



European Monitoring Centre  
for Drugs and Drug Addiction



## **2004 NATIONAL REPORT TO THE EMCDDA by the Reitox National Focal Point**

### **“ITALY”**

**New Developments, trends and in-depth information on  
selected issues**

**REITOX**

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## Summary

During 2003 and the first half of 2004 the major developments within Italy which were initiated in the previous period and 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 June 2004 the Government approved the first National Drugs Plan produced in Italy and sent it to the Regions for consultation. This plan deals with co-ordination, prevention drug demand and supply reduction and international co-operation and gave clear expression to the primary prevention and abstinence oriented policies favoured by the Government. In 2004 the National Department for Drug Policy was made fully operational with a Director and four main sectors. A Ministerial Decree from the Deputy Prime Minister established the competences and priorities for the National Department. A draft revision of the drugs law was also published and submitted for Parliamentary consideration. The guidance for use of the National Drugs Fund, which in 2003 was combined with the National Social Fund, gave priority to activities which would implement either at national or local levels the priority areas of the National Drugs Plan

### *Epidemiology*

In 2003 the second 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 – 54. 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. The ESPAD Italia study shows a general reduction in listed drug use with the exception of cannabis and cocaine use. It also shows an increase 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 three 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. Overall 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 continued. There has also been a decrease in the percentage of all clients testing positive for HCV infection and the percentage of all clients of the Ser.T. testing positive for Hepatitis C shows a slight downward trend over the last five years. 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 2003 were in real terms lower than for 1999. The quantity of heroin seized fell in 2003. The quantity of cocaine seized in 2003 slightly decreased in comparison with 2002, but more recent data for 2004 shows a further increase. 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 2003 and there has been a downward trend in the quantity of cannabis seized over recent years. There was a decrease in the quantity of amphetamine and amphetamine analogue seized but with an upward

trend since the mid '90s. 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 decline. The number of referrals to the Judicial Authority for drug law offences has also fallen. 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. There has been a continued expansion of the sites available. A 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 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.

There has been a continuing increase in the percentage of clients who receive long term (over 6 months) methadone. 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 fallen 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 OI DT 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 A: New developments and Trends

### 1 National Policies and Context

#### 1.1 Overview

There have been some significant developments in terms of national policy and the national context during the