSA and from the Ministry of Justice. The DCSA data shows that of the 33,106 referrals for drug law offences, 1,384 (4.2%) were under 18 and 55 (0.2%) were under 15. Data from the Ministry of Justice refers to young offenders within the youth justice system, including assessment centres, youth prisons, the probation service for juveniles and residential treatment. In the period 1999 – 2002 the number of juvenile drug using offenders passing through the system has fallen from 1,440 to 1.354 but within this total an increasing percentage of offenders is non-Italian (16.5% - 1999 to 25.2% - 2002). For young offenders there is a strong focus on non-custodial alternatives and on active support and treatment interventions, with 79% of these young offenders receiving such an intervention in 2002 compared to 74.5% in 1999. The main change has been a reduction in the use of youth prison matched by an almost equal rise in the use of residential treatment.

Very incomplete data is available on prosecutions for drug offences in 2002. This is in part due to the revision of the data collection system within the Ministry of Justice. The Focal Point has been consulted on these changes and it is hoped that the new system will provide improved, more relevant information. The data which is available notes that at the end of the year there were 31,882 prosecutions in process for drug trafficking. Of these, 1,241 were for organising, financing, promoting or leading drug trafficking activities. Other data on prosecutions is so incomplete as to be misleading if presented here and it is not possible to make any comparison with 2001.

There is some data available from the DCSA of the Ministry of the Interior on drug related offences. It recorded 2,772 offences as drug related, of which 855 (30.8%) were against property (theft and robbery), 749 (27%) were association with the mafia or other criminal conspiracy, 246 (9%) for offences against the gun laws and only 27 (1%) for offences against the person. The vast majority (89.8%) were Italian. Regional distribution of offences shows that Puglia accounted for 16.4% of all offences by Italians and 8.2% of all offences by non-Italians. It is followed by Lombardia, Piemonte and Liguria. In general, around 90% of all offenders are Italian and 10% non-Italian, with five Regions having no referrals of foreign nationals. Two Regions, Umbria and Veneto, have a large number of foreign national offenders. In Umbria, 50.9% of all those referred for drug related offences were foreign nationals whilst in Veneto the equivalent figure was 42%. It is not clear why there should be such a significant level of offending and this may more reflect assessment and recording practices.

Of those recorded as ‘drug related’ offenders, 1,474 (53.2%) were drug dependent. The offences for which this group of offenders were referred were theft and attempted theft (521 cases), robbery and attempted robbery (173 cases), extortion (105 cases), offences against the gun laws (46 cases), murder and attempted murder (12 cases) and rape/sexual offences (6 cases). When these are analysed against the total number of such offences, drug users were reported for 97.4% of all theft/attempted theft referrals and 88.3% of all robbery/attempted robbery referrals. They were also reported for two thirds of offences

against the person. By contrast, for all other offences they were reported in only 37.8% of cases. The evidence thus strongly suggests that drug dependent offenders are largely involved in acquisitive crime, have some involvement in offences against the person (although this may be against other drug users rather than the general public) and are relatively uninvolved in offences concerned with organised crime and protection.

4.3 Social and economic costs of drug consumption

As has been reported previously, there is little data available on the social and economic costs of drug consumption. The National Department for Anti-Drug Policies is undertaking a project to estimate the cost to Italy of drug use and drug-related problems, but no data has yet been published on this and there are no local studies published on this topic.

It is possible to develop a general picture of some of the costs by reviewing the available data. At the national level it is known that annually some € 30.7 million is provided by the National Drugs Fund. The prison service spends some € 15.5 million on assistance to drug users annually and the Ministry of Foreign affairs provides around €12 million annually for international drug control efforts. No data is available on the cost of law enforcement and prosecution costs or on central administration costs, but a substantial amount is also committed to these activities and to the national prevention campaign.

Based on the data from the Regions, it can be estimated that, at a minimum, for direct treatment of people with drug problems some €360 million is spent on treatment in the Ser.T. and some €134.2 million for treatment in socio-rehabilitative services. Additionally, just under €92 million is made available to the Regions from the National Drugs Fund. Taking these amounts together, the currently identifiable costs amount to €644.4 per annum for demand reduction activities – primarily treatment and rehabilitation interventions. No data is readily available on prevention or supply reduction costs, on activities funded at the Provincial, Commune or European level, or on activities funded for training, insertion into employment etc., where funding is provided for an activity, for instance, combating social disadvantage or long term unemployment and where drug users may be one of the beneficiaries.

Using the data from the general population survey, the schools survey, the estimates of problematic heroin use, treatment demand data and updated data on street costs, it is possible to make a tentative estimate at the cost of drug consumption. On the basis of the data, around 4.7 million people tried a controlled drug in 2002. Some 2.1 million people used a controlled drug several times in the year and around 0.5 million people are regular/daily drug users. From these figures the estimated cost of drug consumption in Italy for 2002 is a minimum of €5,398.1 million, the majority of which is expended on daily heroin use.

This estimate of costs is inevitably crude and further work would be necessary to refine the data and develop more precise estimates. However, they do give a broad indication of the economic impact of drug consumption and demand reduction interventions. It is anticipated that the work of the National Department will provide more refined data.

A second estimate comes from the EURISPES Report (2003), which suggests that the total cost of drug use to Italy is between €12 to 14 billion, based on international estimates that the value of the drugs business is around 1 – 2% of the internal production of industrialised countries.

5. Drug Markets

5.1 Availability and supply

There are some regional differences in availability and supply.

Cannabis is widely available throughout the country and is the drug which is most often seized and for which referrals to the Prefect for unlawful possession most commonly occur.

Heroin is also available throughout the country, although the focus of availability appears to be the major urban areas. The evidence on treatment demand suggests, however, that it may be more available now in less urbanised Provinces.

Cocaine is less available and is largely confined to the larger urban areas, although there is evidence that its use is increasing and that this is spreading to the less urbanised areas.

For both heroin and cocaine, assuming that there is a time lag of at least two years – and evidence from the VeDeTTE study suggests a time lag of at least 4 years - between initial use and specific treatment demand, the implication is that these drugs have becoming increasingly available in less urbanised areas but that there has been no major reduction in availability in the more urbanised areas.

Amphetamine is relatively uncommon although ecstasy and its analogues are more common. These substances are found most often in the northern and central regions and less often in the southern regions.

LSD and other drugs remain relatively rare and there is little evidence that their use is increasing.

The trends which can be seen from referral to the Prefect and seizure data are a little confusing. From referrals to the Prefect, there has been a reduction for all drugs, with the main reductions being in referrals for heroin and cannabis possession and a slight increase in the percentage of all referrals relating to cocaine possession. From seizure data, since 1997 there has been a steady reduction in the quantity of cannabis seized and upward trends in the seizures of heroin, cocaine and amphetamine (including amphetamine analogues). This might suggest that whilst cannabis availability remained widespread, the quantity and quality of the other drugs was falling. However, data on purity and price suggest that in real terms the price of all these drugs has fallen whilst only heroin has shown a consistent reduction in purity. Moreover, other data, such as ESPAD and local reports suggest that there is still ready availability of heroin for smoking. Cannabis availability and use appears to show a continued increase throughout the country. Cocaine availability appears to be increasing and to be more widespread. Amphetamine, especially ecstasy and its analogues appear to be available in the northern and central regions but to be less available in the southern regions.

In terms of trafficking patterns, this also varies according to the drug involved. Data from the Central Directorate for Anti-Drug Services suggests that heroin most often arrives at the main sea ports and is then distributed through an internal network. The routes of supply appear to be primarily Bulgaria, China, Iran, Pakistan Turkey, with transit through the Balkan countries and their immediate neighbours.

Cocaine appears to be primarily brought into Italy through major airports and then to be distributed within the country. The major routes of supply are Latin American countries directly or via Spain. In 2002, for the first time the USA was listed as a major country for the routing of cocaine to Italy.

In 2002, hashish was predominantly brought into the country from Morocco and Spain. Also mentioned as routes of supply in 2002 were France, Iran and Pakistan. Interestingly, Albania was not mentioned although it has previously been the almost exclusive source of marijuana and a source of hashish. This would seem to suggest a change in trafficking routes as previous routes were disrupted, rather than any reduction in the involvement of Albanian nationals, a view which seems to be supported by the fact that there was almost no change in the number of Albanian nationals referred to the judicial authority between 2001 and 2002. Sea routes appear still to be the major point of entry followed by re-distribution within the country.

The situation with marijuana is somewhat different. In 2002 the countries listed as main routes of supply were Mexico, South Africa, Malawi, Nigeria and the U.S.A.

For cannabis plants, supply has almost exclusively been through in country production. The Calabria Region and the Province of Reggio Calabria in particular, represents the prime source of all cannabis plants in Italy. This has been the case for many years and strongly suggests that there remains a significant local illicit economy based on growing and selling cannabis.

With regard to amphetamines (including ecstasy) and LSD, new routes of supply listed for 2002 were China, Japan, the Philippines, Thailand and the U.S.A. In previous years Holland has been listed as the almost exclusive supply source. For ecstasy Holland remains the main production centre and again, this suggests changed supply routes rather than a diminution in supply. The evidence seems to point to production and sale within or close to Holland with other nationals, commonly Italians or those with residency in Italy, taking responsibility for importation and internal distribution. The vast majority of seizures occur in the northern and central Regions although there have been seizures of both drugs in other parts of the country.

This appears to reflect the internal demand and supply systems which are focused in the northern and central Regions, especially in those areas which have a developed youth culture in which drug use is one element.

5.2 Seizures

There have been substantial variations in the quantity of drugs seized year by year. Unfortunately data is not available on the number of seizures per drug, only on the total number of drug seizures made in 2000 (17,994) 2001 (17,760). No data on the number of seizures in 2002 is available.

In terms of the quantity seized, there was a continuing increase in the amount of heroin sequestered (Fig. 37), maintaining the upward trend which can be seen from 1997. Although there have been one or two very large seizures, possibly exaggerating the overall

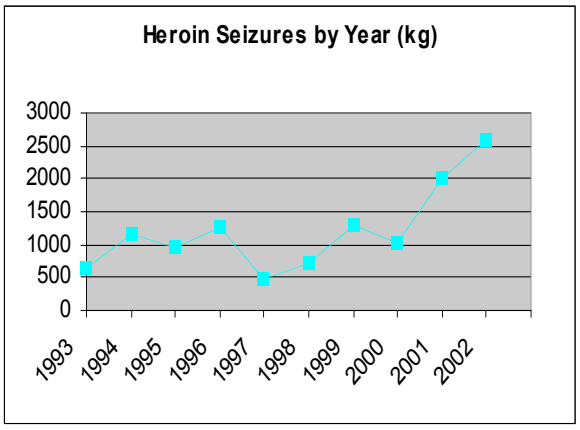

Figure 37 *Source: Ministry of the Interior, DCSA*

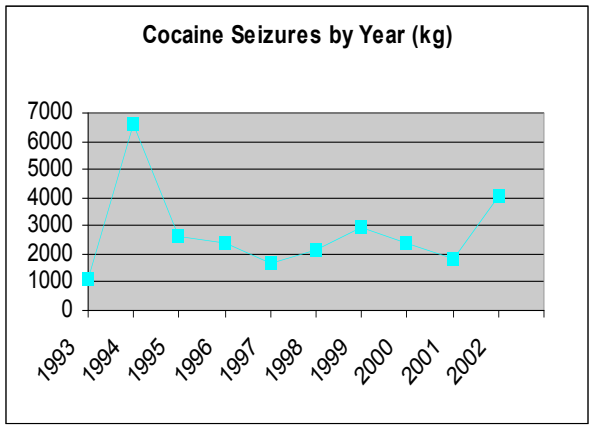

Figure 38 *Source: Ministry of the Interior, DCSA*

trend, the picture is of some increase in trafficking. This view is supported by the fact that heroin continues to be widely available nationally with a reduction in purity over the last four years but also a reduction in the price per gram over the same period. 77% of seizures were within Italy, 22% at the sea borders and 1% airports. The Regions where the largest quantities were seized were Lombardia, with 39.5% of all heroin seized followed by Friuli (10.6%), Campania (10.6%) and Puglia (10.3%). 20.5% of the total seized was taken in two operations in Lombardia and Friuli. From the evidence of heroin seized, it is clear that whilst in some Regions, such as Friuli and Marche, the quantity seized was based on a few large seizures, in other Regions, such as Lombardia, the quantity seized, whilst including some large seizures, was more based on local supply, rather than importation quantities. This supports the view that heroin is primarily brought into Italy through sea routes and then distributed internally.

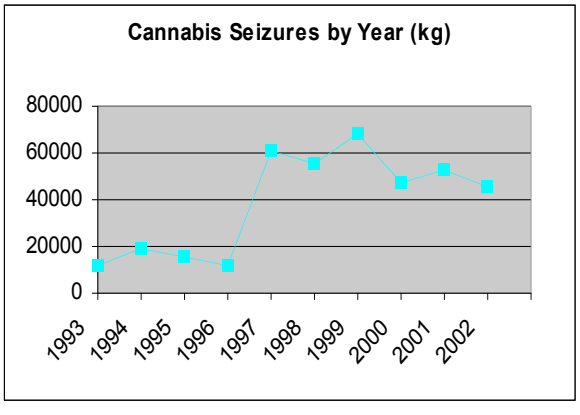

Figure 39 *Source: Ministry of the Interior, DCSA*

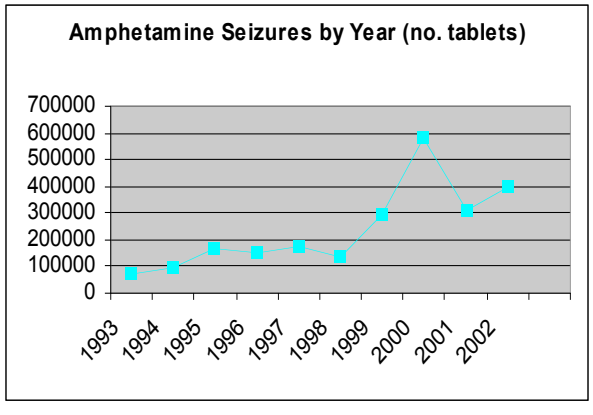

Figure 40 *Source: Ministry of the Interior, DCSA*

For cocaine (Figure 38) the picture is slightly different. Since 1997 the overall trend has been upward whilst price and purity have hardly changed over the last four years. 53.8% of all cocaine is seized at the borders, with 40.1% seized at sea borders and 12.1% at air ports. In terms of the Regional distribution of quantities seized, Lombardia again had the largest quantity, 24.9% of the total, followed by Campania (22.4%) and Liguria (15%). One third of the amount seized in Lombardia came from a single seizure whilst for Campania and Liguria two seizures accounted for 91.8% and 81.8% respectively of the total amount of cocaine seized in those Regions.

The quantity of cannabis seized in 2002 fell slightly and since 1997 there has been a slight downward trend in the quantity seized (Figure 39). The vast majority was found within Italy, (91.2%) and there is a clear difference between the location of hashish (cannabis resin) and marijuana (cannabis leaf) seizures. For all cannabis seizures, the largest quantity was seized in Lombardia (36.5%), followed by Puglia (22.7%) and Lazio (10.4%). However, Lombardia accounted for over 50% of all hashish seized and over 80% of cannabis seized in Lombardia was hashish. By contrast, some 60% of cannabis seized in Lazio was marijuana and some 40% in Puglia. It is not clear whether these differences represent different trafficking or different use patterns, although the former seems more probable. As in previous years, the vast majority of cannabis plants were seized in Calabria, in particular the Province of Reggio Calabria.

Unfortunately no distinction is made between amphetamine and amphetamine analogues and they are combined together under the generic heading 'amphetamine'. However, from data on major seizures it can be seen that at a minimum, 75% of all amphetamine seized was ecstasy or another amphetamine analogue. The overall trend for the quantity seized has been upward for the last 10 years (Figure 40). The sharp increase in 2000 was accounted for by a single, very large seizure amounting to 57.5% of all amphetamine seized in that year and setting this aside there has been a steady increase in seizures since 1998. 47.8% of the amount seized in 2002 was found within Italy and 52.2% at the borders. With amphetamine 41% was seized at the land borders, and a single seizure of ecstasy at Domodossola in Piemonte represented 40.2% of the all amphetamine seized and 77.5% of that seized in Piemonte. The only other Region with a significant quantity of amphetamine seized was Emilia Romagna, with 20.3% of the national total and a single seizure representing 10.7% of the national total and 52.7% of the amount seized in Emilia Romagna in 2002.

The quantity of LSD seized in 2002 was 3,064 doses, more than double the amount seized in 2001. However, the trend over the last 10 years has been downward and there is no indication from other indicators that use of LSD is increasing. 55.8% was seized within Italy and 44.2% at the borders, almost entirely at the land frontier. 74.4% of the national total was seized in two operations in Lombardia (53.4%) and one in Emilia Romagna (21%). These two Regions accounted for 59.6% and 22.6% respectively of all LSD seized and the Lombardia and Emilia Romagna seizures represented respectively 89.4% and 92.6% of the amount seized in these Regions.

5.3 Price, purity

Data on price and purity has been produced by the DCSA of the Ministry of the Interior. The methodology used is to establish a national estimate of price and purity based on the median price and purity recorded in 12 Italian cities - Bologna, Florence, Genoa, Palermo, Milan, Naples, Reggio Calabria, Rome, Trieste, Turin, Venice and Verona. The data has been updated to the end of 2002. However, no information is available on how many samples were used to establish price and purity, or on the source of information. Some caution must be exercised, therefore, in transposing the data to the national level where significant price and purity changes might be found between metropolitan, urban and non-urban areas and seasonally in holiday centres.

With these reservations, Table 21 shows the maximum and minimum wholesale and retail prices in 1999 and 2002 and the maximum, minimum and median purity levels for the same years.

	1999							2002						
	Price (€)				Purity (%)			Price (€)				Purity (%)		
	Wholesale		Retail					Wholesale		Retail				
	Min	Max	Min	Max	Min	Media	Max	Min	Max	Min	Max	Min	Media	Max
Cannabis resin	1756	2582	7.08	8.78	0.11	8.5	16.89	866	1334	6.87	8.48	0.05	13.88	27.2
Cannabis leaf	1033	1394	5.06	6.46	1.09	16.87	33.65	1672	2506	5.38	6.44	0.19	5.5	10.8
Heroin	29438	33311	63.52	77.47	1.8	48.4	95	26072	31266	56.55	68.09	0.6	35.8	71
Cocaine	39251	47514	92.96	134.8	16.7	56.85	97	39754	48182	86.58	105.12	5.6	51.3	97
Ecstasy	5939	6456	19.88	25.05	0.22	25.74	51.26	4980	5402	19.61	24.32	2.3	24.15	46
LSD	9038		24.27	24.79				8750		26,78	28,07			

Table 21

Source : Ministry of the Interior, DCSA

As can be seen from this data, the price per gram/tablet/dose for all the listed substances, with the exception of LSD, was in real terms lower in 2002 than in 1999. By contrast, only the percentage of active ingredient in cannabis leaf and, to a lesser extent heroin, has shown any marked reduction. For cocaine and ecstasy there has been only a slight reduction in the median purity level and for cannabis resin the purity level has increased whilst the price has remained about the same as in 1999. The price reduction in cocaine in particular strongly supports the data from different sources showing cocaine misuse to be on the increase throughout the country. The increased purity of cannabis resin and the real terms price reduction supports the evidence suggesting increased trafficking from new sources and controlled by newer criminal organisations associated with central and eastern European countries. However, given the caveats which must be entered about the methodology for data collection and how comparable it is between years, it is difficult to make any stronger conclusions from the data. At best it is indicative that profitability at wholesale level seems to have increased substantially whilst prices at retail level have remained stable or fallen, suggesting that there remains a strong market for controlled drugs.

6. Trends per Drug

Cannabis

Cannabis remains the most prevalent drug within Italy accounting for the vast majority of both referrals for possession and drug seizures. Data on prevalence of use within the general population confirms the dominance of cannabis as the most used drug. The ESPAD study, data from the Ministry of Defence and local reports and studies all support this view.

The data also shows that cannabis use is becoming more prevalent and suggests that there is an increase in drug related problems associated with the use of cannabis. The ESPAD study shows that lifetime use of cannabis amongst pupils rose from 19% in 1995 to 33.6% in 2002. Last 12 months prevalence and last 30 days prevalence has shown a steady increase year by year, although there was a slight reduction for both in 2002. This reduction was, however, entirely accounted for by a reduction in prevalence for females. Last 12 months and last 30 days prevalence of cannabis use amongst males have both risen and now stand at 32.1% and 22.3% respectively, compared to 27.6% and 18.7% in 2000. This suggests whilst there may be some reduction in cannabis use amongst females, it is rising amongst males. From the ESPAD Italy study the data suggests that just under two fifths of males between 15 and 19 have tried cannabis at least once in their life and that over one fifth use cannabis on a regular basis. Ministry of Defence figures show a slight decrease, although the year on year information is not entirely comparable. Data on treatment demand shows cannabis increasing annually as a primary drug whilst declining as a secondary drug.

Given the level of seizures and the widespread availability of cannabis, it is not surprising that there is such widespread use. It appears to have become established in the general population.

Synthetic drugs

LSD and amphetamines appear never to have gained great popularity and this is confirmed by a number of different indicators. Referrals for possession of either drug are comparatively rare, the

quantity of either drug seized is extremely low and treatment demand arising from use of these drugs is negligible. Although in 2002 not all law enforcement data allowed a separation of the amphetamine type drugs into specific products, the historical evidence is that the majority of amphetamine type seizures relate to ecstasy and there is no reason to suppose that this did not remain the case in 2002. In fact, data on specific large seizures shows that at a minimum 75% of 'amphetamine' seized was, in fact, ecstasy.

Ecstasy is reported to have a relatively high level of use among the younger population, especially in the northern and central Regions. Although as already noted, ecstasy seizures cannot be specifically identified, the quantity of amphetamine seized rose in 2002 and the trend in supply is broadly stable.

Reports from outreach services and from projects focused on the new drugs suggest widespread use, although referrals for possession of ecstasy remain low in comparison to the reported level of use. In the absence of data on tablet content and in the light of the only national data available (Macchia and Gianotti, 1999) it may be that there is an assumption of ecstasy use when the pills contain little or no MDMA.

Data from the ESPAD study for 2002 suggests a reduction in use of LSD, ecstasy and amphetamine. The reduction is again greater amongst females than amongst males but for all three of these drugs there has been a noticeable reduction in male last 12 months and last 30 days prevalence. The general population survey suggests higher lifetime prevalence rates for all three drugs than the school survey. This may reflect a difference between those who remain in the education system beyond compulsory schooling, but firm conclusions cannot be made on the basis of a single population survey.

There appears to be some geographical differences in relation to the use of ecstasy. This may be related to the more developed youth culture in the northern and central Regions, with many more youth oriented events and locations.

Heroin and other opiates

In terms of problematic drug use, heroin remains the most prevalent drug. However, there are some signs that the rate of increase in use may be declining. Over the last eight years there has been a slow but clear reduction in the percentage of people attending the Ser.T. who report heroin as their primary drug whilst the percentage reporting heroin as a secondary drug has remained stable over the same period. Balanced against this, however, has to be the estimates of heroin use which suggest that a substantial number of heroin users remain outside the treatment system. Three out of four of the estimate methods used in 2002 show an increase in problematic heroin use over 2001, suggesting that use may not yet have peaked.

The quantity of heroin seized in 2002 showed a further substantial increase and the annual quantity seized has more than doubled in the last two years. Since 1997 the trend has been for increasing quantities of heroin to be seized and the rate of increase has accelerated in the last two years.

Referrals for possession of heroin having remained relatively stable for 1998 and 1999 and after falling considerably between 1997 and 1998, again declined in 2000, 2001 and 2002. This data must, however, be treated with caution because of the overall decline in possession referrals. Direct drug related deaths are predominantly associated with heroin use, either alone or in combination with other drugs or alcohol.

Overall, the picture remains unclear with regard to the trend for heroin. Some indicators suggest that use may be slowly declining whilst other indicators suggest that the trend is stable or may be slightly upwards. There are some indications that heroin use is rising in the less urbanised Provinces but has stabilised in the more urbanised areas.

There are indications from a number of sources (Drogatel, various Ser.T., etc), from the national data collected by the Ministry of Health and from the ESPAD survey which suggest that young people are trying heroin, but are less likely to inject and more likely to smoke it. Whilst this may be an important trend in terms of drug related morbidity, it may also be a sign of a resurgence of heroin use.

Use of other opiates remains insignificant and no data suggests that there has been any change in recent years.

Cocaine and crack

Crack cocaine is extremely rare in Italy and none of the national data, nor published reports nor anecdotal reports suggests that crack has gained any following within Italy.

The situation with regard to cocaine is less clear. The number of referrals for possession has been increasing annually, as has the percentage of people citing cocaine as their primary drug when seeking treatment. Between 1998 and 2002, the percentage of clients of the Ser.T. reporting primary use of cocaine has risen from 3.2% to 6.9% whilst secondary use of cocaine has risen from 18.4% to 25.1% over the same period. Whilst the percentage of people in treatment with the Ser.T. who use cocaine remains relatively low, this appears to be more related to the predominant focus of treatment programmes on opiate users.

The general population survey, the ESPAD study and the data from the Ministry of Defence show cocaine to be an important drug of misuse. In 2002, there was a small reduction in lifetime prevalence amongst the school age population, again exclusively accounted for by a reduction in prevalence amongst the female population whilst the life time prevalence of cocaine use amongst males rose. A similar pattern can be seen in last 12 months prevalence of cocaine use and overall cocaine use was more prevalent than amphetamines, ecstasy, hallucinogens or heroin. There was an increase in the absolute number of forces personnel using cocaine and an increase in the percentage of personnel identified as cocaine users.

Together, the data suggests that the general level of use is increasing although this has not yet been fully reflected in treatment demand.

The quantity of cocaine seized has fluctuated over the last six years and in 2002 more than doubled in quantity compared with 2001. Since 1993, with the exception of 2001, the quantity of cocaine seized has always been substantially higher than the quantity of heroin seized. The evidence from different indicators suggests that this reflects an overall demand for cocaine and that cocaine is being used sporadically or on a regular but not daily basis not yet leading to the kinds of problems which usually precipitate a treatment demand.

Other indirect indicators, such as calls to Drogatel, show a much higher percentage of calls related to cocaine than is reflected in the indicators mentioned above. It also appears to be more evenly spread geographically with cocaine use reported from all parts of the country.

Overall, the trend with regard to cocaine appears to be upward with increasing numbers using it. The available information seems to suggest two separate but related patterns. In areas where there is a developed drug culture, cocaine use is a small but significant part of that culture. In areas where cocaine is brought into the country, there appears to be local supply as well as distribution to other parts of the country. There is, therefore, a pattern of wider use in the metropolitan areas and pockets of use related to the trafficking and supply routes.

Multiple use

There is relatively little information available about multiple drug use at the national level. However, some data from different sources suggests that this is a developing issue.

The ESPAD survey suggests that there has been a reduction in alcohol and pills combined use between 1999 and 2002, but does not provide information on other possible combinations. By contrast, projects concerned with new drugs, especially those working with discotheques, have noted combined use of alcohol and drugs as a specific issue.

The work of the Forensic Toxicologists Group shows that direct drug related deaths rarely involved a single drug. This data in itself suggests that multiple drug use is an important factor in drug related mortality.

Data from the Ministry of Health about secondary drug use amongst those attending the Ser.T. also suggests that multiple drug use is not uncommon, especially of cannabis, cocaine, benzodiazepines and alcohol.

More localised published reports also indicate that a significant number of people contacted through outreach work use more than one drug (cf. Pavarin and Salsi 1999, Macchia and Giannotti 2000, Secchi et al 2000). It is not always clear from these reports whether other drugs are used simultaneously or as substitutes when the preferred drug is not available. Losi et al (2002) have reported on a retrospective study of a cohort of clients of a Milan Ser.T. who came into treatment between September 1995 and September 1999. The personal drug history of clients, given at the time of entry into treatment, was examined. Those clients who claimed to be only using opiates, cocaine or ecstasy at the time of admission were checked against the urine

analysis conducted at the same time. Poly-drug abuse was found in 66.3% of new clients who claimed heroin as their only drug of misuse, in 28.8% of cocaine users and in 17.7% of ecstasy users. The authors argue that this study strongly suggests that poly-drug use amongst clients of the Ser.T. may be underestimated and that there is a reluctance on the part of clients to recognise their own poly-drug use.
From the data available, limited as it is, there appears to be an upward trend in multiple drug use but there are few qualitative or quantitative reports which could guide the development of more targeted and effective responses.

7. Discussion

7.1 Consistency between indicators

As has been noted previously, there is a limited relationship between indicators arising from different sources. However, there is a broad consistency between the indicators which suggest that they do represent general trends. For instance, the ESPAD data and the data from the Ministry of Defence show common trends in terms of the development of substance use, patterns of substance use and the drugs most frequently used. The data from the Ministry of Health on problem drug users attending the Ser.T. for treatment is consistent with local data reported in published papers or in papers presented at regional and national conferences or on the internet. It also confirms, given the time lapse between drug use and the first approach for treatment, a gradual move away from injection of drugs and a wider pattern of drug use with heroin use declining but use of other drugs increasing. The law enforcement data also seems to confirm these trends although it can be biased by one or two large seizures or by changed policing priorities.
The data on referrals for unlawful possession of listed drugs is not, however, consistent with the other indicators. This may reflect the fact that possession of a listed drug is an administrative offence with low enforcement priority. Discovery of a listed drug may occur in the course of other policing operations and not be the focus of the policing operation. The work which has been undertaken by the Italian Observatory for Drugs and Drug Addiction (OIDT) has led to a progressive improvement in the data available and in the analysis of this data. Moreover, it has undertaken a programme of work to discuss with the relevant Ministries ways in which more consistent and comparable data might be collected, able to support both national drug policy needs and the needs of the individual Ministries. A number of Ministries have undertaken projects financed by the National Drugs Fund designed to improve data collection and comparability, using European standards wherever available. As examples, the Ministry of Health has distributed free software to the Ser.T. to collect data based on the Treatment Demand Indicator. The Central Directorate for Documentation of the Ministry of the Interior has a project to improve data collection on the work of socio-rehabilitative organisations. The Ministry of Justice and the Central Directorate for Anti-Drug Services of the Ministry of the Interior also have projects aimed at improving data collection and analysis. The Prison Administration of the Ministry of Justice has established a project to improve data on drug users passing through the prison system. The Ministry of Health has several projects designed to improve data collection from both private and public drug treatment services. Taken together, it is anticipated that the changes will support the development of both national drug policy needs and the needs of the individual Ministries. It is a priority for both the National Department for Anti-Drug Policies and the National Drugs Observatory that consistent, comparable data should be collected and that it should be capable of cross-reference between Ministries.

7.2 Methodological limitations and data quality

The data received by the Ministry of Health is of good quality and generally provides a consistent and historically comparable picture of treatment demand, typology and staffing at the Ser.T. However, not all Ser.T. submit reports when requested and the number of Ser.T. in operation has also changed year by year. In consequence, in different years there can be different levels of reporting. Moreover, it is possible that in some years the absence of reports from some of the Ser.T. will have little impact on the overall picture emerging from the data, whilst in other years such an absence could have a significant effect on the overall

figures. Wherever possible this has been taken into account but it nevertheless represents a limitation to the data. Some problems have been identified in the guidance for completing the standard forms used by the Ser.T. to report data to the Ministry of Health. This particularly applies to data on drug related infectious diseases. It is not clear whether the data provide is incidence, prevalence or a mixture of the two and it is possible that different Ser.T. interpret the instructions for completion differently. This issue is now being examined in an effort to resolve the situation. For 2002 in particular, at the time of writing this report the annual review of activity in the public drug treatment services (Ser.T.), was not available. In consequence, data has not always been available in a comparable form to previous years. The reporting rate from the Ser.T. has been slightly up on 2001 although there is still data missing from around 44 out patient treatment units managed within the national health system. It is not clear whether these limitations are significant or have an impact on the absolute numbers but not on trends. In 2001 the Ministry changed the technical support for its health statistics system and in 2002 the relevant department within the Ministry had a temporary staff shortage. It has not been possible, therefore, to interrogate the data base or to access data collected using the TDI Protocol.

Data from the Ministry of Defence provides a useful indicator of drug use within the younger male population. However, it is based on identified instances of drug use within the armed services and to a large extent on self-declarations. Information is not provided in a consistent format year on year and there are, therefore, substantial limitations attached to this data.

The data provided by the Ministry of the Interior is of fair quality in respect to drug seizures and referrals to the Judicial Authorities for drug law offences. Data with regard to direct drug related deaths is of less certain quality, based as it is on a view of whether drug misuse was a direct cause of death and with toxicological analysis occurring in a minority of cases. Only very limited data is available arising from the census of socio-rehabilitative services. The quality of this data must also be questioned given that, for instance, the number of people listed as clients of ambulatory services in the census is substantially less than the number of clients listed in published reports.

The data from the Ministry of Justice, in so far as it deals with prisoners, is of good quality in terms of drug law offences but of more variable quality with respect to drug dependent prisoners. In the latter instance the assessment of drug dependence is a combination of clinical signs, of self-declaration and of staff assessment. There is no clear consistency between the data from the Ministry of Health on prisoners receiving treatment from the Ser.T. and data from the Ministry of Justice dealing with the same topic. Similar problems arise with information on offenders passing through the Juvenile Justice Service. However, there is some convergence beginning to develop as the Ser.T. increasingly provide treatment and health care for drug using prisoners.

Reports from the Regions and Autonomous Provinces are variable and they do not follow common reporting methodologies. This makes comparative analysis difficult and provides limited capacity to analyse general and specific trends either nationally or geographically. The Co-ordination of the Regions has sought to develop a common reporting format for material to be included in the Annual Report to Parliament on the State of the Drug Problem in Italy in terms of the topics covered. However, the data included under each topic heading is a matter of decision for each Region. A mentioned above, a number of projects are now underway seeking to develop improved and more consistent monitoring and reporting systems.

In light of the variability of data quality and the methodological limitations associated with the different data sets, the OIDT has placed a high priority on improving data quality. Work is currently planned and in many instances has already been commissioned to pilot new reporting and monitoring systems and to improve methodological and data quality aspects.

A major methodological limitation has been the inability to cross refer between data sets produced by the different Ministries. The OIDT has been examining with key Ministries the possibility of developing a system based on data for an individual drug user rather than on aggregate data for different aspects of the drug problem. This work is now developing as a pilot in three Regions and should allow cross reference between data sets and analysis of elements of an individuals drug career.

PART 3

DEMAND REDUCTION INTERVENTIONS

8. Strategies in Demand Reduction at National Level

8.1 Major strategies and activities

As has already been noted in Section 1 concerned with national strategies and policies, a National Drugs Plan was adopted in February 2002 which identified the focus and priorities for action on drug misuse. For demand reduction, the most important elements were:

- Renewed emphasis on primary prevention, engaging public and private organisations, the community and the family
- Increased utilisation of abstinence focused treatment and an expansion of residential drug free treatment
- Changes to improve accessibility to treatment, including treatment provision within the justice system
- Evaluation to ensure that the most effective, evidence based interventions are used in prevention, treatment, recovery and rehabilitation.

The Plan was adopted by the Government in February 2002. The changes or developments required to implement and measure the impact of it are still under development and the main focus has been on improving co-ordination and preparation of a draft law to establish the structures and guide policy for tackling drug misuse and associated problems. The draft law [1] has been published and now awaits debate by Parliament. It has already been the subject of much professional discussion.

In April 2002 the Minister of Labour published the basis for financing projects through the National Drugs Fund [2]. The areas identified are closely associated with the priorities of the National Plan, for instance, with a focus on integrated actions, interventions around the use of new drugs along with development of early warning systems, reduction of chronic drug use through expansion of drug free treatment options, expanded services for women drug users, training and updating of relevant staff, evaluation of interventions, placement of former drug users into training and employment and work with European partners on interventions with drug users moving within the European Union. In late 2002 the decision was taken, for national budgetary reasons, to reduce by two thirds the allocation to Ministries where projects had not been approved or started. It is expected that at a later date the funding will be restored.

In June 2002 a Ministerial Decree from the Minister of Health in association with the Minister of Welfare [3] was published. This set out the basis for the operation of the Pathological Dependency Departments and the role of the Ser.T. as an operational unit. It provides for accredited private social organisations to be treated on an equal basis with the Ser.T. and provides for a drug user or his family to seek treatment anywhere in the country, reversing the previous requirements for a drug user to present to the Ser.T. serving his or her area of residence for an assessment of treatment needs and

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[1] Revisione del Decreto del Presidente della Repubblica, 9 ottobre 1990, N. 309. Testo unico delle leggi in materia di disciplina degli stupefacenti e sostanze psicotrope, prevenzione, cura e riabilitazione dei relativi stati di tossicodipendenza. Disegno di Legge**.** Approvato dal Consiglio dei Ministri nella seduta del 13 novembre 2003 (Revision of the Presidential Decree 309/90. Unified text of the drug laws. Draft law approved by the Council of Minister on 13 November 2003)

[2] Provvedimento 10 aprile 2002 "Atto di indirizzo generale per la presentazione da parte delle Amministrazioni dello Stato dei progetti da finanziare con le risorse del Fondo nazionale di intervento per la lotte alla droga" Gazzetta Ufficiale della Repubblica Italiana, 30.4.2002 (General Directions to Central and Local Government bodies for the presentation of projects funded through the National Drugs Fund)

[3] Decreto 14 giugno 2002 "Disposizioni di principio sull'organizzazione e sul funzionamento dei servizi per le tossicodipendenze delle aziende unità sanitarie locali - Ser.T., di cui al decreto ministeriale 30 novembre 1990, n. 444." Gazzetta Ufficiale della Repubblica 25 giugno 2002 (Regulation on the organisation and functioning of the services for drug dependence of the local health authorities – Ser.T. established through the ministerial decree 444 of 30 November 1990)

subsequent placement in a treatment programme. The Decree was challenged as unconstitutional and was referred to the Constitutional Court. The Court supported the challenge on the basis that responsibility for health and social services had been devolved to the Regions and the Decree therefore was outside the constitutional authority of the central administration.

8.2 Approaches and new developments

During 2002 there were no new or particularly innovative approaches. Rather, there was the development and gradual implementation of the new approaches promoted through the regulations approved in 1999, which have been described in detail in previous reports to the EMCDDA.

Broadly speaking, the developments have been towards more integrated systems of prevention, treatment, recovery and re-integration at the local level through the establishment of Departments for Pathological Dependencies, including illicit and licit psychotropic substances, alcohol, gambling and eating disorders, with the responsibility of developing strategic planning and implementation plans. Relevant public and private organisations are expected to be involved in both planning and implementation aspects. It is also expected that other specialities should be involved in delivery, such as mental health, child health and maternity services.

The National Drugs Plan has been adopted and, as described above, actions to implement it at local level are now being prepared but no major changes have yet occurred at the local level. It should also be noted that there is a clear separation of role between the national and local administrations. At the national level legislation and regulations establish the basis for strategic planning and service delivery and allocate resources to the Regions. At the local level, planning is expected to reflect an assessment of local needs and delivery of services appropriate to these needs. Thus, although a broad national framework has been established and specific resources have been targeted in line with the National Drugs Plan, it is the responsibility of Regions to deliver services in line with their own assessment and judgement of needs. Substantial variations in strategy and services are likely to continue at the Regional level within the flexibility established by the legislative and financial framework.

There have been no major socio-cultural developments relevant to demand reduction in the reporting period. The changes which have occurred or which are in process essentially relate to policy. These include the National Drugs Plan, increased powers for Regional administrations and a changing role for central administration as facilitator rather than deliverer of services. The impact of developments is likely to be seen gradually over the next few years.

There has been no specific public opinion survey relating either to drug misuse or to demand reduction policy specifically during the year. There is, therefore, no clear basis for stating whether there has been any change in public opinion. There was presentation of and debate about the National Drugs Plan and the new regulation concerned with the operation of the Ser.T. in the media. However, this presentation and debate has either been a reporting of the changes, or a statement of national policy and the basis for changes, or comment on the changes from those directly involved in planning or delivery. It is difficult, therefore, to call this public opinion. Rather, it is a policy and professional debate held in the public arena with no clear response from the wider public. As reported in Part 1, there has been considerably more discussion about the draft drug law revising the Presidential Decree 309/90. Prior to publication of the draft law there was public discussion in newspapers, on television and radio and in specialist publications in which the Government stated its objectives and intentions and in which those with divergent opinions expressed their position. To some extent this discussion was a process of setting out positions prior to approval of the draft legislation in an effort to influence opinion. The debate on the draft legislation is now beginning-

Several major national research programmes are due to report shortly but not all have as yet published final data. These include the follow-up study of drug dependents in treatment with the Ser.T. (VEdeTTE), an evaluation of the quality of the Ser.T. and an evaluation of the quality of therapeutic communities. Data from these programmes has

been presented at several conferences but in general the formal final report has not been made available with full data. For the purpose of this National Report, where data could be accessed, it has been used and has been marked as provisional if it has not been cleared for public use.

Apart from the annual conferences of the various professional or umbrella organisations, there were several important conferences in the year. The first major national conference devoted to the topic of double diagnosis was held in Sardinia. Gruppo Abele held a major conference in Turin, "Strada Facendo", attended by over 1,000 people. The Club Health International Conference was held in Emilia Romagna. Unfortunately the papers from the double diagnosis conference are still unavailable and it has not been possible, therefore, to draw on them for the key topic. Information from the other two conferences has been used where appropriate.

9. Prevention

As reported in the last National Report, the national drugs policy and strategy adopted by the Council of Ministers gave high priority to the prevention of dependencies and of youth problems. The plan has not been formally published but details were included in the Annual Report to Parliament (Welfare 2002). The priority is to strengthen attention on prevention, to increase knowledge of the risks arising from any involvement with drugs or drug users and to promote a sober and active life. A main focus is to be on primary prevention which must be linked to government action for infants and young people in compulsory schooling. Delivery of prevention must be carried out through a range of different types of intervention and aimed at reaching the largest possible number of young people. Interventions should be co-ordinated to involve all society, in particular, the family and the school. The objective of primary prevention should be to avoid initiation into drug use and to support the capacity of the young person to remain drug free. The overall aim of prevention is the promotion of a fully integrated person with improved opportunities to fully participate in training and employment. Prevention must be developed within a network of services involving public bodies and private social organisations. Information campaigns should value the role of individuals in society. The objectives of the national information/prevention campaign should be promotion of a responsible life, strengthening the search for sensations and emotions not based on risk behaviours and therefore to reduce the demand for drugs.

The planning and delivery of prevention is a local responsibility shared between a number of bodies. The Regional, Provincial and Communal authorities all have a role in relation to health, social, educational, employment, vocational training and cultural/leisure functions. Moreover, private social organisations and community organisations are also engaged in preventive work. The exact structures through which prevention is delivered is thus dependent upon local circumstances and there is no single national framework.

No data is available on expenditure on prevention. At the national level, since 1999 some €44.8 million has been allocated from the National Drugs Fund to the Ministry of Education, Universities and Research, of which some €39.1 million was for prevention projects, training staff to deliver prevention or to evaluate programmes. Additionally, other primary prevention projects (including training staff to deliver prevention and health promotion projects) financed by the Fund and promoted by other Ministries accounted for some €17 million. Thus, from the 25% of the Fund available to Ministries, 36.4% was allocated to prevention projects. At the Regional level, it is not possible to identify how much has been allocated to prevention activities but all Regions report that primary prevention and health promotion projects were financed.

9.1 School programmes

Heath education and information on the dangers of alcohol, tobacco and drugs is promoted and co-ordinated by the Ministry of Education, Universities and Research and is within the framework of ordinary educational and didactic activities. There has been a progressive movement to integrate drug prevention as an element of overall health education, both through inter-institutional co-operation following an agreement between the Education and Health Ministries for joint action to promote health as well as through collaboration with local health and social services and in co-operation with parents. At the local level, co-ordination and promotion of the initiatives contained in the annual

programme has been delegated to the Director of Education for the Province who uses a technical committee which has the responsibility to determine the criteria for allocating the funds dedicated to health promotion activities. On this basis, there is no specific model developed for general use within schools. The programmes which operate in the school setting may be within general health promotion activities which are developed or implemented according to locally perceived needs or be specific prevention projects carried out by a range of organisations. Every educational institute has a teacher with proven ability and experience for carrying out health education and drug prevention. As part of the national activity, training courses have been provided for these teachers.

There is a wide range of models available for health education and promotion and no specific national guidance on the model which should be used, only on the core criteria which should be included in a prevention programme. These elements have been described in the previous reports to the EMCDDA. In 2002 there were no specific changes and the core criteria will not be repeated here.

Although there has been a general move away from the use of external experts as the exclusive providers of special drug education programmes, it is still the case that drugs prevention is often treated as a project undertaken by public or private social and health services. Where prevention is placed more within the health education framework, the model has been to use specialist input as appropriate for a specific topic. The choice of external experts will vary from Province to Province according to the expertise available. At present there is no nationally collated data which can provide a succinct analysis of the range of models used or how they are implemented in practice. However, some data has been obtained from a selection of the schools which were involved in the ESPAD Italia survey.

There were 22 responses of which one was targeted at parents of students and one was targeted at teachers. None of the prevention programmes reported that they were using an established prevention programme, all were locally developed. The target population was primarily the 14 – 19 age group and only one project included students under 11 years of age. Parents were only involved in 6 (27.3%) of programmes, and one of these was specifically targeted at parents.

Every project was for a time limited period, the majority for 36 months, largely financed through the National Drugs Fund or other project funds. All but one of the programmes indicated that some evaluation was planned. For 10 (45.5%) only process evaluation was planned, for 2 (9.1%) only outcome evaluation was planned and for 9 (40.9%) process and outcome evaluation was planned.

Looking at the different elements of the programmes, the vast majority (81.8%) had social or personal skills or affective education as the leading element. All of these dealt with personal competencies, such as decision making, assertiveness, self-esteem, goal-setting and resistance to peer pressure. Only four (18.2%) had increased knowledge about drugs and their consequences as the lead element. For the second element of the programme, 17 (77.3%) had social or personal skills or affective education, with only one stated increased knowledge as an element, although three had attitudes to drug use as the second element and one had developing alternatives to drug use. For the third and fourth elements, whilst social skills and affective education remained important, early detection of drug use (20.5%), attitudes and knowledge (15.9%) and 'other' elements (29.5%) dominated.

With regard to the delivery of the programmes, 7 (31.8%) used only professionals (psychologists, doctors, social workers, police, etc.), 11 (50%) were a mixture of teachers and professional expertise, 2 (9.1%) were a mixture of teachers, experts and peers and only 2 (9.1%) were exclusively run by teachers. 15 (68.2%) of the programmes used an interactive approach whilst the remaining 7 (31.8%) used a didactic approach. In total, the programmes were operating in 234 schools and reached 64.744 students, with a range from 3 schools and 718 students to 50 schools and 10,000 students. However, in only one case was the programme integrated into school policy.

At the national level, several different prevention programmes are being piloted using resources from the National Drugs Fund. These build on work which has been

previously reported on the training of teachers responsible for health education and maintaining the work of the information and counselling centres based within schools. At the time of writing, none of these projects are completed and reports on them are not available.

"Student Oriented Schools" is aimed at the upper secondary schools and seeks to establish a framework for students to learn from each other and, through the centrality of the educational relationship, to identify vocations and develop their potential. The project is being externally evaluated by CENSIS.

"Life Skills Education" is based on the approach to health promotion advocated by the World Health Organisation. It is intended that it should be complementary to other developments in the educational sphere by including health promotion dimensions within a process of personal development and social citizenship.

The "Peer Education" project is based on a recommendation of the European Community, which identified this approach as an effective model, along with Life Skills education. The project aims to involve and prepare students, teachers, head teachers, parents and staff from a range of bodies through training and evaluation at Provincial, Regional and national levels. The training and evaluation has been delegated to a university and to a national association operating in the dependency sector. To date the project has been presented to 4,000 students, 400 students have been trained, 100 public and private organisations have been engaged, 240 teachers have been trained to follow and co-ordinate the planned activities and 190 parents have been trained to follow the planned activities.

The "Provincial Council of Students for Drug Prevention" aims to link with the Provincial Student Councils on the theme of well-being, working in collaboration with public and private bodies. The activities include a survey of the needs of young people in the 15 – 18 age group, prioritising interventions on the basis of the survey, establishment of a commission to follow each phase of the project, development of a project in collaboration with relevant experts, training for those to be involved and implementation at both Provincial and individual school levels. The project is being linked into the Youth Network of UNDCP and currently involves 10 Provinces.

No evaluation reports on prevention have been identified published during 2002 or the first part of 2003. Reports have been published describing activities or research on school populations, but not on the results of prevention activities.

9.2 Youth programmes outside school

These types of programmes are largely conducted by the Counselling and Information Centres or by outreach programmes undertaken by public or private services.

In large urban settings and localities, where young people gather, mobile information and counselling centres have been used. There has been no published evaluation about the impact of this type of service although personal observation suggests that they are under used because young people are unwilling to be observed entering them.

The work of the Counselling and Information Centres has been described in previous reports. They are based within schools and drug prevention and counselling for those concerned about drugs is part of their remit. No statistical or qualitative data about their work was available for 2002.

Secondary prevention programmes aimed at young people in leisure settings appear to have been more successful and these are considered in the section concerned with prevention in recreational settings.

9.3 Family and childhood

On the advice of the Ministry of Education, the focus in elementary schools has been on interpersonal relations, personal hygiene and education on the environment, food and the imagination. Particular attention has been paid to experiential programmes and the use of interactive modules.

For teachers, courses have been provided to help them deal with over-impulsive behaviour and aggressive behaviour and training support has been offered in the management of mental and behavioural problems in children.

The form of prevention which is being developed is rooted in helping the children to develop their identity, to stimulate their imagination and to build capacity and confidence in personal relations.

The major activity in this area continues to be the Family Project (Progetto Famiglia). Through this the Ministry of Education has sought to involve the parents of pupils, offering them the opportunity to participate in systematic meetings and specific initiatives. The aims have been:

- to create a deep and long lasting relationship between school staff, social workers and parents aimed at studying and challenging the dependence phenomenon,
- to improve the competence and educational capacity of parents so that they are better able to handle problematic behaviour in children and young people,
- to support coordinated interventions, to improve relations between the family, schools, voluntary and private social organisations and local institutions with the aim of supporting children to develop autonomy and to reduce psycho-biological vulnerability
- to increase the perception of adolescents of the risks involved in using drugs

The project has a budget of €2,065,827.60 over a three year period. Some 120 sessions are offered to parents from five schools during the school year, accounting for some 2,600 school pupils. However, to date no further information has been made available and only process evaluation is planned for the project.

At the local level there have been a range of activities and initiatives to promote effective interaction between the child and parents. Parental attachment and effective parenting has been at the core of this area of activity. Local organisations, both the Ser.T and social enterprises, have been involved in this area and have undertaken a range of actions at the commune and the elementary school levels. Amongst the private social organisations, the most common approach has been to work with parents, primarily mothers, who have personal problems and have children under school age. The focus has been to provide support, counselling and practical assistance to the mothers, whilst offering educational and play facilities for the children.

Unfortunately there is little data published on this work or on its outcomes. However, a review of data from the Regions on projects funded through the National Drugs Fund shows that for the 1997 – 99 funding period, 8 (40%) out of the 18 Regions providing data stated that they funded such projects. The corresponding data for subsequent years was 3 (30%) out of 10 reporting Regions in 2000, 2 (33.3%) out of 6 Regions reporting in 2001 and 2 (40%) out of 5 reporting Regions in 2002. The data is very incomplete with some Regions providing no information and others only providing information for one year. However, it does suggest that prevention projects targeted at this population is not common. It is noticeable that some of the Regions with the highest rates of problem drug use and the most populous Regions do not appear to include such projects within the scope of funding through their allocation from the National Drugs Fund. It is possible that such programmes are largely financed through the Province, which holds responsibility for education, but there is little or no information to prove or disprove such a hypothesis.

9.4 Prevention in recreational settings

As has been previously reported (National Reports 2000 and 2001), an agreement between the Government and the National Union of Dance Hall Operators provided a basis for the development of local prevention activities aimed at young people in leisure settings. The agreement was subsequently used at the local level to develop specific prevention initiatives. There is limited information available to the Focal Point on prevention in recreational settings. These tend to be carried out by local services, both public and private social organisations, financed from a range of different sources but commonly through the National Drugs Fund. Such projects may be time limited and little or no data on their activities or outcomes is published in professional or scientific journals. It is possible to find brief project outlines on a number of web sites but these rarely provide descriptions and data from the activities actually carried out.

From what is known, prevention in recreational settings falls into three broad categories. The first is concerned with the support or and provision of alternative activities to drug use. The second is concerned with the prevention of drug use, mainly 'doping', in the sports setting. The third is concerned with prevention in leisure settings, primarily discotheques, clubs and pubs. For this latter category, there appears to be no clear distinction between traditional definitions of primary and secondary prevention. Rather, many projects appear to include both activities to dissuade from drug use and the prevention of major health damage arising from drug use or unsafe behaviours which might occur under the disinhibiting affects of drugs within the same programme.

To illustrate this arrangement, the system operated within the city of Milan provides an example of both an overall prevention strategy and of each of the broad typologies referred to above.

Prevention is placed within the three yearly strategic plan for dependencies and is in harmony with the overall development of services envisaged in that plan. The model is one which seeks to prevent dependency on any substances and is not specific to narcotic and psychotropic substances. It is an integrated plan between the five districts of the Milan Health Authority and recognises both the drug use is found within the general population as well as having a specific impact on deviant behaviour and marginalisation. There are a number of specific objectives aimed at developing prevention approaches with adults, with young people, with professionals and through information exchange and engaging civil society, opinion leaders, business and industry. The prevention activity was to be continuous and aimed at developing 'multipliers' who would extend the prevention programmes whilst being supported by the professional staff of the Ser.T. The concept of 'multipliers' of prevention was fundamental to the strategy, using adults with educative functions working in close contact with young people. A key reason for this approach was because of the changing pattern of drug misuse within a population which did not traditionally come into contact with treatment services or get referred to the Prefect and the assessment service for offenders. Three examples of prevention programmes in leisure settings show the approaches used.

In collaboration with AGESCI (Catholic Scouts Association) a group of 10 senior scouts from tow Milanese scout groups worked with two staff of the ASL to create an inter-active theatre show designed to be a useful tool to initiate debate on the theme of alcohol and drugs amongst their contemporaries in the Catholic scouts groups in Milan. The show was attended by some 80 people and a video was made of it to provide the basis for continuing discussion and exploration of issues around alcohol and drugs. A weekend was also used for reflection and debate with a 30 scouts from 10 different groups on the theme of alcohol ,drugs and young people. The workshop was carried out with a group of scout leaders and from it various graphics were developed to communicate prevention information to other young people. The prevention programme also included consultations with single scout groups where they wanted more information and to be able to include prevention as part of their own programme of activities and a day with scout leaders on the theme of alcohol and drugs to develop their capacity as 'multipliers' of prevention. A working group was also developed with leaders from the non-Catholic scouts association to develop a prevention programme which could be integrated into the scouting activities.

At the level of sports organisations, in co-operation with the C.S.I. (Centro Sportivo Italiano) a project was implemented with the aim of stimulating prevention as a normal part of the activities of sports associations. The staff of the ASL of Milan offered a training course for the directors and trainers of the C.S.I. with the aim of building a strong base for specific prevention activities directed towards young people participating in a specific sport or sports setting. The training programme had three sessions: "Sport between education and prevention" – aimed at reviewing the role of sports directors and trainers as agents for prevention; "The body between alcohol, drugs and sport", which explored the relationship between perception of your body and the construction of self-identity; "The rules of the game in prevention of dependency", which explored preventive activities which could be integrated into different sports

settings. The training course was free and interactive offered to a maximum of 20 people for the course.

The third example concerns preventive work focused on night-time leisure settings. This was an action research with the managers and staff of discotheques/pubs aimed at identifying what night life organisations could satisfy the need to relax from the daily routine whilst still ensuring the health and safety of those involved. It also has the objective to act as a resource for adults who had a significant interaction with young people in Milan and could be an educational and prevention resource. The objectives of the project were to involve the most popular leisure settings in building specific and continuing prevention activities within the setting and to engage the staff of these settings in the planning and implementation of the activities. The first phase involved the project staffing mapping the leisure settings and behaviours in 25 different locations. This found some differences with experience reported from elsewhere in Italy. There was a concentration on a number of prominent locations which had clear identities and which had different approaches to music, lighting and presentation and to the use of space. It was also the case that there was no location which was only used by young people, rather the population changed during the evening. This was a research phase which used a technical group from the leisure and prevention sectors to review the quality of the entertainment, the internal and external security, the use of alcohol and drugs, the music and structure of the setting and the activities which were observed during the evening. The second phase built on the first to involve the managers of 10 locations, the most representative DJs and staff from the discotheques/pubs. Awareness training was provided to 20 DJs from 9 locations as part of the development of continuous promotion of prevention.

This example of the operation of a prevention strategy and the implementation of specific components is not unusual for many urban areas of Italy. For instance, in Bologna research on drug and alcohol use amongst those attending pubs (32), bars (24) and discotheques (17) and 67 other settings (restaurants, hosteria, pizzeria, etc.) has provided a basis for specific prevention work in such settings. The research found that the use of drugs, especially at weekends, was regularly observed by managers of these settings. Cannabis was most common – observed in 37 places, followed by cocaine (12 locations) and ecstasy (6 locations). The users were not the traditional clients of the Ser.T. but students and workers aged between 16 and 20. They were at risk to dependence, accidents and overdose in part as a result of inexperience and lack of knowledge about the risks of poly abuse. The substances used varied during the evening, alcohol throughout, cocaine and ecstasy before dancing, and cannabis to relax at the end. It was also observable that there was a changing pattern of alcohol use with intoxication becoming more frequent and, to some extent, sought. The response was the development of a training course “Night Professionals” which was a collaboration between the Union of Dance Hall Operators (SILB) and the Commune of Bologna. From this developed the concept of ‘Quality Members’, aimed at improving capacity to identify and reduce the risks associated with alcohol and drug use. It also developed a new professional figure – the reference person for security – introduced by the Prefect of Bologna and approved by the Ministry of the Interior.

Throughout Italy, local planning, most commonly at the level of the commune, is used as a basis for developing preventive work whilst at the Regional level the use of planning mechanisms allows the creation of local approaches within an overall strategy, commonly supported through financing from the National Drugs Fund along with the regular funding of the Department for Dependencies within the Region. As such, there is no universal or common approach, rather there are responses which are adapted or developed to meet identified local conditions.

9.5 Other programmes

Helplines

The national telephone helpline Drogatel has continued to operate throughout the year. Initially established as a helpline in 1993, the service became a call centre in January 1999. In May 2001 there was a further change in the way the national service operated

when it was incorporated into the Contact Centre of the Department of Social Affairs, now the Ministry of Welfare. This resulted in a changed number, a requirement to select the service from a list of services and there was also a minimal charge for calls. Additionally, in 2001 advertising of the number through the national campaign ended. Taken together, these changes appear to have had a significant impact on calls to the service. In particular, it is noticeable that there was a significant fall in the number of calls following the changes from free number to call centre to contact centre. The average monthly number of calls in 1999 was 1,500, falling to 1,250 in 2000, to 771 in 2001 and to 763 in 2002.

Table 22 shows comparable data for 1999 - 2002. There was an increase in the percentage of new callers and an increase in the percent of calls from mothers. Almost half the callers found the Drogatel number in the telephone book, where it is listed in the first section "Emergency Numbers". The largest percent of callers (24%) were in the 26 – 35 age group, although this was a reduction from 2001 where 27.8% of calls came from this group. There was a very substantial reduction in calls from the under 26 years population, from 22.6% (2001) to 12.8% (2002) and in one year calls from those under 36 years fell from 50.4% of all calls to 36.8%. In the same period calls from drug users fell from 21.9% to 7%. This strongly suggests that the changes made in 2001 – new number, no longer free, no immediate access to advice/counselling, no advertising in the national campaign – have had a strongly detrimental impact on use of the service by young people and drug users. 36% of calls sought information about drugs, primarily heroin, cannabis and cocaine. Amongst those categorised as drug users, 61% were regular users, 10.6% occasional users and 13.7% 'suspected' users. For this latter group, calls were primarily from mothers of young people in the 14 – 25 age group who suspected their children were using cannabis or cocaine. Interestingly, whilst of all calls to the service, 59.9% were from women, amongst drug users, 76.9% were from men. This seems to confirm information from a range of other sources which suggests that women are less likely to use controlled drugs, more likely to be occasional users and more likely to stop use or seek help at a much earlier age than men. Amongst drug users, heroin (35.5%), cocaine (21.8%) and cannabis (19.9%) were the drugs most cited. However, amongst those who had not previously sought help, cannabis (26.8%), cocaine (26.5%) and heroin (20.8%) were most cited. This again supports the indications arising from other data sources suggesting that treatment services as presently constituted appear to be unattractive to non-opiate users.

Callers to Drogatel 1999 - 2002

	1999	2000	2001	2002
No of calls	20,001	15,000	9,252	9,156
% of new contacts	46.2	45.4	38.6	47
% of calls aged <26	19	21	22.6	12.8
% of calls from mothers	20	22	24.6	26.5
% of drug users	23.6	23	21.9	7

Table 22 *Source: Drogatel*

There are also a number of local telephone information and help lines, for instance, "Charlie", operated by the Social Co-operative 'Il Ponte' based in Tuscany. This service started some 10 years ago to provide a contact point for those concerned about dependency and related problems. It received Regional support in 1996 and now has a toll free number making it available to the whole of Italy. The service is operated by 50 volunteers with 5 telephone lines and 7 linked computers with internet access. On average 5,000 calls are received each month, primarily from those in the 15 – 35 age group, evenly balanced between male and female callers. The system is not exclusively concerned with dependency issues now, but has evolved to respond to the problems presented by young people, primarily psycho-social problems, difficulties with relationships and sexuality. These are acknowledged factors in substance misuse and as such the service has an important preventive function.

National Drug Prevention Campaign

The 2002 national drug prevention and information campaign had two elements: the use of radio and television spots, along with posters, magazine insertions, etc.; activities across the country focused around the tour of three large "motor homes". The first element was undertaken by a professional public relations/marketing company. The second element was undertaken by a group of private social organisations under the leadership of Comunità San Patrignano. This involved three large motor homes touring Italy and distributing information on drugs, attending concerts and youth events to provide the opportunity for the transmission of experience from young people to young people. The motor homes travelled some 80,000 km with over 150 stopovers and some 65 cities visited. The vehicles were fitted with multi-media equipment which allowed young people to record their own experience in various formats. The tours actively engaged local private social organisations in the prevention activities with the aim of establishing a continuing basis for prevention work once the campaign moved on to its next location. The campaign also included a 'video clip' competition for upper secondary schools promoted jointly by the Prime Minister's Office and the Giffoni Film Festival. The video clip was to be up to 60 seconds on an anti-drug theme with the winners invited to attend the Giffoni Film Festival in July 2003.

Documentation and Information Centres and the Internet

The annex listing drug related web sites in Italy shows the extent to which the internet is used to provide information about drugs or services for those concerned with drug misuse. Many of the sites are intended solely to provide information about an organisation and its work. An increasing number, however, are specifically concerned with providing news and information about drug misuse or designed as an inter-active site for young people including drug prevention as part of their remit.

In the former group, there are an increasing number of documentation centres now on line. Such centres can be found particularly in Emilia-Romagna, Lombardy, Tuscany, Piemonte and Veneto. Emilia-Romagna has established an on-line network of documentation centres "Dip&Doc" which publishes a regular electronic newsletter providing information about publications and events and links into the electronic data bank. Tuscany is in the process of creating a similar network and already has several documentation centres on-line. Together, a group of documentation centres from different Regions have formed a network "ACADìA", aimed at developing capacity within the centres, developing common documents (bibliographies, etc.), standards and improved access to electronic information and documents.

In the second group, the national prevention campaigns have always had a dedicated web site. At present the the web sites developed for the 2000, 2001 and 2002 campaigns are all off line, although evaluations and results from the 2000 and 2001 campaigns are available on the Focal Point web site. Both sites provide information about events, about drugs and provide games with a drug and alcohol misuse prevention theme. At the local level, there have been an increasing number of sites such as, for instance, Il piccolo chimico (Modena), Spazio Giovani (Parma), CONT@TTO - SPAZIO ADOLESCENTI (Province of Varese), Usi e Abusi (Province of Brescia) and Dialoghi di Tossicodipendenza (Piemonte). There is no published data about the level of use of these sites for 2001 and it is not, therefore, possible to provide any evaluation of their utilisation or to make an assessment of their impact. In all cases, however, they are part of an overall contribution to prevention rather than stand-alone prevention projects.

10. Reduction of drug related harm

As has been previously reported, there has been a shift in national policy away from harm reduction in favour of prevention and reduction of chronic drug misuse. The consequence of this move is not to deny the importance of assisting drug users to reduce the long term harms arising from drug misuse but to focus on such activities within the context of work with dependent users and as an activity within an overall framework of treatment leading to

abstinence and rehabilitation. The draft legislation which is to be examined by Parliament during 2004 aims to establish more clearly the basis for interventions with drug users.
There has been considerable discussion within the professions about the direction of public policy as it has been articulated through speeches from ministers and the Extraordinary Commissioner and there has been vocal opposition expressed to some of the proposed changes. However, it has been repeated on several occasions that the changes proposed with relation to harm reduction are concerned with placing such activities in a defined context of care for problematic drug misusers not a rejection of such activities in total.
Health and social services are a Regional responsibility and as such the approaches which may be adopted can vary considerably. There is increasing discussion occurring about the problems which might arise from contrasting policies between neighbouring Regions. There have always been some differences because of variations in local conditions – the size of the Region, the level and type of drug misuse, the level of urbanisation, social and economic conditions, etc. However, the concern which is now being expressed is that these variations will increase and will be influenced by political and social opinion rather than scientific evidence.
Whilst discussion continues on the proper focus for drug demand reduction and the role of harm reduction, many projects concerned with reducing drug related harm continue. These have commonly been financed for three year periods and in practice changes will only occur as new funding and new projects become available.
At the local level, the forms of intervention are primarily outreach programmes (unità di strada) operated by both public and private social and health organisations and specific projects, usually funded through the National Drugs Fund. These latter projects include needle and syringe exchange programmes, distribution of leaflets on drug related infectious diseases and how these can be avoided, leaflets on what to do in case of overdose and work with drug users at festivals and in discotheques.
Harm reduction with drug users is largely integrated within the wider work of drug misuse services and there does not appear to be specific harm reduction professionals. There are, however, links between low threshold and outreach services and sharing of experience amongst those working in these sectors. This commonly occurs within Regions, where many staff know each other or through the various professional associations whose meetings provide an opportunity to meet.
For the reasons already given, there is no direct co-ordination between national policy and local practice.

10.1 Description of interventions

There is little published data about the activities of harm reduction programmes. Two reports from Milan, and a report from the Bologna Metropolitan Drugs Observatory, all published on the internet, provide some information as does unpublished data from Magliana 80 and Villa Maraini in Rome. They also provide some examples of the activities undertaken and the nature of the projects which are most commonly provided.
The outreach projects operating in Italy in general combine information dissemination, outreach to users and at risk groups, counselling, referral, equipment provision/exchange and assistance with intoxication/overdoses.
The Milan 'unità di strada' reported contact with 1,351 people during 2002, accounting for some 20,490 encounters. Of those contacted, 1,004 were drug dependent – 761 Italian males, 126 Italian females, 102 non-Italian males and 14 non-Italian females. Together, the drug dependent group were encountered on 18,791 occasions. The service provided syringes (113,971 given out, 77,222 received), distilled water, sterile swabs and condoms. It also provided medications (834 occasions) and Narcan (733 occasions), the latter relating to actual or possible overdose situations. Information on drugs or sexually transmitted/infectious diseases was offered on 519 occasions, counselling on the same topics or on the availability of services was provided on 904 occasions, 330 referrals to drugs, health or social services were made and 2,193 leaflets on a range of topics were distributed. SOS Stazione Centrale, also in Milan, reported that in 2002 it met 1,255 people, of whom 347 (27.6%) were drug dependent – 282 male and 65 female, accounting for 4,149 contacts (35.9% of all contacts). The

services offered included counselling and referral (30.2%), support with no referral (29.8%), basic services – food, shower, clothes, post collection, use of the telephone (31.9%) and night shelter (6.5%). The Bologna data refers to 121 people contacted in 2002, a reduction from the previous year although it is suspected that this is because not all clients were recorded rather than an actual reduction in people contacted. The median age of contacts was 28.7 and the male : female ratio was 3.3 : 1. The majority were Italian and heroin dependent and 43% were homeless. Interestingly, the mobile methadone unit has almost a quarter of its clients who are non-Italian whilst the outreach service only had 4.1% of non-Italian clients. Magliana '80 operates an outreach service and has reported on a project focused on ecstasy use. The project made contact with 11,491 young people , 48.7% of whom used drugs. Of these, 72.4% were in the 15 – 20 age group. A significant percentage of drug users (93.2%) used more than one drug, commonly using two or more substances at the same time. 45.2% of users also reported symptoms experienced as a result of drug use, with sleep disturbance (50.9%) most common, followed by alimentary disturbance (23.8%) and mood disturbance (16.5%). A total of 10,630 contacts were made with the users with counselling, information about drugs, services and sexually transmitted diseases and referral where appropriate being offered. Reporting on its outreach work over the last 10 years, Villa Maraini noted that in the period 25.3.1992 – 25.3.2002 it had had 433,063 contacts with 13,490 individual drug dependents, 1,225 of whom were non-Italians. There were 1,008 occasions when the outreach staff intervened to deal with an overdose and in 7,764 instances emergency medical treatment was needed. Reporting on activity in 2001, of 24,243 contacts in 2001, 19,002 (78.3%) were with drug dependents, 4,002 (26.6%) of the drug dependents were female and 1,266 were involved in prostitution. In the year there were 117 new contacts, of whom 24 were non-Italian. 16,036 syringes were distributed, 7,083 returned and 8,615 phials of distilled water were given out.. Most users were poly-drug abusers, commonly with benzodiazepines and ketamin. There were 32 instances of direct intervention at an overdose, Narcan was handed out on 282 occasions and emergency medical intervention was required on 680 occasions. There were some 353 referrals to treatment or assessment services, counselling was given on 1,218 occasions and safety cards or leaflets were distributed on 3,171 occasions. The outreach team consisted of doctors, psychologists, social workers, volunteers, student placements and Red Cross volunteers and included former drug dependents.

These examples of harm reduction outreach services provide an example of a common pattern in larger urban and metropolitan areas of Italy. Syringe distribution is also commonly available from machines throughout the country and injecting equipment can be bought from pharmacies.

There is little evidence of specific training on how to avoid or deal with an overdose. As reported last year, many outreach services which make Narcan available to drug users also provide leaflets or cards on overdose and how to use Narcan. There is no known evaluation of the impact of such approaches. However, there has been a continuing reduction in the number of overdose deaths in Italy, which may in part be a result of information campaigns, along with changing patterns of use. The evidence from the Bologna emergency service (118) also shows that there has been both a reduction in the number of emergency interventions and in the severity of the overdose situation. This suggests that the work of outreach services may have made a contribution to the overall reduction of overdose and overdose deaths. It is also interesting to note that the profile of those seen by the outreach services seems to be different from that of those in contact with the Ser.T. The male to female ratio is much lower than for the Ser.T., a much higher percentage are homeless or insecurely housed and the health and social problems encountered are more intense. There also appears to be a significant number of non-Italians in this population, who may not be eligible for treatment within the general health care system and who are, therefore, both at greater risk to infections and other drug-related harm and a potential basis for the spread of infection.

Within Italy there is no provision of safe injection rooms and it is likely that at present these would be unlawful, although this has not been tested. The City of Turin

established a commission to examine the scientific evidence for the provision of such a service which concluded its work in February 2003. There were doubts about the effectiveness of such rooms, given the complexity of the drug problem and no formal decision has yet been made. A project proposal to establish such a service in Turin was submitted for financing through the Regional allocation of the National Drugs Fund but it is not known whether this was successful.

10.2 Standards and evaluation

In terms of standards, as has been previously reported, each Region is required to establish the basic standards for social and health services. Such services must be registered with the Region and accredited to undertake work with a particular client population. The standards adopted may vary from Region to Region and there is no single national standard. However, in general the standards which have been adopted cover the services to be offered, the qualifications of staff, recording and reporting requirements and physical settings. Most Regions now have in place the local laws establishing the basis for accreditation of services and many have provided or financed courses to qualify or re-qualify staff working in such services.

No specific evaluations of harm reduction services were identified as being published during the reporting period. Research studies and reports on work undertaken have already been reported above in illustrating the approach to outreach harm reduction.

11. Treatment

There have been no major developments in treatment strategies during the reporting period. As has already been noted, national policy has placed emphasis on the reduction of chronic drug misuse. Within the draft legislation this is more clearly identified as progression to abstinence rather than induction into and maintenance in long term treatment, especially with substitution treatment. There is substantial debate about this approach but at present it remains a proposal and the strategies which have been in place for several years remain in place.

11.1 "Drug-free" treatment and health care at national level

Drug free treatment is primarily aimed at achieving and sustaining long term abstinence from drug use. Within this definition, treatment with opiate agonists and short-term methadone treatment aimed at achieving detoxification are considered to be drug free treatments as both have the objective of achieving abstinence. Also included in this definition are residential rehabilitation services, day rehabilitation and psycho-social interventions in both public and private treatment services without the use of maintenance drugs.

It is extremely difficult to offer clear criteria for admission into drug free treatment services. The vast majority are operated by independent private socio-rehabilitative organisations and they each operate their own systems for admission. Moreover, there are differences between the criteria for admission into a treatment service and criteria for admission into a specific programme. For instance, many private socio-rehabilitative organisations use their 'first contact' programme, commonly called "accoglienza", as a means of assessing treatment needs and determining the appropriate programme.

For treatment services using antagonists or short term (under 3 months) methadone to achieve detoxification, the criteria for admission are the same as for admission to substitution or maintenance programmes. The difference is essentially in the assessment of treatment needs based on age, length of dependent drug use and mode of administration, as well as on psycho-social factors such as motivation, social and employment circumstances, etc.

For rehabilitation services and psycho-social interventions two different criteria may apply. For the former, the presence of a wish to change, even if this does not represent a strong commitment, or pressure to participate in the programme either as a result of legal proceedings or from the family or employers may be sufficient basis for admission into the preparation (accoglienza) phase. For the latter, a second criteria may apply,

that substitution drug treatment is inappropriate, for instance where cannabis, cocaine or synthetic drugs are involved.

The census carried out four times a year by the Central Directorate for Documentation of the Ministry of the Interior shows that on 31 December 2002 there were 803 residential, 243 semi-residential and 223 non-residential socio-rehabilitative services operating in Italy. This is an overall reduction of 33 services from the same period in 2001, with reductions in residential services (-3.8%) and non-residential services (4.7%) a whilst there has been an increase in the number of semi-residential services (+4.3%). At the time of writing there is no data on the number of places available in the different types of service. Table 23 shows the distribution of the services by type of service and geographical area.

Socio-Rehabilitative Services

	Residential		Semi Residential		Non-Residential		TOTAL	
	12/01	12/02	12/01	12/02	12/01	12/02	12/01	12/02
North	455	433	114	116	117	122	686	671
Centre	181	173	61	61	38	30	280	264
South	144	146	44	52	61	53	249	251
Islands	55	51	14	14	18	18	87	83
TOTAL	835	803	233	243	234	223	1,302	1,269

Table 23 *Source: Ministry of Interior*

The largest number of services is in the northern Regions. This is expected as these are also the Regions which have the largest numbers of problematic drug users and the highest urban densities. The data on clients attending these services is less clear. The census for 31 December shows that there were returns from 90.2% of all relevant services. This represents a reduction in the percentage of replies compared to both 2000 and 2001. There was also a reduction in the number of people attending the services compared to previous years with 17,324 reported in December 2002 compared to 19,397 in 2001 and 19,289 in 2000. This would suggest that occupancy levels have fallen. The reason for this is not clear and may relate to several factors including over capacity of such services and longer term retention of drug users in substitution treatment with the Ser.T. A particular situation for Italy is that nearly all public funding for drug treatment services is through the health services budget of the Region. The national health service managed treatment services (Ser.T.) are required to approve the placement of a client in a private socio-rehabilitative service if public funding is to finance the treatment. There is, therefore, a potential conflict between treatment demand, clinical judgement and the treatment offered. For the Ser.T. to be in a position to bring more people into treatment, it must retain a higher proportion of the available resources. If it moves people through into rehabilitation services, these are proportionately more expensive and reduce its capacity to meet treatment demand. Discussions are currently underway in an effort to resolve the problem, but no solution has yet been found.

The classification of services used in Italy does not allow a full appreciation of the types of programme available. Residential services may include detoxification, crisis intervention, rehabilitation, preparation for social re-insertion and vocational training services. Semi-residential services are all those which require attendance for a substantial part of the day, usually five days a week. The may include day therapeutic programmes, assessment centres, vocational training and harm reduction services. Non-residential services are ones which may involve attendance by appointment or may have open access but where attendance is voluntary. In either case full time daily attendance is not required. Semi-residential and non-residential services may be provided in combination with methadone treatment from the Ser.T. Residential treatment in general does not involve the Ser.T. except where residential detoxification or crisis intervention is being undertaken. The available data concerning people in socio-rehabilitative services and funded by the health service shows that in 2002 3,126 treatments were classified as psychological support, 607 as psychotherapy and 7,159 as social work. As can be seen from these figures, the total number of interventions recorded by the Ser.T. for clients in socio-rehabilitative services during the year are

fewer than the total number of persons recorded as attending a socio rehabilitation service on a single day (31 December) of that year. This suggests that a significant number of people in such services are funded through the Ministry of Justice as an alternative to imprisonment, or through project funding through the National Drugs Fund or other public or private sources or through funds secured by the socio-rehabilitation service itself.

Socio-rehabilitative services are required to be registered with the Region and are subject to Regional regulations on the minimum expected standards, on staffing levels, qualifications and training. These regulations vary from Region to Region and the only common base is the Regulation agreed by the Permanent Conference for Relations between the State and the Regions of 5 August 1999 which provided the broad basis for the standards. A registered service is entitled to receive payment from the local health authority for clients referred to them by the Ser.T. Normally there is fixed amount paid per week with a standard rate for residential therapeutic communities, residential pedagogical/rehabilitation services and for semi-residential services. Additionally, services may have an agreement with the Ministry of Justice to provide treatment services as an alternative to punishment or as an alternative to imprisonment. They may also have an agreement with the Prefecture for provision of services to those referred for unlawful possession of a listed drug. In such cases, they will receive payment for clients referred through the criminal justice system separately from payment for clients received through the Ser.T. Non-residential services are in general financed through project funding from a range of different sources. There is no mechanism at either national or Regional level to identify the total amount of funding available from public and private sources.

Psycho-social treatment provided by the Ser.T. may be a stand alone treatment or it may be in combination with substitution or maintenance treatment. In 2002 there were 139,807 people in treatment with the Ser.T. alone. Of these, 70,427 received psycho-social treatment. As the total number of treatments offered to clients of the Ser.T., including substitution treatment, was 256,705, many of those receiving psycho-social treatments also received substitution treatment and it is not possible to identify how many people only received such treatment.

As noted above, it is difficult to identify the exact number of drug free treatments as opposed to the number of treatments in a particular setting. However, it is a reasonable assumption based on the available data that residential and semi-residential treatment services in the socio-rehabilitative sector provide drug free treatments based on the definition given earlier.

From the Central Directorate for Documentation data (Table 24), the number of people in residential treatment on 31 December 2002 (11,730) was less than the number in such treatment on the same day in both 2001 and 2000. For the same dates there were also reductions in the number of clients in semi-residential services and non-residential services. This data seems to confirm what appears to be a long term trend for a reduction in the use of residential services, which largely accounts for the reduction in the use of drug free treatments, whilst the number of substitute or maintenance treatments has continued to increase. There must, however, be some reservations about the available statistics, which only provide data for utilisation on a particular day. There is no national data available on total admissions into drug free treatment or on programme completions / premature departures. It must be assumed that admissions were higher than one day figures but without improved recording and data collection there is no means of identifying effectively the true extent of drug free treatment utilisation. The

Socio-Rehabilitative Services

	31/12/2000	31/12/2001	31/12/2002
Residential	12,777	12,170	11,730
Semi Residential	2,032	2,107	1,894
Non-Residential	4,480	5,120	3,700

Table 24 *Source: Ministry of Interior*

Italian Federation of Therapeutic Communities (FICT) reports that the 49 centres which were members of the Federation had 11,164 clients in residence in 2002 and that 708 people completed the treatment programme during the year. In terms of staffing, the 49 centres had 937 full time and 125 part time staff and used 236 external consultants, 2,913 volunteers and 152 conscientious objectors in 2002. Only 168 people were employed in administration of the centres. This data, which only refers to a part of the socio-rehabilitative services available in Italy, seems to support the contention that there are significantly more people in treatment with socio-rehabilitative services than are financed by the health system. It also suggests that the total number of people seen by these services is greater than that reported by the Ministry of the Interior census. However, without more information on retention and completion rates it is difficult to know with any accuracy the total contribution made to drug treatment by the socio-rehabilitative sector.

Only one published report on any aspect of drug free treatment has been identified as being published during the year. Checcucci (2002) reports on sexuality and drug dependence and the development of a specific programme within a therapeutic community. Taking as the starting point that drug use affects sexual behaviour and personal relations and if not dealt with during treatment can contribute to a higher rate of relapse into substance misuse. The programme sought to develop a positive understanding of sexuality and the creation of a non-destructive approach to sexual and personal relations. 76 male clients were involved whose sexual characteristics were established through observation and personal history questionnaires. As a result of the programme, there were significant improvements in knowledge of sexuality, with sexual stereotyping more readily challenged and improved capacity to develop appropriate personal relations. The report does not indicate what impact there was on relapse rates or long term benefits of the approach which was taken.

11.2 Substitution and maintenance programmes

Objectives

There are several different objectives which might be pursued in the provision of substitution and maintenance programmes and there is no single model. Broadly, the objectives have been defined in the Guidelines for Harm Reduction Interventions developed by the Ministry of Health and described fully in the National Report for 2000. These see the purpose of substitution or maintenance programmes as drawing and retaining people in a treatment centre, reducing the likelihood of high risk behaviour and creating a more stable situation for interventions aimed at directing the client towards long term abstinence. Whilst the national guidelines are explicit about the objectives, it is probable that there are different objectives operating at local level which are clinical assessments of the appropriate objective for a client. It is not clear whether there are explicit general objectives or implicit assumptions about the purpose of a particular treatment modality at the local level.

Criteria for admission

As with the objectives, there is little data about the criteria for admission into a substitution or maintenance programme which are used at local level. The definition of such programmes is that there is provision of a pharmacological intervention, usually methadone administered orally, on a medium (3 – 6 months) or long term (over 6 months) basis. Admission to such programmes usually follows unsuccessful detoxification treatment, continued use of street drugs and/or continuing high risk behaviour. However, there is at present no data which can allow a full classification of the criteria which are applied. In Bologna there is a mobile methadone unit which has amongst its criteria for accepting clients that they are unable to use the fixed location service effectively because of their legal status, for instance non-residents without legal status, homeless drug users, etc..

Availability, financing, organisation and delivery

There are 555 public drug treatment services – Ser.T. – managed within the framework of the national health service. The Ser.T. operate within a Department for Pathological

Dependency at the Provincial level and are responsible to the relevant Regional Department. This may be the Regional Department of Health, of Health and Social Policy, of Social Services – there are a number of different titles which are used, depending on the size of the population resident in the Region and whether there is justification for a small number of generic departments or a larger number of topic focussed departments. In heavily urbanised Provinces, the Ser.T. may be operational at district level. In less urbanised Provinces it is not uncommon for the Ser.T. to operate from a number of different locations, providing many local services which operate for limited hours. The general aim has been to increase accessibility for people with drug problems. This has become of greater importance given the wider spread of problematic drug use into smaller urban settings. The staffing of the Ser.T. has moved gradually towards a more health oriented service with the percentage of staff who are doctors or nurses / health assistants rising whilst their has bee a reduction or stabilisation in the percent of staff who are educators or social workers. However, as data was not available on the balance between full time staff, part time staff and those contracted to provide specific services as required, nor on the type of service in which staff operated, it is possible that the non-medical staff are more actively involved in treatment interventions.

Regions have autonomy in the delivery of health care services and determine priorities in line with local needs. They are guided by the national health plan prepared by the Ministry of Health and approved by Parliament and by specific health legislation or regulations and by specific guidelines which might be issued through the Ministry. The funding of treatment services for people with drug problems is from the general allocation to Regions for all health care provision, as well as from local taxation and from projects financed through the National Drugs Fund. Few Regions have detailed information available about expenditure on drug treatment.

Substitution drugs and mode of application

The most widely used substitute drug is methadone. For the 139,807 people reported as receiving treatment directly from the Ser.T. in 2001 there was a total of 256,705 treatment interventions of which 56.9% were pharma-cological and 43.1% psycho-social. This represents a steady reduction in the percentage of all treatments which involved a pharma-cological type of intervention, falling from 58.4% in 1998. For those who do receive such an intervention, figure 41 shows the percent by year and type of pharmacological intervention provided. As can be seen from this, there has been a steady increase in the use of long term methadone whilst the use of other types of pharmacological intervention have remained stable or declined. In 2002 there was a levelling of in the use of long term methadone, which may reflect the gradual reduction in the percentage of clients with opiates as their primary drug and may also be a response to policy, parental and client resistance to methadone. Taken together, the data would seem to suggest that:

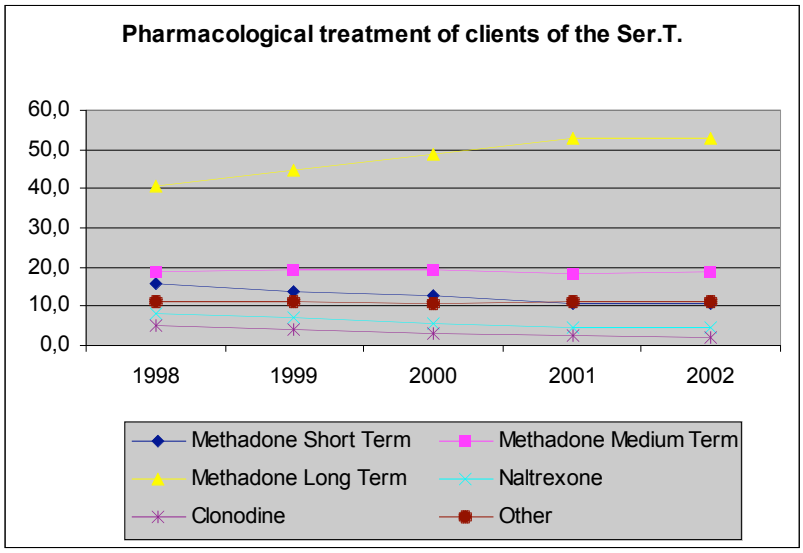


Figure 41 *Source: Ministry of Health*

- there has been a reduction in the use of pharmacological treatments over the last five years,
- this reduction is greater than reduction in the number of people with primary opiate dependence and
- long term (over 6 months) methadone treatment is focused on clients who have not proved amenable to shorter term interventions.

With much smaller numbers involved, there has also been a small increase in the number of pharmacological interventions being provided to clients in socio-rehabilitative settings. In 1998 22.4% of treatment interventions in such settings were pharmacological and in 2002 the equivalent percentage was 26.3%. Again, this has involved an gradual increase in long term methadone prescribing and a reduction in the percentage receiving other types of pharmacological interventions. It is not entirely clear how this should be interpreted. The most likely explanation would be that there has been an increased use of residential treatment and crisis intervention services with the aim of stabilising the drug intake of chronic opiate users, who subsequently become outpatient clients receiving long term methadone. Those receiving short term methadone or other types of pharmacological intervention are more likely to be undertaking detoxification prior to admission into a therapeutic community.

Very little descriptive or qualitative data has been produced describing the operations of the Ser.T. and only more generalised statements are available. Normal practice in most Ser.T. is for an assessment of new clients and where a pharmacological intervention is considered appropriate, the initial aim is to stabilise the client on appropriate medication without him/her resorting to illicit drug use. Initially the prescribed drug is consumed under supervision and subsequently it may be collected from a designated pharmacist. The long term aim is to achieve abstinence from the continued use of listed drugs. Prescribed drugs for the treatment of dependency are only available in oral form.

Psycho-social counselling

As with substitute prescribing, little descriptive or qualitative data is available on psycho social counselling within the Ser.T. The type of counselling available is categorised as psychological support, psychotherapy and social work interventions. It is not possible, from the available data, to know how many people receive this type of intervention without pharmacological interventions, how many may transfer from pharmacological to non- pharmacological interventions and vice-versa and how many are in receipt of both types of intervention simultaneously. The form for reporting the data seeks to avoid double counting and requires the primary intervention only to be recorded. The sole occasion where a client may be recorded for both types of intervention is where they constitute two distinct treatment episodes. It is very likely that clients receiving a pharmacological intervention are also in receipt of psycho-social interventions, but no specific data is available. What is clear and might be expected, is that clients directly treated by the Ser.T. most commonly have a pharmacological intervention whilst clients who are in socio-rehabilitative services or in prison predominantly receive psycho-social interventions. The data indicates that of clients who receive a psycho-social intervention, 54.9% have social work support, 32.6% psychological support and 12.5% have psychotherapy.

Diversion of substitution drugs

There is little data about diversion of substitution drugs and the available information suggests that it is not a major problem. There are some anecdotal reports of illicit methadone being readily available in some cities, but there is no documented support and specific research would be necessary to determine the actual situation.

Substitution prescribing is normally undertaken by the Ser.T. or by a general medical practitioner working in co-operation with the Ser.T. There is normally visual supervision of consumption for new clients of the Ser.T. and this is ended once the client is considered stable on the maintenance dose. With the additional control of non-repeatable daily prescription, the opportunities for diversion are limited.

From the available data, in the last five years referrals to the Prefect for unlawful possession of methadone has never exceeded 150 referrals in the year and in 2001 there were only 113 referrals. The second measure might be the percentage of clients of the Ser.T. with secondary drug use who report use of methadone. In the last four years, the highest percentage was 2.4% in 1998. In 2002 only 1.9% of clients of the Ser.T. had methadone as a secondary drug.
Taken together this data suggests that there is limited diversion of methadone and that it is not a drug of choice for those seeking drugs on the illicit market.

Evaluation results, statistics, research and training
Much of the epidemiological data has already been dealt with in Part 2 of this report and will not be repeated here. Table 25 provides the key data. The major research project concerned with the evaluation of substitution treatment is the VeDeTTE Study (Evaluation of the effectiveness of treatment for heroin addiction), commissioned by the Ministry of Health and co-ordinated by the Department of Public Health, University of Turin and the Public Health Agency of the Lazio Region. The study involved 115 Ser.T. in 13 Regions and recruited 12,373 clients into the study over an 18 month period. In the same period, 24,602 people were in treatment with the participating Ser.T. Of those recruited, 10,454 had valid data available for analysis. The study population, therefore, represented 42.5% of the available treatment population. Figure 42 shows the distribution of clients by Region. Although to date formal final results from the study have not been published, data from the study has been presented on several occasions including a day conference dedicated to the study organised by the National Health Institute. The data available is detailed and to some degree complex and full presentation of it will be deferred until publication in the scientific press has occurred. However, a summary of the key findings is offered here. 1,249 people were new clients, 1,981 were re-entering treatment and 7,224 were in treatment already when recruited to the study. For all the Regions, around 10% of clients had their first treatment within the last year. There were, however, greater variations between the Regions when length of time since first treatment was started with between 20% and 30% having started treatment over 10 years ago. As might be expected, almost 50% of new clients began treatment less than one year ago whilst almost 30% of clients already in treatment when recruited to the study had started treatment over 10 years ago. 23% of clients had continued their education after compulsory schooling, compared to 54% of general Italian population in the same age range. 33% were employed, 32% casually employed

Clients of the Ser.T.

	1998	1999	2000	2001	2002
New	31042	32398	31510	32920	31,766
Continuing	108905	110551	115636	117407	123,320
Male/female ratio	6.3:1	6.2:1	6.4:1	6.4:1	6.4:1
Mean age new M.	28,0	28.2	28.5	29.1	29.5
Mean age new F.	27.1	27.6	27.7	28.2	28.5
Mean age continuing M.	31.2	31.6	32.0	32.4	32.4
Mean age continuing F.	31.1	31.4	31.8	32.0	31.8
Primary drug heroin	85,6	83,6	82,7	81,4	79.5
Primary drug cocaine	3,2	4,3	5,3	5,7	7.0
Primary drug cannabis	7,6	8,0	8,0	8,2	9.1
Primary drug other	3.6	4.1	4.0	4.7	4.4

Table 25 *Source: Ministry of Health*

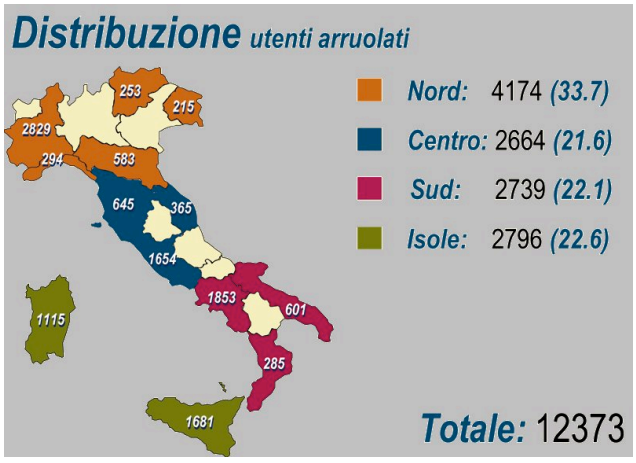


Figure 42 *Source: Studio VeDeTTE*

and 35% unemployed. For both males and females first use of heroin occurred at 19.6 years of age. For males there was a gap of 5.3 years between first heroin use and first entry into treatment whilst the equivalent gap for females was 4.4. This seems to support the inferences drawn from other data that female drug users tend to enter treatment earlier, although it is also the case that outreach services see a higher proportion of females than do fixed location services, suggesting that there may also be problems for these services in attracting female clients. In the course of the 18 month period of the study, 48,902 treatment interventions were provided to the 10,454 clients, with 9% referred into a therapeutic community and 46% receiving methadone treatment. For new clients, 36% were offered gradual detoxification with methadone, 26% methadone maintenance and 4% were referred to a therapeutic community. For those who were already in treatment, 12% were offered gradual detoxification with methadone, 47% methadone maintenance and 8% were referred to a therapeutic community. Clients in general had multiple problems, legal, social, personal and health. In terms of retention in treatment, there was a higher retention rate for methadone maintenance compared to residence in a therapeutic community. Some factors which increased the likelihood of early drop out included legal problems, unstable accommodation and unemployment. For both types of intervention, those under 25 years of age were more likely to drop out than older groups. There were also some specific indications of risk factors for early drop out from the two types of treatment. For methadone maintenance, the evidence showed that a daily dosage of below 60 mg was an indicator for likely drop out. A daily dose above 60 mg doubled the likeliehood of retaining the client in treatment. Methadone maintenance alone was also less likely to retain the client in treatment than methadone maintenance in combination with psycho-social interventions. These findings were important because the media daily dose of methadone in maintenance treatment was 40 mg, below that indicated by both this study and the international literature. However, it was noted at the conference that one of the problems in providing the optimum daily dosage was client resistance and that there was a need to inform clients and their family about treatments in order that the most effective interventions could be offered. For the therapeutic communities, education beyond compulsory schooling and less compulsive heroin use before admission seemed to increase retention rates. These findings may to some extent reflect the structure and programme content of therapeutic communities. The less compulsive use of heroin would also suggest the importance of a treatment path from highly compulsive use through pharmacological treatment, a gradual reduction in compulsive use and preparation for entry into a drug free treatment to achieve long term abstinence. The data presented here comes from the conference and will be augmented with further descriptive and analytical data once the results of the study have been formally published. There have been a number of other studies published during the year, the most interesting being reports on the use of buprenorphine in the treatment of drug dependency. Auriemma et al (2001) have reported on an evaluation of treatment outcome for 347 patients enrolled into a buprenorphine programme in two Naples Ser.T. There were 318 males and 29 females receiving daily sublingual buprenorphine at dosages between 2 and 12 mg. Some 50% of those recruited to the therapy dropped out, 62% of whom entered a methadone treatment programme and 38% of whom were lost to treatment. Those who remained in treatment showed improved psycho-physical and quality of life measurements. They also had a significant reduction in the use of illicit opiates and cocaine both during treatment and at a two month follow-up. 17% of those recruited to the buprenorphine treatment completed successfully. Salamina et al (2002) have reported on the first year of the use of buprenorphine in the Piemonte Region. 19 Ser.T. in the Region provided data about their treatment of 699 clients enrolled into the study. 346 clients (49.5%) received substitution treatment with buprenorphine with 134 being in a reduction regime and 211 in a maintenance regime. There were no significant differences between the median age, age of the onset of dependence or time of being drug dependent between those given methadone and those given buprenorphine treatment but female clients were more likely than male clients to be offered other reducing or maintenance

buprenorphine treatment. Although the study was not a trial with random allocation of treatments, it found that buprenorphine was readily integrated into the range of treatments used by the Ser.T. It also found that use of other drugs whilst in treatment was significantly lower amongst those treated with buprenorphine than those treated with methadone. At the end of the study period, 91.7% of the clients enrolled in the study were still in treatment and it was those on a methadone reduction programme who were most likely to drop out. Guerrini et al (2002) have reported on the use of sublingual buprenorphine in opiate dependents with long addiction histories. This retrospective study, carried out on a first group of heroin or methadone users undergoing buprenorphine treatment in the Ser.T. of Monza (Province of Milan), aimed to identify factors that might predict the outcome of this treatment. A clear correlation was found between the history of addiction of the clients and the maximum daily dosage of buprenorphine administrated. The authors concluded that much higher doses of (8-10 mg) should be administered to clients with a long history of abuse at the initiation of streatment rather than the low doses (4-6 mg) more usually offered, to limit their withdrawal symptoms and improve treatment compliance. De Rosa at al (2002) report on the use of buprenorphine chloridrate with 36 heroin addicts at the Pharmacological Outpatient Unit of the Dependence Department in Ancona. Twenty-seven clients were recruited from a methadone maintenance programme, while the remaining 9 were heroin abusers at enrolment. All the clients were rated over a 60 day period, using biological, psychological and social evaluation scales (CRAV Scale, Wang Scale, SCL-90, and EUROPASI). Urine tests were also performed to detect substance abuse. Twenty-five clients completed the study, and showed significant improvements with respect to withdrawal symptoms, psychic conditions (obsessive traits, hostility and depression), and social roles (particularly job performance, substance abuse and legal problems). Tests taken on a control group of 36 patients undergoing methadone maintenance treatment (on average daily doses of 20.19 mg) showed similar rates for retention in therapy to those of the buprenorphine treated sample, but a much higher frequency of heroin abuse (as detected by the urine screen). There is evidence emerging that buprenorphine is increasingly being used in the treatment of opiate dependence and specific data on this form of treatment is being compiled by the Ministry of Health. It is expected that it will be available for the next report.

11.3 After-care and re-integration

Links with national strategy and legislation

As has already been stated, after-care and social re-integration or specifically targeted in the National Drugs Plan adopted in February 2002. The legislation which provides for maintenance of employment and support of a drug dependent employee whilst undertaking drug treatment was described fully in the National Report for 1999. In summary, article 124 of the Presidential Decree 309/90 establishes the rights and duties of employers and employees where an employee is drug dependent or where an immediate family member is drug dependent. Circular 164 of 6 December 1991, issued by the then Ministry of Labour, provides operational guidance for both employers and employees. A drug dependent employee has the right to return to work within three years if entering a therapeutic treatment programme. A family member has the right to unpaid leave to participate in the treatment programme where this is necessary. The National Drugs Plan has indicated a need to further improve these legislative and regulatory arrangements, but has not specified the changes which are required. It has, however, proposed that drug dependents should be included in the “disadvantaged” cateory of paragraph 1, article 4 of law 381/91. This change would facilitate the employment of drug dependents within the work of social co-operatives, providing additional mechanisms to gain skills and re-enter the labour market.

Objectives, definitions and concepts

The overall objectives of after-care and re-integration are to assist the drug user to return to social relations and employment without recourse to illicit drug use or other harmful behaviours. The definition of after-care and re-integration, therefore, at the

national level at least, is that it represents the final step in the treatment process aimed at achieving and maintaining long-term abstinence from use of listed drugs. There may be variations in the definitions used at local level, but at policy level there is no disagreement with the nationally defined objective. There are more variations at local level on the concepts of after-care and re-integration. This is primarily related to whether after-care and re-integration is focused on abstinence from all listed drugs, including drugs which might be prescribed in drug treatment, or focused on abstinence from the use of street drugs whilst continuing to receive substitute drug treatment, or focused on abstinence from problematic drug use. There has been little written about different definitions and concepts of after-care and re-integration. It is not possible, therefore, to say precisely what definitions are most commonly applied. It is, however, usual for after-care to be concerned with relapse prevention, support groups, social programmes and family support. There may also be early intervention programmes where there is a relapse. Re-integration is usually concerned with education or vocational training and supported housing to assist the drug user to return into the community.

Accessibility for different target groups

After-care and re-integration is primarily targeted at those who have undertaken a therapeutic treatment programme. This may have been within a residential therapeutic community or within a therapeutic day programme. It may also be targeted at drug users who have achieved stability on substitute drug treatment with improved physical health and social functioning, where they are in a position to re-enter employment or education. Most therapeutic treatment services provide after-care and assist in the re-integration of clients.

Organisation, financing, managing, availability and delivery

Therapeutic treatment services are most commonly provided by private social services, although there are also such services offered by the Ser.T. Like any service for drug dependents, they must be registered with the Region in order to receive public funding. Services may be financed from a range of different sources. Where the after-care and re-integration programmes can be seen as part of the overall therapeutic programme, specifically the re-entry phase of the programme, this may be financed by the local health authority, the Ministry of Justice or the Prefecture. Educational support services may be financed by project funding from the Province or Commune. Vocational training is most commonly financed through project funding from the Region, the National Drugs Fund or the Ministry of Employment and Social Policy. There has also been substantial funding through the European Commission for vocational training programmes. This is discussed more fully in the key topic.

As noted above, most therapeutic treatment services provide after-care and re-integration services. However, there is no national data available on the extent of these programmes, in so far as they are part of the normal rehabilitative activities. It is not possible, therefore, to say whether they are sufficient to meet identified need although they are widely available in some form.

The core of after-care and re-integration delivery is the re-entry phase of a therapeutic programme where the client begins to spend more time outside the programme whilst continuing to live within a supportive environment. Within this phase aspects of relapse prevention will be developed and ways of managing risk situations will be explored. Depending on the size of the organisation managing the service the re-entry phase may be located away from the main therapeutic treatment centre. A number of organisations have also developed social centres which are available to those who have or have had drug problems. The aim of these centres is to offer a safe environment for socialisation, education and training. Education and vocational training tends to be more ad hoc because of its project funding base. Many therapeutic services have developed their own vocational programmes in which clients learn specific skills as part of the rehabilitation programme. For example, San Patrignano near Rimini is famous for its breeding of champion show-jumping horses and produces wine from its own vineyards. Comunità Incontro produces prosciuto, olive oil and wine.

Other organisations produce small leather goods, pottery products, furniture, etc. These activities aim at both providing clients with new, marketable skills whilst also producing products which can promote the work of the organisation and produce an income for it. Delivery of the programmes tends to be split between therapeutic staff providing the support services and skilled practitioners, with therapeutic competences, providing the training/educational inputs.

Statistics, research and evaluation results

There is limited data available on utilisation of after-care and re-integration services or on research and evaluation on these services. During 2002 and early 2003 there were only a few publications on this topic. Costaggini (2003) reported on a project funded by the European Commission to explore the process of integration back into society of former drug dependents. The project involved organisations in Italy, Spain and Denmark. The report identified employment as a key measure for ex-drug dependents to affirm the success of rehabilitation. It also noted the importance of rehabilitation programmes providing individually focused treatment within a structured rehabilitation programme in order that after-care planning and entry into employment could be effectively planned. It found that small and medium sized enterprises were the best point of entry into employment for former drug users. In such settings they felt more secure and could be offered better support. It also noted the importance of continued support from drug service staff following formal completion of treatment not only for the ex-drug user but also to reduce the fears and anxieties of employers and supervisors. The report proposed that there was an important role both for employer associations and for trade unions to improve awareness, to promote 'social' employment and to educate their members about drug use and recovery. A special supplement of "Dal Fare al Dire", a joint publication of the Piemonte Region and the Piemonte Branch of the Italian Society for the Study of Addiction was devoted to the topic of entry into employment for drug dependents. The supplement contained papers presented at a conference on the topic held in Turin in June 2002. Using the 1997 - 99 allocation from the National Drugs Fund, 44 projects were financed concerned with re-entry into society and employment. A number of articles then described work undertaken to support or assist drug dependents and ex-drug dependents re-enter the labour market. In summary, the articles emphasise the importance of advice and counselling to prepare for entry into employment and of continued support for the transition period from drug dependent in treatment to independent person with a legitimate income and all the rights and responsibilities of a citizen. Several of the articles also emphasised the importance of developing networks to promote entry into the labour market, thus providing fuller and more effective mechanisms to support both employees and employers. In addition to these newly published reports on after-care and re-integration the data provided in the key topic "Social Exclusion and Re-Integration" in the last national report and for the EMCDDA publication on the same theme represents the most recent information available.

Training

There is no data available at the national level on the type of training available for staff working in the after-care and re-integration sector. As much of this activity is undertaken in the form of projects, funded from a variety of sources, many of the staff are external experts employed to provide vocational training with full time staff of the organisation acting as support staff to assist where a client has particular difficulties. In such circumstances, no additional training beyond that for the normal professional functions of staff has generally been developed.

12. Interventions in the Criminal Justice System

The provision of drug treatment services for drug dependent prisoners is widely available throughout Italy, provided by the Ser.T., private social organisations and by staff within the prison service. The Ministry of Justice has estimated that the total annual cost of assistance to drug dependents in the prison system is €15.49 million. To this figure must be added the cost of alternatives to imprisonment and the cost of proceedings from the administrative offence of unlawful possession of a controlled drug.

The National Drugs Plan has proposed that increased attention should be given to drug dependent prisoners through the expansion of abstinence oriented services. To this end it has proposed that drug dependent prisoners, where they are eligible according to the regulations, should have the right to enter a rehabilitation programme guaranteed as an alternative to imprisonment. It has also proposed that specific structures should be created within the ambit of the Prisons Administration of the Ministry of Justice, managed in collaboration with private social organisations, as a preparatory phase for admission into a drug free rehabilitation programme. As has been noted in the last national report, the guidance for use of the National Drugs Fund reflects the key topics highlighted in the National Plan. However, it will not be until the end of 2003 that information about these developments will start to become available.

12.1 Assistance to drug users in prisons

Abstinence oriented treatment

The majority of treatment interventions for drug users in prison are abstinence oriented aimed at using the opportunity to focus on continued abstinence on release from prison. Figure 43 shows the type of intervention provided for drug using prisoners over the last 6 years. There has been a continuing increase in the number of people receiving treatment whilst in prison with an upward trend for both psycho-social and pharma-cological treatments. Up to 2001, the use of pharmacological treatments had been increasing more rapidly than for psycho-social treatments. However, in 2002 there was an increase in psycho-social treatments whilst the number of pharmacological treatments remained almost stable. There is little data available on the contents of non-pharmacological treatments. However, within the broad categories for this type of intervention, in 2002 32.1% received psychological support, 65.1% social work intervention and 2.8% psychotherapy. In the five year period 1998 – 2002 there has been a slight increase in the percentage receiving psychological support and a small decrease in the percentage receiving social work intervention, but these changes are not significant.

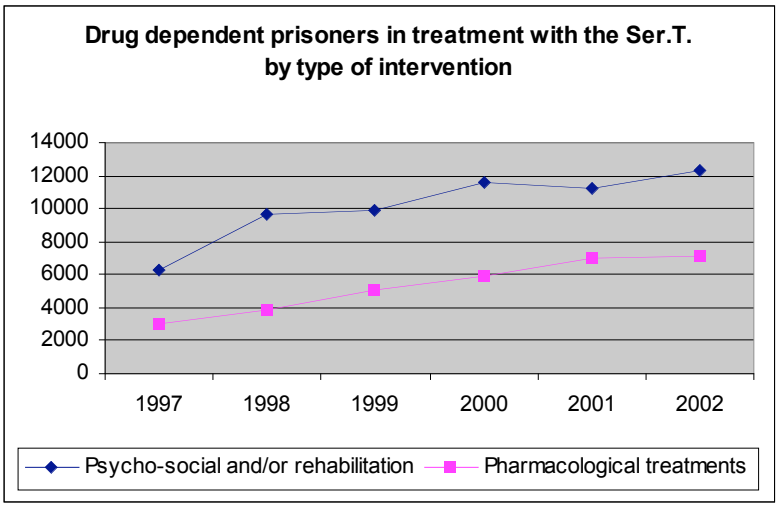


Figure 43 *Source: Ministry of Health*

Substitution treatment

The steady increase in the use of pharmacological interventions coincides with the increasing role of the Ser.T. in the provision of health care and drug treatment to drug dependent prisoners. Figure 44 shows the pharmacological interventions provided over the last six years as a percentage of all pharmacological treatments provided. As can be seen from this, there has been a gradual reduction in the percentage of short term methadone interventions and upward trends in the provision of both medium (3 – 6

months) and long term (over 6 months) methadone interventions. The use of other drugs has shown considerable fluctuations. These include symptomatic treatments and the use of buprenorphine. It is not entirely clear how this data should be interpreted. The most probable explanation is that detoxification and symptomatic treatments are provided to people who are not eligible for alternatives to imprisonment or continued detention and to those who intend to enter a drug free therapeutic programme. Continuing substitution treatment is provided to prisoners who are awaiting trial and may not receive a prison sentence, who are imprisoned for a short time or who are already known to the Ser.T. Although this seems to be the most likely explanation, further exploration of this area is necessary to provide more definitive data. Given the continuing increase in non-Italian drug dependent prisoners as a percentage of all drug dependent prisoners, it is also possible that they are more likely to receive detoxification or symptomatic treatment given the problems of providing longer term community based treatment for this population.

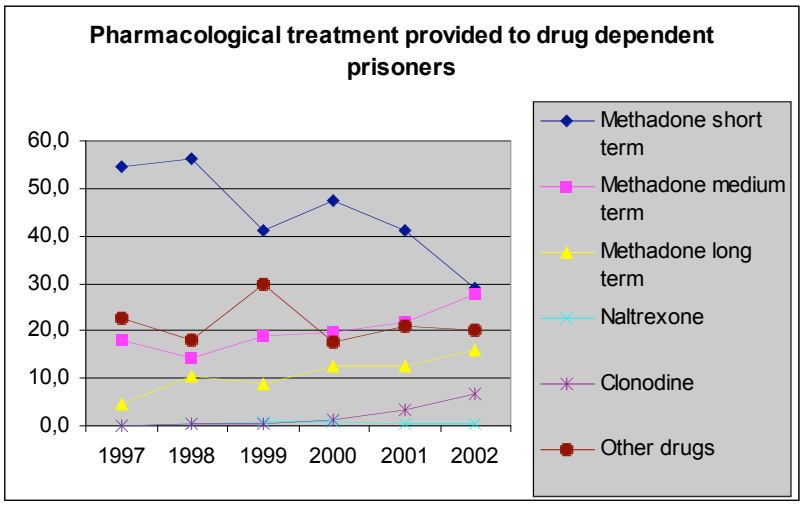


Figure 44 *Source: Ministry of Health*

Harm reduction measures

No harm reduction measures are carried out within the prison system of Italy. As part of the counselling and support offered to drug using prisoners, it is not unusual for them to be warned of the dangers of a return to drug use, especially at the level of use prior to imprisonment or through injection. However, there is no specific data on the contents of counselling, or on the types of risk behaviour most common amongst newly released drug using prisoners.

Community links

The transfer of responsibility for the health care of prisoners to the Ministry of Health and thus to the Regions and local health authorities has increased links with community services. Data from previous years shows clearly the continuing increase in the number of drug dependent prisoners in treatment with the Ser.T. The equivalent data was not available for 2002, but given the increase in the number of treatments offered to drug dependent prisoners it would be surprising if this increase had not continued. However, the involvement of the Ser.T. is not uniform throughout the country. The Department for Prison Administration of the Ministry of Justice has noted that there are a number of problems including misunderstandings between the prison and local health authority, inadequate planning on the part of the Ministry of Health, the absence of clear directives from the Regional Health Departments

In addition to the contacts with the local health services, a large number of private socio-rehabilitative organisations are also involved in work with drug dependent prisoners. These contacts vary from maintaining contact with an individual already known to the organisation through the provision of psycho-social support services to providing assessment and rehabilitation services for drug dependent prisoners as an alternative to detention or in preparation for release from prison. As has been described in previous reports, for many years it has been an objective to encourage drug dependent offenders into therapeutic treatment both as an alternative to a prison sentence and as an alternative to continued detention. The active involvement of

community services, especially therapeutic communities, has therefore been promoted. These services are registered with the Ministry of Justice and are financed by the Ministry for prisoners in their care.

12.2 Alternatives to prison for drug dependent offenders

The overall objectives of alternative to prison are to provide community supervision and support to avoid re-offending and to assist a long term prisoner return to the community. For drug using offenders, the specific objectives are to engage the offender in a therapeutic programme to achieve abstinence from illicit drug use with the ultimate objective of full rehabilitation from all drug use.

The Directorate General for Alternative to Prison Penalties (Direzione Generale dell'Esecuzione Penale Esterna) of the Ministry of Justice is responsible for co-ordinating and overseeing the work of the Probation Service (CSSA - Centri di Servizio Sociale per Adulti). The Probation Service at local level supervises offenders and works closely with both the Ser.T. and private socio-rehabilitative services where these are providing specialist interventions for the offender. A parallel structure operate within the Juvenile Justice System, with a separate probation service for young offenders (USSM - Uffici di Servizio Sociale per Minorenni). Where an offender is assigned to the Probation Service, the funding for treatment in a therapeutic programme is paid by the Ministry of Justice. In 2001 the Ministry of Justice allocated € 973,521 to the Regional Offices of the Prison Administration for social re-insertion projects, such as re-insertion into work and vocational training for drug and alcohol dependents under probation supervision. This does not represent the full extent of funding but is indicative of the level of activity.

The two probation services are professionally staffed with qualified practitioners who also receive both continuing training and ad hoc training programmes on specific topics. They are also able to draw on the expertise of staff in the Ser.T. and in therapeutic training programmes.

Accessibility to alternative measures

There are two types of alternative measure available in Italy. Substitute sanctions are decided by the judge as a replacement for imprisonment at the same time as s/he passes sentence. The intention is to avoid offenders receiving short sentences from going to prison. Community measures are granted by a specific judicial authority, the Supervisory Court, during the execution phase of a penalty, at the offender's request. The following substitute sanctions are available:

- semi-detention - where a penalty does not exceed one year
- monitored liberty - where the penalty does not exceed 6 months
- payment of a fine - where the penalty does not exceed 3 months

A custodial sentence may not be replaced by a substitute sanction where the judge believes the offender will not observe the conditions attached to the sanction. Moreover, a custodial sentence cannot be replaced by a substitute sanction in the following circumstances:

- if, in the last five years, the offender has received one or more convictions totalling over two years
- if, in the ten years prior to the offence the offender has been convicted more than twice for offences of the same kind; or has been returned to custody while subject to a substitute sanction because s/he has broken the conditions attached to it, or whose measure of semi-liberty has been revoked, or who has committed the offence during supervised liberty (Libertà vigilata) or special supervision (Sorveglianza Speciale)
- if the offences belong to particular categories of crime listed in certain articles of the Penal Code or in special penal provisions

The range of community measures available is substantial. For drug dependents, the specific measures available are assignment to the Probation Service and Suspension of the Penalty. They are also eligible to all the other general community measures or concessions. Drug using offenders may be ineligible for community measures for a

variety of reasons, but where they satisfy the criteria for a particular measure or concession, they have the right to apply for it. What is less clear is whether all drug using offenders who are eligible for alternative measures can in practice access the necessary treatment services. The National Drugs Plan foresees the need to develop additional resources and guarantee a right of access to therapeutic alternatives to imprisonment. This might suggest that whilst the legislative framework is satisfactory, the implementation arrangements remain inadequate.

Information strategies

The availability of substitute sanctions and alternative measures is widely known, the arrangements having been in place for many years. There are no specific information strategies to alert drug using offenders of the availability of substitute sanctions or community measures. However, the various parties involved in the judicial process – defence lawyers, supervising magistrates, judges etc. are all aware of the options and there is a common objective of placing a drug using offender within a therapeutic programme wherever possible as an alternative to detention in custody.

12.3 Evaluation and training

No evaluation results with regard to the treatment of drug using offenders in prison nor concerning substitute sanctions or community measures for drug using offenders has been published recently. There are some articles providing commentaries or descriptive accounts of activities which can be found on Italian web sites, for instance Progetto Teseo carried out by the Ser.T. of Padova in the Veneto Region contains a description of the project and a number of interesting articles, but no published results.

Statistics and research

The Ministry of Justice has produced substantial statistics on drug using prisoners and on drug users assigned to the Probation Service. More detailed data is available about drug using juvenile offenders. It should be noted that this data refers to drug using offenders as the definition of dependence used in the statistics is not based on a clinical assessment but includes clinical assessments, self-declarations, prison staff assessments and observations.

The Prisons Administration of the Ministry of Justice estimates that between 40,000 and 50,000 drug using adult offenders pass through the prison system every year. On 31 December 2001 there were 15,442 prisoners assessed as having a drug problem, representing 27.9% of the total adult prison population on that date. There has been a very substantial change in the pattern of prison admissions over time (Table 26). It is also noticeable that for both Italian and non-Italian drug using offenders there has been a major change in their offending. For 2002 data is not available which would allow examination of the types of offence for which drug dependents were received into prison. Data from previous years which was included in the last national report shows the category of offence for which drug users were detained as a percentage of all offences for which Italian drug users and foreign drug users were detained. For Italian drug using offenders, there had been a reversal and non-drug law offences predominated. For foreign drug using offenders the change had not been so dramatic but a similar trend could be seen. For 2002 comparable data is only available for the first 6 months of the year. This suggests that non-drug law offences were more prevalent for Italian drug dependents than drug law offences although there was a slight increase in the percentage of drug law offences – from 45.4% to 46.1%. For non-Italian drug dependent offenders, there was a similar situation with a slight increase in drug law offences, from 59.1% to 61.1%. As the data refers to offenders detained in prison, this might suggest that these are the more serious offences or are ones where preventive detention is considered necessary. It is also possible that Italian drug using

Changes in the Percentage of New Admissions to Prison by Category

	1992	2002
Italian non-drug users	55.4	40.9
Italian drug users	30.1	22.0
Foreign non-drug users	10.4	29.3
Foreign drug users	4.2	7.8

Table 26 *Source: Ministry of Justice*

offenders have acceptable accommodation for release either awaiting trial or to take up a non-custodial alternative. By contrast, foreign drug using offenders may not have residency and may also have problems of communication, making it difficult for them to be released pending trial or to take up an alternative to prison.

The statistics on adult offenders assigned to the Probation Service show that nationally 26% (6,863) of all assignments were drug using offenders. This is a 1% drop from 2000 although an increase in the number of assignments. There are significant differences between areas of the country. In the northern Regions around 35% of all assignments are of drug using offenders whilst in the southern and island Regions drug users represent only 15% of assignments. This difference is considerable and cannot be explained solely by different levels of offending or seriousness of offences. It suggests that access to community measures is more restricted in the southern Regions and this may reflect a paucity of therapeutic services. It might also reflect less acceptance of treatment as an alternative to punishment for drug using offenders within the judicial system. Further investigation would be necessary to understand the reasons for such substantial variations.

In 2002, 1,353 drug using offenders passed through the Juvenile Justice Service of whom 77.8% were Italian and the vast majority were male (95.3%). 15.1% of drug using juvenile offenders were aged 14 – 15, 66.2% aged 16 – 17 and 18.7% aged 18 or over. The balance between Italian and non-Italian drug using offenders changes substantially between the age groups. Only 58.3% of offenders are Italian in the 14 – 15 age group whilst for the 16 – 17 age group it is 78.2% and for the 18 or older group it is 85.6%. It is likely that this reflects a higher likelihood of detection for this group. This seems more certain as 65.8% of all non-Italian drug using juvenile offenders are from Africa and this rises to 75% in the 14 – 15 age group.

In terms of patterns of drug use, 46.5% were occasional drug users, 43.9% regular users, 9% drug dependent and data was not available on 0.6% of young offenders. Cannabis was the drug most commonly used (70.1%) but 12.4% reported use of opiates and 9.7% use of cocaine.

Young offenders may go to an assessment centre (CPA – Centri di Prima Accoglienza), a youth prison (IPM – Istituti penali per minorenni), be assigned to the youth probation service (USSM) or sent to a community which has a convention with the Juvenile Justice Service (COM – Comunità ministeriali).

Allocation of drug using young offenders by year and nationality

	1998		1999		2000		2001		2002	
	It	Non-It	It	Non-It	It	Non-It	It	Non-It	It	Non-It
CPA	43.5	60.2	43.9	52.3	43.3	51.5	41.7	46.8	44,3	51,3
IPM	25.4	33.3	22.8	39.2	22.3	41.4	19.7	38.7	17,3	32,3
USSM	31.1	6.4	33.3	8.4	28.1	4.0	35.4	11.2	34,0	13,5
COM					6.3	3.1	3.1	3.3	4,4	2,9

Table 27 *Source: Ministry of Justice*

The use of youth prison has declined over time for both Italian and non-Italian drug using offenders (Table 27), however drug using offenders still represent a relatively high percentage of all juvenile offenders in youth prisons. It is not clear why this should be so. It may reflect a number of factors. One may be the relative seriousness of the offence. A second may be that the offender has no residency or accommodation and it is not possible to permit release to a community measure. A third may be that the offender cannot communicate in Italian, limiting the opportunity to use of community and therapeutic alternatives. The latter two factors may be particularly important as a non-Italian young offender is twice as likely to be held in a youth prison as an Italian young offender and 2.5 Italian young offenders are assigned to the USSM for every one non-Italian assignment. Drug using young offenders represent 17.7% of all admissions to the CPA, 19.3% of all admissions to youth prison, 14% of all admissions to COM but only 2.8% of assignments to the youth probation service. This may reflect the type of offence and/or the wish to have a clearer picture of the needs of the drug user in order that appropriate interventions might be provided.

There is some information on the treatment or interventions provided to drug using young offenders. Table 28 shows referrals to drug treatment services and Table 29 shows the type of intervention provided within the different services of the juvenile justice system. It is not possible to analyse the referrals to treatment by type of drug or frequency of use. However, it is not unreasonable to believe that the majority of referrals would be of daily users, especially those using opiates or cocaine on a daily basis. As a percentage of all drug using young offenders admitted per juvenile justice service, 36.4% of admissions to the Comunità Ministeriale were referred to a drug treatment service, as were 29.4% of assignments to the youth probation service. By contrast, only 11.2% of admissions to youth prison and 4.7% of admissions to an assessment centre were referred to specialist treatment. In terms of specific treatment offered, data is only available on pharmacological interventions. It is reasonable to suppose that the treatment offered was directed at detoxification and long term abstinence given that this is the standard practice of the Ser.T. for the vast majority of drug dependents attending for treatment in the under 20 age group and especially for those under 18. However, there is no specific study examining the treatment provided to this population or the outcome of the treatment provided.

Referral of drug using young offenders to treatment services - 2002

	Male	Female	Total
Assessment centre	25	4	29
Youth prison	30	2	32
Youth probation	100	15	115
Community	20	-	20
TOTAL	175	21	196

Table 28 *Source: Ministry of Justice*

Pharmacological treatment provided to drug using young offenders

	CPA	IPM	USSM	COM	TOTAL
Methadone	8	12	15	-	35
Psychopharmacy	7	35	3	4	49
Symptomatic	5	24	1	-	30
Non-specific	31	17	1	-	49

Table 29 *Source : Ministry of Justice*

Two specific evaluations concerned with the work of the N.O.T. (Nucleo Operativo Tossicodipendenze – the service attached to the Prefecture concerned with assessing and working with people referred to the Prefect for unlawful possession of a controlled drug). The Parsec Association in Rome has reported on research undertaken for the General Directorate for Civilian Services of the Ministry of the Interior and the Prefecture of Macerata (Region of Marche) has published the report from an evaluation of the N.O.T. and the workings of Article 75 of the Drugs Law [1]. For the Parsec research, 98 of the 103 people in charge of a N.O.T. were interviewed and 391 of the 550 staff. The research noted that the services had developed and adapted at the operational level to reflect the observed needs of the local area. Social workers were key professional figures but the number employed had fallen from 210 to 190 over time. Nevertheless, their contribution had helped the development of the whole social sector in their operational area. The report noted the considerable variations in the number of referrals, from 12,404 in 1990, to a maximum of 41,548 in 1997 and down to 22,575 in 2001. It also noted that there were considerable variations between the referral and the interview with the staff of the N.O.T. For example, in Rome this took 851 days on average, whilst in Milan it was 246 days and in Bologna 358 days with the national average being 412 days. In fact, Article 75 requires the interview to be arranged within five days of the referral. 25.6% of interviews occurred within 6 months of the referral, 28.9% between 6 months and 1 year after the referral, 28% between 1 and 2 years after the referral and 17.3% more than two years after the referral. The research also noted that there was no real co-ordination between the law enforcement agencies (who make the referral to the Prefect) and the N.O.T. (who seek to prevent continued drug use). They operated to different assumptions and the ability of the police to make referrals could not be matched by the capacity of the N.O.T. to interview those referred

[1] Article 75 of the drugs law 309/90 deals with the administrative offence of unlawful possession of a controlled drug

and to undertake effective secondary prevention activities. In practice, it was noted that the N.O.T. was marginalized in comparison to other services operating in the drugs field, which was unfortunate given its potential to make contact with young drug users at an early point in their drug using career. In conclusion, the research proposed that greater selective focus on the same referrals by the Prefecture and the N.O.T. could greatly improve the effectiveness of their secondary prevention role through early intervention with drug users.

The Macerata research examined referrals to the Prefect from 1990 to 2000, involving 1,224 people, 92.4% male and 98.7% Italian. 19.9% of referrals were 18 – 20 years of age, 39.5% aged 21 – 25 and 19.9% aged 26 – 30. Although data was frequently not recorded, around two thirds of referrals were single one third had only completed compulsory schooling and half were in stable employment. The majority of people were referred to the Prefect on one occasion only. 79% of all referrals occurred from police stops of cars or of persons in the street. This seems to support the view expressed earlier in the report that referrals to the Prefect for unlawful possession are a secondary consequence of enforcement of non-drugs legislation. In line with the Parsec research, the Macerata research shows that 54.2% of interviews with the N.O.T. occurred within 6 months of the referral, 33.1% within one year and 12.7% one year or later after the referral was first made. Of the decisions made about the individual referrals, 49.2% were formally advised to cease drug use, 24.2% were referred for treatment to the Ser.T. and 9.9% received an administrative sanction (forfeit for a defined time of driving, licence, passport, etc.). There is further information about those who were referred to the Ser.T. The time lag between referral to the Ser.T. and first attendance at the service was less than one week for around 75% and for the vast majority within 2 weeks of the referral. This contrasts sharply with the time lag between referral to the Prefect and interview with the N.O.T. Of all referrals to the Ser.T., 3.9% did not attend after several reminders, 83 % attended and for 13.1% the referral procedure was in progress. Of those who did attend the, 2.3% did not start the programme. For those who did start the programme with the Ser.T., 86.6% completed treatment. The research also suggested that administrative sanctions, especially suspension of the driving licence, was an effective deterrent to further use for those who were occasional or irregular drug users of 'light' drugs, primarily of cannabis.

Training

Training for work within the criminal justice system operates at different levels. The Higher Institute of Prison Studies (Istituto Superiore di Studi Penitenziari) has responsibility for the training of senior staff and works in collaboration with universities, national research institutes and with local public and private organisations as appropriate. In particular, it has a number of projects funded through the National Drugs Fund aimed at identifying training needs (Project Val.O.RI), training strategy (Project PANDORA) and training evaluation (Project F.I.T.T.). Continuing training of staff is decentralised and is the responsibility of the Regional Prison Administrations.

They have focused on two specific areas begun during 2001 and continued in 2002. First, they have undertaken work aimed at developing a more integrated system for work with drug using offenders. These

Project Teseo Training Programme

Of crimes and punishments: *guidelines on detention*
Alternatives to Prison: *Analysis of successes and failures*
Drug dependents in prison: *Special treatment units or diversified custody?*
Health in Prison: *Problems arising from HIV infection and abstinence syndrome*
Work within and outside the walls: *Special treatment units and other possibilities*
Treatment programmes in alternative measures: *Parent and child relationships*
Non-Italian Prisoners: *Possibilities for rehabilitative interventions*
Alcohol and Prison: *from treatment to alternative measures*
The prison team and local services: *the flow of information and working together*

have included both staff working within the prison system and staff from the Ser.T., local public services and private socio-rehabilitative organisations. An example is Project Teseo, which concluded at the end of 2001. Its training module involved 10 training sessions spread over the year for 100 people working for the prison system and in the Ser.T. The box shows the titles of the training sessions. The introductory session presenting the project overall has not been included. Each is hyperlinked so that the documents (in Italian) can be directly accessed. Within the Juvenile Justice Service the particular focus has been on training of staff on developments and new problems, especially those related to misuse of synthetic drugs. There has also been continuing training to support the provision of health education within the Service.

13. Quality Assurance

New trends and developments

There have been no significant new trends or developments during the year. Under an agreement approved on 5 August, 1999 by the Permanent Conference for Relations between the State, the Regions and the Autonomous Provinces, minimum standards were established for the accreditation of private services for drug dependents and for public services. The standards cover the requirement to be registered with the relevant local authority, the physical standards of the accommodation/building, the provision of explicit details about the services offered, ethical issues, staffing levels, qualifications and training, administrative reporting, monitoring, evaluation and data submission. Each Region was responsible for approving regulations at the local level to implement the national agreement. There has been a process occurring of local consultation, the development of draft regulations, debate of the drafts through to final approval of the regulation. This has inevitably taken time and the main activity has been a gradual implementation of the local regulations in the context of further changes arising from devolution to the Regions of full responsibility for planning and provision of health care, assumption of responsibility for the health care of prisoners and changing arrangements for the delivery of prevention, drug treatment and rehabilitation services.

A further change occurred in 2001. As part of the enactment of Law 328/2000 for the implementation of an integrated system of interventions and social services, the Government drew up the first National Social Services/Interventions Plan. This underlined the need for essential performance levels to be established at a national level to ensure that a common standard of service was offered to all citizens. The different levels of government (Region, Province, Commune) were requested to provide themselves with tools capable of identifying the needs of the population and the adequacy of the services provided to respond to these needs. The performance standards are relevant to drug services (residential and semi-residential treatment, residential or day assessment services and community based interventions). Implementation of the National Plan should, therefore, lead to the establishment of quality standards and the monitoring of socio-health services for recovery from drug dependence. This activity was already planned for services in the drugs field through the State-Regions accord of 1999. Moreover, as part of the implementation of the accord, a regulation was issued in 2002 establishing the principles for the organisation and functioning of the local health authority managed treatment services – Ser.T. and for placing these services and the accredited private social organisations on an equal footing. The effective implementation of these arrangements has met with many difficulties as a result of the recent constitutional amendment which has devolved competence in the socio-sanitary sector to the Regions and as has been noted earlier, the 2002 regulation has been overturned by the Constitutional Court.

Formal requirements

The formal requirements for quality assurance are determined at local level and vary from Region to Region. There is no common quality assurance system outside the minimum standards which have been described in previous reports (National Report Italy 2000). The minimum standards which have been adopted do not necessarily represent quality assurance procedures and an increasing number of services are applying to receive the ISO mark as a means of ensuring that quality procedures are operated within the service.

Criteria and instruments

As noted above, there are no national criteria other than those providing for minimum standards and Regional procedures vary considerably with few having any true quality assurance criteria or instruments.

An exception is the Veneto Region where a substantial manual on quality management has been produced (Serpelloni [ed.] 2002). This multi-author publication is available in both hard copy and electronic form (http://veneto.dronet.org/database/vis_bibl/bib_zip/tqm.zip) and covers both theoretical and practical elements. It is not known to what extent this manual is used within the Veneto Region or how many organisations or Regions have used it either in its entirety or as a basis for developing their own quality systems.

PART 4

SELECTED ISSUES

14. Evaluation of Drugs National Strategies

14.1 Existence of evaluation

As has been reported elsewhere, the National Drugs Policy and associated Priorities was approved by the Cabinet in 2002. The Policy had a series of key elements:

Prevention of dependence and youth problems

- it must be carried out through a range of different types of intervention and aimed at reaching the largest possible number of young people. Interventions should be co-ordinated to involve all society, in particular, the family and the school. Primary prevention aimed at no initiation into drug use and supporting the capacity of the young person to remain drug free. The aim of prevention is to be promotion of a fully integrated person with improved opportunities to fully participate in training and employment. Prevention must be developed within a network of services involving public bodies and private social organisations. Information campaigns should value the role of individuals in society. The objectives of the national information/prevention campaign should be promotion of a responsible life, strengthening the search for sensations and emotions not based on risk behaviours and therefore to reduce the demand for drugs.

Public services for dependencies

- the Government should make the most of the experience developed by the Ser.T. The State-Regions Accord of January 1999 makes it necessary to strengthen provision of psycho-social services in association with other public and private organisations operating in the sector. This should also involve developing projects in conjunction with mental health and child/maternity services so that available resources are optimised. Dependency Departments must be organised so that there is direct participation at the operational and decision making levels of accredited private social organisations, voluntary associations and family associations.

Socio-rehabilitation services – public and private

- the Government must ensure the availability of responses for the treatment of and rehabilitation from drug dependence and guarantee freedom of choice for drug dependents and their families to enter a rehabilitation programme run by an authorised organisation anywhere in the country, whether public or private. To this end, the regulations relating to certification of drug dependence will need to be changed. Given the goal of having many more people in rehabilitation, a building programme to create new centres or enhance existing centres is required. Public service resources must be made the most of through integration with private social services with equal dignity for both parties. Training should be provided for staff and volunteers.

Drug dependents in prison

- special attention should be given to drug dependent prisoners and, when requested in accordance with the regulations, the right to access to a rehabilitation programme should be guaranteed as an alternative to detention. Specific structures should be created within the ambit of the Prison Administration and managed in collaboration with private social organisations as a preparation for admission into drug free rehabilitation.

Placement back into work

- to promote re-entry into work on completion of a rehabilitation programme, professional training programmes must be encouraged. This should include: implementing the State – Regions Accord on work training for drug dependents; including drug dependents in the "disadvantaged" category of para. 1, art. 4 of the law 381/91 relating to social co-operatives; stimulating entrepreneurial initiatives by ex- drug dependents; improving the regulations which govern the arrangements for workers undergoing rehabilitation.

Evaluation of interventions

- to ensure that the most effective prevention, treatment, recovery and rehabilitation programmes are used, procedures for evaluating and accrediting public and private services need to be established. Planning in the different areas of intervention will be promoted linked to finely tuned methodological instruments and to the production of data on both

process and outcome. Particular attention should be focused on medium – long term evaluations of interventions in relation to the social circumstances of different parts of Italy.

The Priorities which were adopted were:

- to tackle effectively new forms of dependency from observation of their arrival through to the implementation of different services and measures appropriate to new needs
- to strengthen attention on prevention to increase knowledge of the risks arising from any involvement with drugs or drug users and to promote a sober and active life. A main focus on primary prevention which must be linked to government action for infants and young people in compulsory schooling
- to achieve a better balance between treatment, recovery and rehabilitation services, investing with a focus on treatment aimed at achieving full recovery, free from all drug use and from long-term presence in a treatment service
- to dedicate technical and financial resources to the full integration of drug dependents in society and employment, affirming the rights of citizenship and to employment of each person, especially at the end of treatment
- to measure the quantity and quality of responses and to strengthen the system for observing the situation and the responses with the aim of supporting the most effective actions and avoiding wasted effort
- to consolidate and re-enforce the actions of the technical/policy bodies which support the Government policy in respect of drugs and drug dependency – the OIDT, the Scientific Committee of the OIDT, the National Department for Anti-drug Policies and the National Commissioner for Anti-drug Policies

The Policy and Priorities have led to a number of actions, including preparation of the draft legislation, work to identify the true cost of drug misuse to the economy, dialogue with professional and scientific associations and exploration of the data available at a national level and how this might be improved. However, no specific targets or outcomes have been proposed and a detailed Drugs Plan is not yet in place. This in part reflects the fact that almost all drug demand reduction activity is a local (Region, Province and Commune) responsibility where the central administration has limited authority. By contrast, almost all drug supply reduction activity is a central responsibility. Regions are being asked to develop clear objectives for their own strategies and means of evaluating outcomes and a more detailed reporting system has been gradually developed in order that the Annual Report to Parliament on the State of the Drug Problem in Italy might be as complete as possible. However, Regions cannot be obliged to furnish information at present and in consequence the data available is often partial.

Although there are substantial difficulties in evaluating the National Policy and its Regional implementation, the priorities which have been adopted include a specific commitment to measuring the quantity and quality of responses to improve effectiveness. The mechanism which has been adopted for this is to develop the National Department for Anti-Drug Policies and the draft legislation proposes to consolidate this Department within the Office of the Prime Minister, bringing together the National Drugs Observatory, the Scientific Committee of the Observatory, the Consultative Council and management of the National Drugs Fund and the national information and prevention campaign. However, until the consolidated Department is established, evaluation remains fragmented between different Ministries and different offices within the same Ministry. In this respect, there are different reporting and evaluation systems.

The Ministry of Labour and Social Policy is responsible for management of the National Drugs Fund and monitors projects financed through the Fund. Within the General Directorate for Dependencies, it manages the National Drugs Observatory and has been developing improved mechanisms for data collection and interpretation. It is also responsible for preparation and presentation of the Annual Report on the State of the Drugs Problem. This report contains contributions from all relevant Ministries and all the Regions. Moreover, as well as providing a report on activity which is being undertaken, it has also become increasingly analytical of trends in drug misuse through

a series of in depth examinations of specific themes, as well as through a detailed epidemiological analysis.

The Ministry of Health collects data from all the national health service managed public drug treatment services. This data covers information on those seeking treatment for a drug problem, on the treatment provided and on the organisation of the treatment service. The data is published annually, although the report is primarily a descriptive account.

The Ministry of the Interior has two Departments with responsibilities for drug related matters. The Central Directorate for Anti-Drug Services (DCSA) publishes an Annual Report on the activities of law enforcement agencies dealing with offences against the drug law and the special register of drug related deaths. This report has also become more detailed in recent years, providing greater information about the activities undertaken and about drug law offenders. The Central Directorate for Documentation maintains information of people referred to the Prefect for unlawful possession of a controlled drug and also undertakes the quarterly census of socio-rehabilitative services for drug misusers. The data on unlawful possession is provided for use in the Annual Report to Parliament. The census data is published quarterly and there is also a consolidated publication providing annual data.

The Ministries of Justice and of Education also have responsibilities in this area. They do not produce specific reports, although the do provide information for inclusion in the Annual Report to Parliament. In addition, the Ministry of Justice publishes some information directly through its own web site reporting on both proceedings for drug offences and on drug dependents within the prison or juvenile justice system.

These data collection and reporting mechanisms utilised by individual Ministries do not in themselves constitute an evaluation of the national policy and priorities. They do, however, provide the basis of information which allow both specific targets and specific measures to be developed and a mechanism for indirectly measuring the relative impact of the new approaches which have been adopted.

14.2 Methodology of evaluation

At present this section is not applicable for Italy. It is anticipated that when the new drugs legislation has been approved arrangements will be put in place to monitor and evaluate the impact of the National Drugs Policy and achievement of any specific targets which are agreed.

15. Cannabis problems in context: understanding increased treatment demand

15.1 Demand for treatment for cannabis use

There is limited data available within Italy on the use of cannabis as a primary drug amongst those who receive treatment from either public or private drug treatment services.

Nationally, the percentage of clients of the Ser.T. with primary cannabis use remained stable between 1999 and 2001 at 8% of all clients. Figure 45 shows the increase in primary cannabis use of clients of the Ser.T. from 1990 to 2002. In that period there

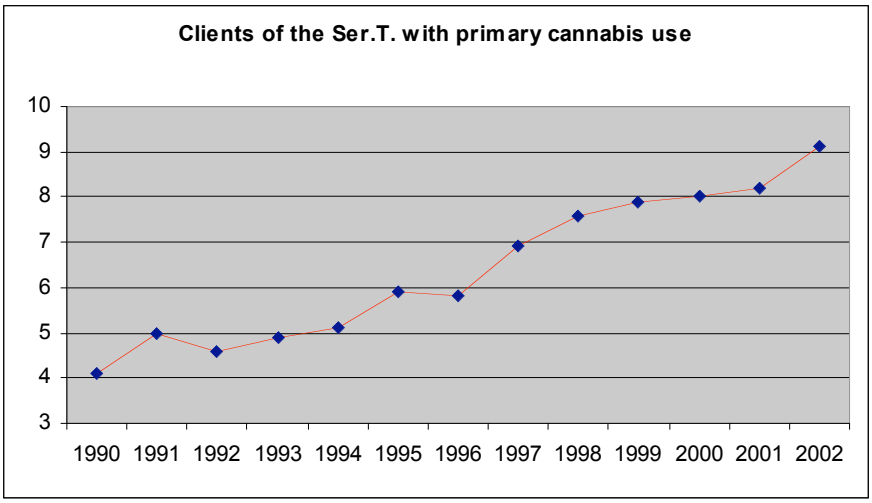


Figure 45 *Source: Ministry of Health*

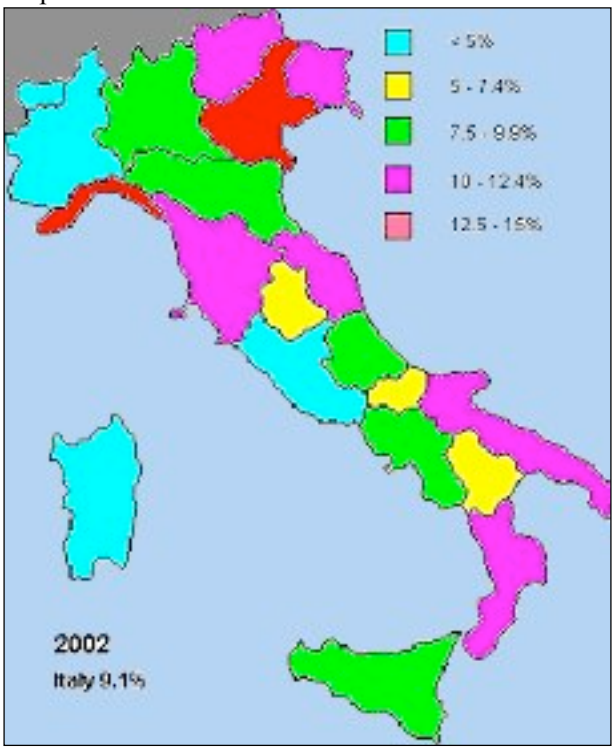
has been a doubling of the percentage of clients and in absolute numbers this represents a rise from some 2,735 clients in 1990 to 14,056 in 2002. The trend has been consistently upwards with the substantial rise in treatment demand occurring since 1996. There are large Regional variations in treatment demand for primary cannabis use, as can be seen from maps 16 – 19. The reason for these variations are not clear and do not seem to fit any particular pattern. Whilst some Regions have shown a steady increase in the percentage with primary cannabis use (e.g. Veneto and

Percentage of clients of the Ser.T. with primary cannabis use by year

Map 16

Map 17

Map 18



Map 19

Source for maps: Ministry of Health

Liguria), others have shown a steady decrease (e.g. Umbria, Marche, Calabria) and others no pattern (e.g. Toscana, Lazio, Sardegna). It is possible that for some Regions the heroin epidemic has abated and consequently treatment demand from problematic use of other drugs has risen whilst conversely treatment demand for heroin has risen in other Regions, reducing the percentage of people with primary cannabis use. An examination of primary heroin and cannabis use by Region over a six year period (1997 – 2002) suggests that for some there is a correlation between changes in primary heroin use and primary cannabis use, but this is not consistent and cocaine has replaced heroin in other Regions. However, where there has been a reduction in clients with primary cannabis use, with the exception of Campania, there has been an increase in the percentage of clients with primary heroin use. A possible hypothesis, therefore, is that, given finite resources, the Ser.T. make an assessment of need and accept into treatment clients with the most problematic situations, which might account for variables in the percentage of clients with cannabis problems in treatment with the Ser.T.

Data using the Treatment Demand Indicator protocol is only available for 2000 for Italy. This data is for three Regions and one large city, with 92 Ser.T. (18% of the national total) involved and 18,787 (13%) of all clients of the Ser.T nationally for 2000.

1,230 people were reported as primary cannabis users. Data is missing for a substantial percentage of clients in terms of primary drug use and age, but from the available data, male clients with primary cannabis use seem to enter treatment later than females. For male first treatments 37% of clients were in the 25-29 age group where it was 50% for females in the same age group. It is not possible to identify source of referral by primary drug use, but it is reasonable to assume that a higher proportion of primary cannabis users are referred by the N.O.T. following referral to the Prefect for unlawful possession of a controlled drug compared to other drug users. In the latter case self-referral is the more common route. This hypothesis seems to be supported by data from the drug services in Modena which shows that of 200 new referrals for primary cannabis use, 64% came via the Prefect. The Macerata research (Simenoni et al 2003) and a retrospective study of referrals to the Prefect for cannabis possession in La Spezia (Gallo et al 2003) also seem to suggest a similar pattern.

Data on the profile of clients other than that on age is not available by type of drug. However, it is noticeable that cannabis users appear to be referred into treatment earlier, suggesting that the hypothesis of cannabis users being more often referred through the N.O.T. as having validity. The data from the Ministry of the Interior shows that people referred for unlawful possession of a controlled drug are younger than the age profile of clients of the Ser.T. For cannabis users, the T.D.I. data lacks information about frequency of use for all clients, but is fuller for first treatments. Of these, 30.6% were using cannabis daily, 17.7% between two and six days a week and 27.8% once a week or less. Significantly, data on other drug use suggests that this population of cannabis users was a poly-drug using group with a large number (963) having heroin as a secondary drug and 232 having methadone as a secondary drug. There were also significant numbers using cocaine and other stimulants, hypnotics and sedatives and hallucinogens. The primary cannabis use group was also the group which had alcohol as a major secondary drug.

Gallo et al (2003) suggest that compared to the 1993 – 1994 period, when a comparable survey was undertaken, that there was an increased need to refer people from the N.O.T. to the Ser.T. for treatment for cannabis use. The age of those found in unlawful possession of cannabis had fallen significantly between the two periods and a large percentage (53.7%) took cannabis alone rather than as a group activity. This pattern of use was seen as indicating an important shift in drug using behaviour where the drug had assumed greater importance and treatment was more likely to be required. Another factor which may have had an impact on an increase in referrals over time is that the purity of cannabis, particularly cannabis resin but also cannabis leaf, is reported to have increased significantly over time (OIDT 2003). This could have resulted in more acute health and social problems arising from cannabis use and led a larger number of people to seek treatment, or to others to identify a need for the cannabis user to be referred into treatment.

15.2 Prevalence of problematic cannabis use and patterns of problems

In terms of prevalence or problematic use of cannabis, there is almost no data available in Italy. No estimates of the level of problematic cannabis use have been made and there is no common definition of what constitutes problematic drug use. The discussion above suggests that there are different definitions applied by the N.O.T., the Prefecture and the Ser.T. and that 'problematic' is seen as a relative term which is dependent on a range of factors including the drug used, frequency and mode of use and the availability of treatment resources.

There have been very few reports published on problems associated with cannabis use. Casalboni at al (2003) have reported on a 5 year research on drivers under the influence of alcohol or drugs. Their findings showed alcohol to be the primary factor in accidents where intoxication or impairment due to a substance was involved or where drivers were stopped and tested for the presence of alcohol or other drugs. It also noted that in identifying the use of other drugs as a cause for accidents or impaired driving there was a problem because quite often the driver had used alcohol and a drug. Nevertheless, where a drug was identified, cannabis was found in 57.8% of cases where a drug was identified. Taggi and Macchia (2003) report on the use of drugs and driving safety. The study examined two different surveys on drug use by young people and surveyed the views of young people on the risks associated with using drugs and driving. 250 young people out of a total survey population of 9,589 said there was no serious risk of an accident from using cannabis and then driving, whilst 1,643 said the risk was entirely dependent on the quantity used. When they were asked which drugs could be used without dangerously impairing the driver, 1,797 (18.7%) said cannabis. In both instances, males were much more likely to underplay the impact of substances on driving ability.

The only other study which has been identified in which cannabis is specifically mentioned is by Siliquini et al (2002) which reports on psychiatric pathologies in drug users. Based on a survey of 5 mental health departments between January 2001 NS June 2002, total of 176 people were identified – 63 men and 113 women. Of these, 58 declared that they were drug users, and 32 had cannabis as their main drug. Thus 18.2% of those diagnosed with a psychiatric pathology were cannabis users. Drug use was most prevalent amongst the male patients – 50.8% of male patients were drug users compared to only 22.1% of female patients. The diagnosis of the cannabis patients was established as dependency/abuse (7 patients), schizophrenia (6 patients), mood disturbance (8 patients), anxiety (6 patients) and other diagnosis (5 patients). No other studies relating to problems arising from cannabis use have been identified.

15.3 Specific interventions for problematic cannabis use

There has been no research published in recent years on treatment of primary cannabis users and no data is maintained by treatment services specifying the type of treatment offered by primary drug use. It is reasonable to assume that the treatment offered would be psycho-social and non-pharmacological but no detailed data is available. There is no indication of any specific facilities or specific programmes for problematic cannabis use in Italy. The Ser.T. have provided treatment for problematic drug users, as have private socio-rehabilitative services, using a range of therapeutic methods. With the exception of some pharmacological interventions, these are not drug specific treatments but are focused on assessed needs of the client. The Macerata research (Simeoni et al 2003) suggests that referrals into treatment for unlawful possession of a controlled drug are in treatment for significantly a shorter period than voluntary admissions to treatment. This may in part reflect the treatment time minimum established in the law, which establishes a three month treatment period for drugs such as cannabis and four months for drugs such as heroin. It is not clear from the research whether some clients move from 'required' to 'voluntary' clients of the Ser.T. at the end of the three or four month treatment period. However, the T.D.I. data for 2001 shows that primary cannabis users are predominantly new clients whilst primary opiate and cocaine clients are predominantly established clients. This suggests that treatment for

cannabis users is shorter, may be more commonly provided as a result of a referral from the N.O.T. and is not continued once the required treatment time has been completed.

16. Co-morbidity

16.1 Main diagnoses, prevalence

There is very limited data available on either the definition of co-morbidity used within treatment services in Italy or on the prevalence of psychiatric co-morbidity. The first major national conference on the topic was held in Sardinia in October 2002. However, the papers from that conference are still not available and it has not been possible to draw on what was a major contribution to knowledge about the current situation in Italy. Mammana (2003) has observed that in Italy there is a particular problem because there is in general a lack of a full diagnostic approach to dealing with patients. Rather, he argues, there is a simple diagnosis of drug dependence and treatment is initiated on this basis without full evaluation of the patient's circumstances and condition. The major study undertaken on the Ser.T. – the VeDeTTE study – at present has made no reference to psychiatric co-morbidity or to treatment related to such a condition. In sum, therefore, the available qualitative and quantitative data is limited.

Pozzi et al (1997) undertook a study aimed at evaluating the prevalence of DSM III-R Axis I morbidity among drug dependents presenting for treatment at the Ser.T. 317 consecutive clients were recruited to the study and were evaluated for current clinical morbidity in the first phase. In the second phase 65 probands were evaluated using the Composite International Diagnostic Interview and the European adaptation of the Addiction Severity Index. The substantial difference between the number of clients in the first and second phases was as a result of refusal to participate in the interviews by clients. Some current psychiatric morbidity was found in 26.2% of those assessed by staff in the first phase and in 22.2% of those interviewed, with a lifetime co-morbidity for the interviewed group assessed as 32.3%. The most common diagnoses were of anxiety and mood disorders. An earlier study by Clerici et al (1989) evaluated the psychopathological profile of 226 heroin users in a therapeutic community in Milan. Using DSM III the study found that 30% of clients were diagnosed in Axis I and 61% were in Axis II of personality disorders. 16% were within the diagnostic spectrum for schizophrenia and 25% had histrionic, narcissistic, anti-social and borderline personality disorders. Siliquini et al (2002) examined patients of 5 mental health services in Piemonte. Of the 176 patients considered, 58 reported drug use during the taking of the clinical history – 8 opiates; 5 hallucinogens; 2 amphetamines; 11 cocaine; 32 cannabis. Amongst the drug users, 29.3% were diagnosed as drug dependent, followed by mood disorders (22.4%), anxiety (20.7%) and schizophrenia (15.5%). These more recent findings among psychiatric patients show similar percentages to those found in the earlier studies by Pozzi et al and Clerici et al. The Siliquini study noted that the prevalence of drug use overall in the patients of the mental health services was not higher than that in the general population for the same age range. However, it was notably higher for cocaine and heroin use, but lower for amphetamine use. Preliminary conclusions from the first phase were that psychiatric pathology was higher amongst opiate and cocaine users than amongst the general population but that there was no difference in psychiatric pathology between the users of 'new' drugs (amphetamines and amphetamine analogues) and the general population. This latter conclusion was, however, strongly tempered by the observation that users of these drugs relatively rarely presented to specialist services and there could be under-reporting with a latency period between use, patterns of use and presentation to specialist services. No other data specifically reporting on prevalence or diagnosis has been identified for use in this report.

16.2 Impact of co-morbidity on services and staff

There has been limited data published on the impact of co-morbidity on services and staff. The national conference referred to above had contributions which related to this

topic but which are not yet available. There have been a number of reports indicating increasing levels of concern about psychiatric co-morbidity in drug users (Bellio 2001, Lo Russo 2001). Zanda et al (2001) reported on the experience of the Tuscany Region. Three basic models of treatment were identified: a sequential model which dealt with the most serious problem first and then those less serious in order; a parallel model in which both the drug and the mental health problems were dealt with contemporaneously by different treatment systems; an integrated model where co-morbidity was dealt with by a treatment team with competence in both drug treatment and treatment of mental disorders. Within Tuscany, it was noted that both the Ser.T. and the private social organisations had independently sought to establish the availability of appropriate resources, had developed therapeutic approaches which aimed at integrating the available resources and had taken advantage, both independently and in joint projects, of funds from the National Drugs Fund to engage the mental health services in providing treatment. To facilitate continued development, the Regional Health Plan had included funding for training to develop capacity in responding to co-morbidity. Antonelli (2001) has reported on the experience of CeIS of Spoleto in working with clients with co-morbidity. 61% of clients were found to have psychiatric problems and it was determined that specific provision was needed for this population. A protocol was established with the Ser.T. and with the Department of Mental Health to ensure that the necessary services and support structures were in place. Joint training was undertaken over a two month intensive period. However, even with continued training it was found that difficulties arose which could not be readily resolved. Antonelli proposed that there was a need for a psychiatric evaluation before the referral was made in order that treatment could be appropriately geared to the needs of the client. Puttini (2001), discussing the experience of a therapeutic community in the Province of Trento noted similar experiences. The service had developed a system for daily observation and reporting to identify specific changes and had also engaged clients in self-diagnosis as part of the treatment process. In this report it was also noted that the type of therapeutic approach adopted needed to be adjusted depending on the psychiatric condition especially with regard to group work and the size of the group.

As has been noted above, there has been increasing development of joint training between mental health and drug treatment staff. No data is available on specific training undertaken for mental health service staff alone. However, many training courses are designed for all those involved in a specific sphere and it is normal for training courses concerned with co-morbidity to involve staff from both service sectors. An example is a training course organised in Pescara. This involved three consecutive days in which the main issues of drug dependence and psychiatric disorders were presented. They were then followed by five half day sessions spread over several months where clinical cases were presented and discussed. A second example is an intensive training course designed for the staff of the Ser.T., primarily in Tuscany, with eight days of training devoted to drug misuse and mood disturbance and eight days devoted to drug misuse and anxiety.

16.3 Service-provision

Within Italy, following the 1978 reform of mental health services, hospital in-patient treatment for mental illness was discontinued and provision was exclusively based in community services. There has also been a separation of drug treatment and mental health services, even though they are often based within the same department in the Regional health service. As a consequence of these separate developments and the different service priorities pursued, there is limited cross-competence between the two sectors. Moreover, the progressive treatment of drug dependents commonly involves referral into a residential therapeutic community to complete treatment and prepare for a return to society drug free. These communities have used a psycho-social model of intervention and have not in general used diagnostic tools to establish overall treatment needs of clients. There is no clear model for the referral of clients from drug treatment services to mental health services and some suggestions that there is resistance from

mental health services to accept drug dependent patients because of lack of expertise in working with this client group. In consequence, protocols have been or are in the course of being developed for collaboration between services. Margaron (2001) has reported on a protocol developed in Livorno and Semboloni (2001) on that developed by a working group for the Region of Liguria. These protocols have established the basis for collaboration between drug and mental health services, the procedures for referrals, clinical information exchange, treatment responsibilities, etc. The result of such protocols has been to improve and develop co-operation between the two sectors. However, it remains common for separate protocols to be established between the different services and programmes rather than a single integrated model to be in place. There are indications that this is changing in favour of an overall model of intervention involving all relevant services and programmes but no formal data on this has been published and the papers awaited from the national conference in Sardinia should provide further information.

In terms of treatment availability, there is little data published in terms of specific services as opposed to treatment provided within the general treatment services for drug dependents. FICT (2002) reports that amongst its members some 18 specialist services for dual diagnosis clients are available. Interestingly most of these services are in the north of Italy which may reflect the geographical distribution of membership but may also reflect a greater focus on this issue in northern and central Italy. It is the case that the majority of published reports and the centres of expertise on this topic are in Lombardy, Piemonte and Tuscany. In terms of the services offered by these 18 programmes, no data is available. Together they report that there were 295 places available for clients with psychiatric co-morbidity and that during 2002, to mid-October of that year, 452 clients had been accommodated in the services. It is known that there are other special services for clients with dual diagnosis but it is not possible to identify the total number of services or of treatments provided.

Only one paper specifically addressing outcomes of treatment has been identified. Clerici and Carrà (2003) report on a study conducted on consecutive patients attending two Ser.T. and a private social therapeutic programme providing services for the metropolitan area of Milan. 544 clients were recruited into the research. Clients were divided into three groups: those receiving out-patient treatment with and without substitution prescribing; out-patient clients with intensive psychological or psycho-educational interventions or who have entered a residential treatment programme; clients who have been in residential treatment for over 6 months or who have received intensive outpatient treatment with more than one type of psycho-social intervention. Sub-groups were also identified consisting of those with only drug dependence; those with severe mental illness plus drug dependence; those with personality and/or mood disorders and drug dependence; and those with multiple psychiatric disorders and drug dependence. Follow up was carried out on 418 clients. Treatment duration in excess of six months was found to have a significant impact on treatment outcome for all groups. The research, although qualified for a number of reasons, suggests that where treatment access was readily available and constant, there was a significant impact on clients with psychiatric co-morbidity. It also suggested that treatment intensity in residential settings has an important effect on successful outcome but that the level of treatment intensity in out patient settings appeared to have no specific impact on outcome. The research concluded that there was further need for integration of different therapeutic techniques in order that treatment benefits from composite treatments might be maximised by re-enforcing motivation to participate in and comply with treatment.

16.4 Examples of best practices and recommendations for future policy

At present it is not possible to offer any examples of best practice within Italy. Although there is an increasing number of services working with this population or having developed dedicated treatment programmes and services, there is virtually no published evaluation of their effectiveness or appropriateness to the conditions which they were intended to treat. It is hoped that as these services/programmes develop and

when they have operated for a longer period that they will be in a position to provide reports on activity and outcome which could form the basis for recommendations for future policy.

In terms of both policy and professional discussion this subject has received a very high profile in the last two years with increasing attention focussed on approaches which can provide integrated treatment models. To a large extent, therefore, the issue is one of awaiting quantitative and qualitative analysis of prevalence, treatments and outcomes in order that effective best practice can be identified and promoted.

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➢ Data Bases/Software/Internet addresses

Data bases used for the National Report

The main data bases available for the National Report are those of the Health information System (SIS) of the Ministry of Health, the Prison Administration and Juvenile Justice Service of the Ministry of Justice, the Military Health Service of the Ministry of Defence, of the Central Directorate for Anti-Drug Services of the Ministry of the Interior and of the National Health Institute for data on HIV and AIDS. The Institute of Statistics (ISTAT) has searchable data bases on the population and a variety of social, economic and demographic topics. The National Drugs Observatory is developing its own systems incorporating data from all relevant Ministries and the Regions in order that a national picture can be developed.
In addition to these national systems, a number of Regions have data bases available on aspects of the drug problem either through the relevant Regoinal Department or through Regional or Provincial Drugs Observatories. Amongst the most developed are those in Piemonte, Emilia-Romagna, Veneto, Lombardia and Abruzzo.

Relevant internet addresses

Much data which is not formally published in journals is available on the web sites of Italian organisations. Most commonly this data is descriptive of services provided with little quantative or qualitative data. Where quantitative data is available there may be no indication of the reference period. Nevertheless, all the listed web addresses were consulted to identify material which might be relevant to the National Report. It has not always been possible, therefore, to provide full references for material, however, where possible the web address of the reference has been hyperlinked.

Ministries and national institutions

Ministero del Welfare Dipartimento per le Politiche Sociali e Previdenziali Dipartimento per le politiche del lavoro e dell'occupazione e tutela dei lavoratori Direzione Generale per la prevenzione e il recupero dalle tossicodipendenze e alcooldipendenze e per l'Osservatorio permanente per la verifica dell' andamento del fenomeno delle droghe e delle tossicodipendenze	http://www.welfare.gov.it/default.htm http://www.welfare.gov.it/aree+di+interesse/Default.htm?AREA=2 http://www.welfare.gov.it/aree+di+interesse/Default.htm?AREA=1 http://www.welfare.gov.it/aree+di+interesse/politiche+sociali/tematiche+sociali/droghe+e+tossicodipendenze/default.htm
Ministero della Difesa Direzione General Sanità Militare	http://www.difesa.it/ http://www.difesa.it/sgd/index.html
Ministero di Giustizia Dipartimento dell'Amministrazione penitenziaria Dipartimento per la Giustizia Minorile Le Statistiche della amministrazione penitenziaria Le Statistiche della giustizia minorile	http://www.giustizia.it/ http://www.giustizia.it/ministero/struttura/dipartimenti/dip_amm_penitenz.htm http://www.giustizia.it/ministero/struttura/dipartimenti/dip_giust_minorile.htm http://www.giustizia.it/misc/STATISTICHE.HTM http://www.giustizia.it/misc/STATISTICHEDAP.HTM

Ministero dell'Interno Direzione Centrale per i Servizi Antidroga (DCSA) Direzione Centrale per la documentazione e la statistica Dipartimento per le libertà civili e l'immigrazione Dati statistici	http://www.mininterno.it/ http://www.interno.it/sezioni/attivita/sicurezza/dip_ps/dcsa/s_000000223.htm http://pers.mininterno.it/ http://www.interno.it/sezioni/organizzazione/dipartimenti/s_000000218.htm http://www.poliziadistato.it/pds/online/antidroga/antidroga.htm
Ministero dell'Istruzione, dell'Università e della Ricerca Direzione Generale per lo status dello studente, per le politiche giovanili e per le attività motorie	http://www.istruzione.it/ http://www.istruzione.it/mpi/amministrazione/dg_studente.shtml
Ministero della Salute Direzione Generale della Prevenzione Dati di attività dei Ser.T.	http://www.ministerosalute.it/ http://www.ministerosalute.it/ministero/sezMinistero.jsp?label=dip2&id=43
Istituto Superiore di Sanita Osservatorio Fumo, Alcol e Droga	http://www.iss.it/ http://www.ossfad.iss.it/
ISTAT	http://www.istat.it/

The National Drug Prevention Campaign

Campagna 2000.	
Valutazione della Campagna informativa 2000 Risultati della Campagna informativa 2000.	http://www.ceis.it/focalpoint/download/valutazione2000.pdf http://www.ceis.it/focalpoint/download/Risultati2000.pdf
Campagna 2001.	
Il vero sballo Risultati della Campagna informativa 2001.	http://www.ilverosballo.it http://www.ceis.it/focalpoint/download/Risultaticamp2001.pdf
Campagna 2002.	
O ci sei, O ti fai	http://www.ociseiotifai.it/

Other national organisations

Art Therapy Italiana	http://www.arttherapy.it/
Centro Italiano Sviluppo Psicologia	http://www.tossicodipendenze.net/
CGM - Consorzio nazionale della cooperazione sociale Gino Mattarelli	http://www.retecgm.org/
Chiedi ad Anri!	http://www.tox.it/anri/index.htm
COMBATT	http://users.iol.it/andrea_michelazzi
Coordinamento Nazionale Comunità d'Accoglienza	http://www.cnca.it/
Coordinamenti Regionali Enti Ausiliari per le Tossicodipendenze	http://www.intercear.it/
CORA	http://www.agora.stm.it/coranet/coraita/ita-home.htm

Cost A6 Italia	http://www.iefcos.it/valuta/
DRONET	http://www.dronet.org/
e10dance	http://www.e10dance.com/
ERIT Italia	http://www.erititalia.freeweb.supereva.it/
Federazione Italiana Comunità Terapeutiche	http://www.fict.it/
Federazione Italiana Organismi per le persone senza dimora (FIO.psd).	http://www.fiopsd.org/
Federazione Ialaiana degli Operatori dei Dipartimenti e dei Servizi delle Dipendenze - FeDerSerD (Ser.T.)	http://www.federserd.it/
GioFil	http://www.ciis.it/
Gruppo S.I.M.S. (Studio e Intevento sulle Malattie Sociali)	http://www.sims.it/
I.E.F.Co.S	http://www.iefcos.it/
In - dipendenza donna	http://www.indipendenzadonna.org/index.php
IREFREA Italia	http://www.irefrea.org/italia/inicio.htm
ITACA Italia	http://www.itacaitalia.it/
Lila	http://www.lila.it/
Lottiamo insieme contro la droga	http://communities.msn.it/Lottiamoinsiemecontroladroga
Medicina delle Tossicopdipendenze	http://www.medol.com/mdt/
Mo.V.I. - Movimento di volotariato Italiano	http://www.volontariato.it/
Narcotici Anonimi	http://www.na-italia.it/
Nando Melillo Volontario	http://www.pegacity.it/ospedale/case/1103/index.htm
Progetto "Nuova Alice"	http://www.nuovaalice.org/
Psychomedia	http://www.psychomedia.it/
La pagina Web di Riccardo C. Gatti	http://www.droga.net/
SITD (Società Italiana Tossicodipendenze)	http://www.sitd.org/
Servizio Sociale su Internet	http://www.serviziosociale.com/

Italian Regions

Abruzzo (http://www.regione.abruzzo.it/)

Associazione L'ARCOBALENO Centro di Accoglienza Residenziale "La Ginestrella"	http://www.srd.it/larcobaleno/larcobaleno2.html
Centro di Solidarietà di Pescara	http://www.olografix.org/ceis/
Centro di Solidarietà Val Vibrata	http://www.centrosolidarietavalvibrata.it/
Il Ponte, Cooperativa di Solidarietà Sociale	http://www.advcom.it/ilponte/default.htm
Progetto obiettivo "Sei unico" - Regione Abruzzo	http://www.seiunico.it/
C.L.E.D. - Comitato Lotta Emarginazione Droga	http://www.seiunico.it/cled
Scuola Abruzzese di Formazione in Medicina Generale	http://geocities.com/HotSprings/Villa/3063/
L'Associazione Soggiorno Proposta	http://web.tiscalinet.it/sogproposta

Basilicata (http://www.regione.basilicata.it/)

Cooperativa di Solidarietà L'Aquilone Cooperativa Sociale a r.l. ONLUS	http://www.aquilone-onlus.it/

Calabria (http://www.regione.calabria.it/)

C.A.S.T. di Ciro Marina	http://www.xcom.it/tenda/
La Casa del Sole	http://www.comunitalacasadelsole.it/
Onlus Progetto Maya	http://www.ecn.org/gramna/maya

Campania (http://www.regione.campania.it/)

Associazione La Tenda	http://www.xcom.it/tenda/
Associazione Promocentro	http://utenti.tripod.it/promocentro/
L'Alternativa - ONLUS	http://space.tin.it/associazioni/irega/
Centro di solidarietà "Le Ali"	http://www.tightrope.it/leali/index.htm
I.C.A.T.T. Eboli	http://www.icatteboli.it/
Insieme per Cambiare	http://utenti.lycos.it/SerTCaserta1/index.htm
Provaci	http://spazioinwind.libero.it/bianca/provaci.htm
Ser.T Distretto 49, A.S.L. Napoli 1	http://digilander.iol.it/sertd49aslna1
Ser.T. Distretto 51, A.S.L. Napoli 1	http://digilander.libero.it/sert51/

Emilia-Romagna (http://www.regione.emilia-romagna.it/)

Agenzia Sanitaria Regionale - Emilia-Romagna	http://www.regione.emilia-romagna.it/agenziasan
Regione Emilia-Romagna “Progetto regionale tossicodipendenze”	http://www.regione.emilia-romagna.it/tossicodipendenze/
Alchemia	http://utenti.tripod.it/axla/index.html
Associazione Nefesh	http://www.geocities.com/Athens/1915/
Associazione Papa Giovanni XXIII	http://www.apg23.org/apg23/index.html
Associazione Papa Giovanni XXIII - Modena	http://www.comune.modena.it/associazioni/apg23mo/
Associazione Papa Giovanni XXIII Reggio Emilia	http://www.libera-mente.org/
Centri di Accoglienza - Comunità La Rupe - Bologna	http://www.centriaccoglienza.it/
Centro d'Amicizia	http://www.centrodamicizia.it/index.html
Centro di Solidarietà di Modena	http://www.ceismo.it/
Centro di Solidarietà di Parma	http://www.ceisparma.org/index.html
Centro di Solidarietà di Reggio Emilia	http://www.solidarieta.re.it/
Centro Sociale Livello 57 - Bologna	http://www.electroniclabs.net/index.htm
Comunità San Maurizio	http://www.sanmaurizio.org/
Comune di Reggio Emilia - Unità di prevenzione	http://up.comune.re.it/
Dip&Doc	http://www.stradanove.net/dipdoc
Dipendenze patologiche Forlì	http://www.ausl.fo.it/giovani/Servizi/sert.htm
Dipartimento dipendenze Modena	http://www.giannimorandi.it/Prof/dipatol.htm
Drogaonline - Centro di Solidarietà Reggio Emilia	http://www.drogaonline.it/
Exodus Bondeno - "Casa di Carlotta"	http://www.exodus.it/sedi/bondeno
extasy.it - AUSL Ravenna	http://www.extasy.it/
La Nuova Strada - Associazione Utenti del Ser.t di Rimini	http://lanuovastrada.interfree.it/obiettivi/obiettivi.html

On the Road	http://www.ontheroadonlus.it
Osservatorio epidemiologico AUSL Bologna	http://www.ossdipbo.org/
Il Pellicano	http://www.assilpellicano.org/
Per non andare in galera, se possibile....	http://www.comune.fe.it/legge-simeone/introduzione.htm
Il piccolo chimico - Comune di Modena, SERT Modena	http://www.stradanove.net/news/testi/index/pc.html
Progetto Dune	http://www.stradanove.net/info/droga/intro.html
Progetto nuove droghe - AUSL Reggio Emilia	http://www.ausl.re.it/pnd/default.htm
Ritorno al Futuro	http://www.freeweb.org/volontariato/ritornoalfuturo/
San Patrignano	http://www.sanpatrignano.org/
Ser.T di Cesena	http://www.ausl-cesena.emr.it/sert/Default.htm
Ser.T. della Provincia di Modena	http://www.monicaepaolo.it/
Ser.T. Faenza	http://www.ausl.ra.it/h3/h3.exe/aauragest/funicoweb?NRECORD=0000000094
Ser.T. Ferrara	http://www.comune.fe.it/legge-simeone/aiuti/sert.htm
Ser.T di Imola	http://www.regione.emilia-romagna.it/web_gest/enti/usl/uslimola/dist-3.htm
Ser.T. Lugo	http://www.ausl.ra.it/h3/h3.exe/aauragest/funicoweb?NRECORD=0000000071
Ser.T. Ravenna	http://www.ausl.ra.it/h3/h3.exe/aauragest/funicoweb?NRECORD=0000000093
Ser.T. Rimini, Progetto SIDA	http://www.geocities.com/HotSprings/9949/italiano.html
Spazio Giovani	http://spaziogiovani.ausl.pr.it/index.php
S.O.S. DROGA	http://digilander.libero.it/gruppodonminzoni/
Spazio Giovani AUSL Piacenza	http://www.esaicosabevi.com/giovani.htm
Unità Mobile SerT	http://www.ossdipbo.org/UMobile/

Friuli-Venezia Giulia (http://www.regione.fvg.it/)

Associazione La Ricerca	http://www.laricerca.org/
Comunità Terapeutica per Tossicodipendenti Finisterre	http://members.xoom.it/C_Finisterre/
Dipartimento delle Dipendenze, Trieste	http://www.ass1.sanita.fvg.it/sert/welcome.htm
La Viarte	http://laviarte.pcupdate.easyspace.com/comunit1.htm
Nucleo Cittadini e Genitori	http://www.ncgoliberidalledroghe.org/
Sert Udine	http://www.friuli.to/sert_ud/

Lazio (http://www.regione.lazio.it/)

Servizi Tossicodipendenze - Regione Lazio	http://213.175.14.99/redazione/sanita/asl.nsf/sert?openview
Agenzia Comunale per le Tossicodipendenze	http://www.comune.roma.it/act
ARDEA per la VITA	http://utenti.tripod.it/ARDEAperlaVITA/index-2.html
Associazione l'Arcobaleno	http://www.srd.it/larcobaleno/
Associazione La Torre	http://www.associazionelatorre.org/
Ce.A.P. - Centro Ascolto per le Politossicodipendenze	http://www.ceaproma.it/
Il Centro Diurno "Stella Polare"	http://web.tiscali.it/StellaPolare/

Il Centro Gledhill	http://www.comunita.it/doppiadiagnosi/Default.htm
Centro Italiano di Solidarietà (CeIS)	http://www.ceis.it/
Centro di Solidarietà "San Crispino"	http://www.isa.it/ceis
Comunità "Massimo"	http://www.monasterolanuvio.it/inter.htm
Dipartimento Disagio, Devianza, Dipendenze, ASL di Frosinone	http://www.asl.fr.it/dipar/dipar_d3d.html
Dipartimento delle Dipendenze, ASL Roma A	http://www.asl-rma.rm.it/DiD.htm
Fondazione Villa Maraini	http://www.villamaraini.it/
Gruppo Magliana '80	http://www.magliana80.it/home.htm
La Promessa - onlus	http://www.romacivica.net/lapromessa/
Il progetto "IMPRONTE"	http://utenti.lycos.it/progettoimpronte/homepage.htm
Progetto Mosaico	http://www.mclink.it/assoc/ecstasy.info
SERT, ASL Roma H (Ciampino, Nettuno,Velletri,Genzano, Frascati)	http://web.genie.it/utenti/s/sertnet/
Ser.T. ASL di Viterbo	http://www.asl.vt.it/cittadino/servizi/tossicodipendenze.html
Volere volare Oltre il Muro	http://www.oltreilmuro.it/

Liguria (http://www.regione.liguria.it/)

Centro di Crescita Comunitaria, La Spezia	http://www.infinito.it/utenti/ceislaspezia
il Centro di Solidarietà "L'Ancora"	http://www.centroancora.it/ and http://members.tripod.com/centroancora/
Centro di Solidarietà di Genova	http://www.csgenova.org/
Centro Sociale Mobile, Imperia	http://utenti.lycos.it/centrosocialemobile/
La Loppa Associazione	http://mail.netteam.it/laloppa
SerT ASL 3 Genovese	http://www.asl3.liguria.it/servizi/05_dipendenze/0201.htm
SerT ASL 4 Chiavarese	http://digilander.iol.it/gianninoulivi and http://www.asl4.liguria.it/Servizi_sul_territorio/Sert/sert.html
Ser.T. di Imperia	http://www.asl1.liguria.it/indice/guida.htm
SerT La Spezia	http://www.ausl5.la-spezia.it/droga/index.htm
Villaggio del Ragazzo	http://www.villaggio.org/comunita.html

Lombardia (http://www.famiglia.regione.lombardia.it/dip/dip.asp)

A.G.A. 14 Associazione ONLUS	http://www.associazioni.milano.it/itsos//aga%2014/
Aisel	http://www.aisel.it/
ASL Bergamo, Dipartimento delle Dipendenze	http://www.asl.bergamo.it/web/intsert.nsf
ASL Milano	http://www.asl.milano.it/droga
Asl di Varese Dipartimento Dipendenze	http://www.asl.varese.it/dipartimenti/dipendenze.html
Associazione "Albero"	http://www.associazionealbero.it/
Associazione Comunità "IL GABBIANO" onlus	http://space.tin.it/associazioni/ropoten
Associazione Mondo X	http://www.mondox.it/
Associazione Progetto Arca	http://www.progettoarca.org/
Associazione Saman	http://web.tin.it/saman/
Centro "Gulliver"	http://www.gulliver-va.it/
Centro per lo Studio e la Terapie	http://www.cestep.it/

delle Psicopatologie /Ce.S.Te.P)	
Centro Terapeutico Riabilitativo Territoriale	http://www.geocities.com/MadisonAvenue/Boardroom/3307/asl.html
Comune di Milano	http://www.comune.milano.it/webcity/documenti.nsf/
La comunità Casa del Giovane	http://www.cdg.it/
Comunità Mondo Nuovo	http://www.mondonuovo.org/start.htm
Comunità Nuova	http://www.comunitanuova.it/
La Cooperativa Sociale TETTO FRATERNO	http://www.pegacity.it/informa/case/4375/presenta.htm
CONT@TTO - SPAZIO ADOLESCENTI	http://www.con-tatto.it/
CREST	http://www.crest.it/
Droga Milano	http://fc.retecivica.milano.it/Rete%20Civica%20di%20Milano/Societa'%20e%20Politica/Salute%20e%20Sanita'/DROGA%20MILANO%20SOS/
ECCAS	http://www.asl.bergamo.it/web/intsert.nsf/pages/Homepage
EXODUS	http://www.exodus.it/
Fondazione Promozione e Solidarietà Umana	http://www.promozioneumana.it/home.asp
Fraternità Capitanio	http://www.fraternitacapitanio.org/
inSERT	http://www.droga.net/
Lautari	http://www.lautari.com/
Coop. Sociale Tangram2	http://www.tangram2.it/
Pinocchio Comunità Terapeutica	http://digilander.iol.it/comunitapinocchio/
Progetto N.A.I.F - nuovi abusi informazione formazione	http://217.169.97.38/aslcomo/naif/index.asp
Reinserimento Socio Lavorativo per Tossicodipendenti	http://www.inserisciti.it/
Servizio Dipendenze, A.S.L. dell Provincia di Cremona	http://www.aslcremona.it/html/carta_servizi/sanitarie/dipendenze.htm
Ser.T. Montichiari	http://www.sdrogabrescia.it/SerT.htm
Ser.T., A.S.L. dell Provincia di Milano 2	http://www.aslmi2.it/assi/SDipendenze/tossicod.htm
Ser.T., A.S.L. dell Provincia di Milano 3	http://www.mi3.asl.it/carta/frame/frame_int4c.htm
Usi e Abusi (Provincia di Brescia)	http://www.sdrogabrescia.it/
Marche	(http://www.regione.marche.it/)
"Ama-Aquilone" Cooperativa di Solidarietà	http://www.ama-aquilone.it/
AVAPA	http://www.studiofabbri.com/avapa
Centro di Solidarietà "Vita Nuova"	http://www.csv.marche.it/spazioadv/vitanuova
Progetto Icaro	http://www.rinascita.it/progetto_icaro/
Ser.T. di Macerata	http://www.asl9.marche.it/SERT/home.htm
Ser.T. di Pesaro	http://www.ausl1ps.marche.it/CarteServizi/CartaServiziPS/DipPatologiche.htm
Ser.T. di S. Benedetto del Tronto	http://www.asl12.marche.it/sert.html
Ser.T. di Senigallia	http://www.asl4.marche.it/territoriale/sert.htm
Molise	(http://www.regione.molise.it/)

Associazione Crescere Onlus Molise	http://www.crescereteremoli.it

Piemonte (http://www.regione.piemonte.it/)

Osservatorio Epidemiologico delle Dipendenze, Regione Piemonte - ASL 5 - Servizio di Epidemiologia	http://www.oed.piemonte.it/italiano.htm
Associazione Fides	http://web.tiscalinet.it/Fides
l'Associazione Le Patriarche	http://www.lepatriarche.org/
Centro Imago	http://www.centroimago.it/
Centro Kades	http://digilander.libero.it/kades/kades.htm
Comunità Terapeutica Saint Jacques	http://www.freeweb.org/associazioni/saintjacques/
Comunità Cenacolo	http://www.comunitacenacolo.it/index.htm
Cooperativa Sociale Terra Mia	http://www.arpnet.it/~terramia/
Cyber Pupazza	http://space.tin.it/associazioni/ileoncin/
Dialoghi di Tossicodipendenza	http://www.dialoghiditossicodipendenza.it/
Fermata d'Autobus	http://www.fermatadautobus.org/
Gruppo Abele	http://www.gruppoabele.org/
Gruppo "Arco"	http://www.arpnet.it/arco/
Il Porto	http://www.ilporto.org/
LENAD	http://www.lenad.it/index.htm
Lucignolo and Company	http://www.lucignolo.org/
Dr. Franco MORETTI	http://users.iol.it/fm_psy
Nelson Mandela Comunità	http://www.comunitamandela.it/
Ser.T. ASL 1 (Torino)	http://www.asl1.to.it/cartaservizi2001/sert.htm
Ser.T. ASL 7 (Settimo T.se - Chivasso - S. Mauro/Gassino)	http://www.asl7.to.it/medspec_asstossic.htm
Ser.T. ASL 9 (Ivrea)	http://www.asl.ivrea.to.it/sert/index.html
Ser.T. ASL 10 (Pinerolo)	http://www.asl10.piemonte.it/sert/index.htm
Ser.T. ASL 11 (Provincia di Vercelli)	http://www.asl11.piemonte.it/servizi/tossico.htm
Ser.T. ASL 13 (Provincia di Novara)	http://www.asl13.novara.it/intranet/I-Servizi-/Ser-T-/index.htm
Sert ASL 14 Verbano Cusio Ossola	http://www.asl14piemonte.it/ita/sert.htm
Ser.T. ASL 15 (Cuneo)	http://www.asl15.sanitacn.it/Sert.html

Puglia (http://www.regione.puglia.it/)

Servizi Tossicodipendenze - Regione Puglia	http://www.servizisocialipuglia.it/
Associazione NARCONON® "Il Gabbiano" (ONLUS)	http://www.narconontop.org/
L'Associazione ONLUS "Solidarietà Salentina Recupero Giovanile" - SO.R.GI	http://www.sorgi.aiutiamo.org/
Associazione Pugliese Rilancio o.nl.u.s.	http://www.apri.aiutiamo.org/
Cattedra di Tossicologia Forense	http://www.tossicologia.uniba.it/index.html#0
Comunità Airone Taranto	http://www.airone.org/
Comunità Emmanuel	http://www.emmanuel.it/alcooltossicodip/dipendenza.asp

Consorzio Promosud	http://www.promosud.it/
Cooperativa Sociale C.A.P.S.	http://caps.freeweb.org/
Cooperativa Sociale Teseo	http://digilander.libero.it/teseoct/Home%20page.html
F.A.C.T.	http://digilander.iol.it/Arpi/
Gruppo SIMS SAVA (TA)	http://www.geocities.com/simssava
RIDUCIAMO IL DANNO PER LEGGE!!!	http://www.ba.dada.it/larete/
Ser.T., ASL Bari 3	http://www.auslba3.it/ServiziTerritoriali/s45tossi.htm
Ser.T., ASL Bari 5	http://www.auslba5.it/DistrettiSocioSanitari/Sert.htm
Ser.T., ASL Brindisi 1	http://www.auslbr1.brindisi.it/seconda/CDSFrame2.htm#tossicodipendenza
Ser.T., ASL Lecce 2	http://www.asl2maglie.le.it/dipartimenti/TOSSICODIPENDENZE.HTM

Sardegna (http://www.regione.sardegna.it/)

ACAT Alto Oristanese	http://www.catabbasanta.supereva.it/
Associazione di Volontariato - Centro di Accoglienza "Don Vito Sguotti"	http://associazionedivolont.freeweb.org/
Associazione Mondo X - Sardegna	http://web.tiscalinet.it/mondoxsardegna/
Dipendenze	http://web.tiscali.it/problematicita/index.htm
Univerità di Cagliari, Dipartimento di Neuroscienze	http://vaxca1.unica.it/~saramu/new

Sicilia (http://www.regione.sicilia.it/)

L'Associazione "Casa Famiglia Rosetta"	http://www.casarosetta.it/
L'Associazione Gruppo Nuova Speranza	http://digilander.libero.it/grupponuovasperanza/
Azienda USL 6 - Palermo	http://www.ausl6palermo.org/energia.htm
Il Centro di Solidarietà F.A.R.O.	http://www.farosol.it/
Comunità Nazareth (Catania)	http://www.comunitanazareth.it/home.htm
Cooperativa Fenice	http://www.fenicecoop.org/
Il Disco Truck Tour No drugs Libera la vita !	http://www.discotruck.it/
L.C.D. - ONLUS	http://www.lcd-karibu.org/index.htm
Linea Verde Avola	http://iblaservice.monrif.net/index1.html
Ser.T. in Sicilia	http://www.regione.sicilia.it/sanita/x(foglioA).htm
Ser.T. ASL 17 (Ragusa)	http://www.ausl7.rg.it/Strutture/servTossic.htm

Toscana (http://www.regione.toscana.it/index.htm)

Associazione Genitori Comunità Incontro	http://www.agcionline.org/
Associazione Insieme	http://www.odissea.it/coorATanas/insieme.htm
Associazione Progetto Aliante (onlus)	http://www.progettoaliante.it/
CENTRO CAOS 41	http://www.asf.toscana.it/modules.php?op=modload&name=Sections&file=index&req=viewarticle&artid=43&page=1
Centro Documentazione e Ricerca sul Fenomeno delle Dipendenze Patologiche (Ce.Do.S.T.Ar.)	http://www.cedostar.it/
Centro di Solidarietà di Firenze - onlus	http://www.csfirenze.com/Index2.html
Centro di Solidarietà di Lucca	http://www.ceislucca.it/

Centro di Solidarietà di Prato	http://www.comune.prato.it/associa/centsol/
Centro Studi, Ricerca e Documentazione su Dipendenze e AIDS	http://www.cesda.net/
Centro Studi e Documentazione Provinciale sulle tossicodipendenze e l'emarginazione	http://www.cesdop.it/
Centro Terapeutico Riabilitativo di Vallerotana	http://www.ouverture.it/maremma/associa/assgenvo.htm
Dipartimento Dipendenze, Firenze	http://www.asf.toscana.it/modules.php?op=modload&name=Sections&file=index&req=viewarticle&artid=41&page=1
Dipartimento delle Dipendenze, Grosseto	http://www.usl9.grosseto.it/pagine/info/dipen.htm
Fides Associazione	http://web.tiscalinet.it/Fides
Fondazion Charlie	http://www.fondazionecharlie.org
Fondazione Istituto di Ricerca "Andrea Devoto" - Firenze	http://www.fondazioneandreadevoto.it/
Il Gabbiano	http://space.tin.it/associazioni/ropoten/
Gruppo SIMS	http://www.sims.it/associazioni/SIMS/
PROGETTO CEDRO.net	http://www.cedostar.it/cedro.htm
Ser.T.	http://www.sert.it/
Sert USL 2, Lucca	http://www.usl2.toscana.it/sert/
Ser.T. USL 3, Pistoia - Zona Valdinievole	http://www.usl3.toscana.it/UOAziendali/sertvdn/sito/default1.htm
Sert USL 6, Livorno	http://www.usl6.toscana.it/sert/home.htm
Sert USL 7, Siena	http://www.usl7.toscana.it/distretti/sert.html

Trentino-Alto Adige (http://www.regione.taa.it/)

Associazione "La Strada" / Verein "Der Weg"	http://www.lastrada-derweg.org/
Azienda Provinciale per i Servizi Sanitari, Provincia Autonoma di Trento	http://www.aziendasanitaria.trentino.it/direzioni/cura/sert.htm
Azienda Servizi Sociali di Bolzano	http://www.aziendasociale.bz.it/se04_01_20.html
Centro Trentino di Solidarietà - ONLUS	http://digilander.libero.it/marcoligorio/cts/Home.html
CSDPA	http://www.irsrs.tn.it/csdpa/

Umbria (http://www.regione.umbria.it/)

Agenzia SEDES - Regione Umbria	http://www.sedes.it/
Associazione C.D.S. Cammino della Speranza	http://www.associazionecds.com/HomePage.htm
C.A.S.T.	http://www.freeweb.org/freeweb/cast/
Comunità Incontro	http://www.comunitaincontro.org/
Dipartimento per le dipendenze patologiche, ASL 3 di Foligno	http://www.asl3.umbria.it/carta/assterri/6.htm
Progetto Cura la Vita	http://spazioinwind.libero.it/prr/prr/index.htm
Ser.T. ASL 4, Provincia di Terni	http://www.asl4.terni.it/azienda/sert/sert.htm

Valle D'Aosta (http://www.regione.vda.it/)

Servizio Tossicodipendenze e Salute Mentale	http://www.regione.vda.it/sanita/servterritoriali/dipendenze/default_i.asp

Veneto (http://www.regione.veneto.it/)

ACAT Portogruarese	http://www.acatportogruarese.it/

ASL Vicenza, Piani di Zona	http://www.pianodizonavi.org/
Auto Aiuto Corallo	http://www.autoaiutocorallo.org/
CBFT	http://apf.cbft.unipd.it/#
Centro "Don Lorenzo Milani"	http://www.ceisdonmilani.com/
Centro di Solidarietà di Belluno	http://www.sunrise.it/ceis
CeIS Treviso	http://www.ceistreviso.it/
Comunità terapeutica-educativa "San Gaetano"	http://www.sgaetano.org/
Comunità terapeutica "Villa Renata"	http://www.villarenata.eurovenezia.org/
Consorzio EuroVenezia	http://www.eurovenezia.org/
Disintossicazione.it.	http://www.disintossicazione.it/index.htm#
Dronet Veneto	http://veneto.dronet.org/
Itinerari di Sicurezza Sociale - Associazione Famiglie Veronesi Contro La Droga	http://www.itinerarisicurezza.org/
Ser.T. Vicenza	http://www.pianodizonavi.org/auto_strutture/sertvicenz949574680.htm
Temerari	http://www.temerari.it/
Progetto Teseo	http://www.sert2-pd-it.com/

ANNEX

- **Drug monitoring systems and sources of information**

  The main monitoring systems within Italy are operated by the Ministry of Health and by the Ministry of the Interior. Other monitoring systems provide information about drug misusers within their wider responsibilities.

  The Ministry of Health collects data on the activities of the national health service managed drug treatment services (Ser.T.). The data to be provided is defined by national regulation and there are two reporting dates each year, one in June and one in December. In June and December services are required to provide some data about clients in treatment. In December each year they are required to provide additional data about clients as well as data about the treatment service itself. The data is analysed and prepared in standard format by the Health Information System of the Ministry of Health and is published in both an annual report and in the *Bollettino per le Farmacodipendenze e l'alcoolismo*. The data is also sent to the Regions.

  Additionally, especially in the central and northern Regions, Regional Observatories or Regional monitoring systems have been established to collect and analyse local drug related data and to inform policy and practice. Unfortunately the systems operated by the Regions are not always compatible with each other, with the national arrangements or with European requirements. Efforts are continuing to improve the systems and develop a minimum of common standard elements.

  The Ministry of the Interior, through the Central Directorate for Anti-Drug Services (DCSA), is responsible for data on drug law offences, seizures of drugs, anti-drug operations carried out by components of the Judicial Police and direct drug related deaths. Through the Central Directorate for Documentation (DCD), it is responsible for data on referrals to the Prefect for unlawful possession of a listed drug and for the twice yearly census of socio-rehabilitative services. The data maintained by the DCSA is submitted electronically through the dedicated computer network for the law enforcement agencies. It has both operational and statistical purposes. The statistical elements are generally of high quality but are not always produced in ways which meet the European requests for data. This is more related to processing

procedures and historical practice. The data itself is available. The DCD data with regard to referrals to the Prefect is also submitted electronically as part of normal reporting procedures. Data on the socio-rehabilitative services is at present very limited, only covering minimal data on location, type of service, capacity and occupancy. This data is dependent upon services responding to the questionnaire and is not of high quality. The DCD is presently undertaking a project to improve the data. At the Regional level, the regulation approved by the Permanent Conference for Relations between the State, the Regions and the Autonomous Provinces in August 1999 established the minimum standards for a service to be registered with the Region and the monitoring and reporting requirements. However, exact application of the regulation is a matter for individual Regions. It is hoped that there will be improved linkage between the data collected at the Regional level and that at the national level in order that a parallel picture to that for the Ser.T. can be created for the socio-rehabilitative services.

The Ministry of Justice collects data on people accused of or convicted for an offence, on people held in the prison system and on people supervised by the probation service. This data includes information about people identified as drug dependent, about HIV status and about offence (drug law or other). The data is submitted by the relevant institution or probation service office. However, there are some problems at present with the data. There is no clear definition of dependence and the basis for an individual being assessed as drug dependent can vary from institution to institution. The data on HIV status and on decisions made concerning people who are HIV positive and displaying clinical signs of AIDS is good although again it is not clear how complete the data is. Similar problems can be found with data on juvenile offenders and with data on people serving community based sentences. Again, efforts are being undertaken to improve the quality of the data. This may occur with the greater involvement of the Ser.T. in the prison system. Data on proceedings for drug law offences and for proceedings against drug users for drug related offences is also available. This data was cumulative in that it only showed all proceedings and conclusions of proceedings in the year, not the number of proceedings initiated in a year or concluded in that year. Changes have now been made to the recording system, in consultation with the OIDT, which should lead to further improvement in the available data.

The Ministry of Education has supported the ESPAD Italia survey which is to be conducted for three years from 2000 to 2002, thus creating a data set from 1999 to 2002. This is the most comprehensive national survey of drug use amongst the young population of Italy and provides invaluable data on trends.

The Ministry of Defence and the Ministry of Labour and Social Policy both collect some data concerned with drug use in the armed services and drug use in the workplace. However, this data is not collected on a scientific basis but on the basis of reports received. The Ministry of Labour and Social Policy, Department for Social Policy and Social Security, has also assumed responsibility for monitoring use of the National Drugs Fund, for the National Drugs Campaign and evaluation of the campaign, for the operation of Drogatel and for the National Drugs Observatory. These were previously within the Department of Social Affairs of the Presidency of the Council.

The National Drugs Observatory (OIDT), based within the Ministry of Labour and Social Policies, has worked with the different Ministries and with the Co-ordination of the Regions in an effort to establish improved data collection arrangements which meet European standards and which allow cross reference between data sets from different sources. Additionally, the OIDT collects data from all the sources discussed above in order to prepare the Annual Report to Parliament on the State of the Drug Problem in Italy. Through its Epidemiology section it is able to develop the data from different sources to produce estimates of drug use and problematic drug use using different indicators and calculation methods and to produce estimates at the national, regional and province levels. The OIDT is, therefore, in a position to utilise the data from a range of sources and to act as the central co-ordination point for institutional data.

Documentation and study centres are available throughout Italy. These are local or Regional facilities and data cannot always easily be obtained from them at the national level. An increasing number of centres now publish reports or summaries of research on their web sites and these documents have been used extensively in preparation of this report. However, for the majority the only means of obtaining such data remains when it is published in a scientific journal or presented at a major conference or included in data submitted to the Co-ordination of the Regions for inclusion in the report submitted to the Ministry of Labour and Social Policies for inclusion in the Annual Report to Parliament.

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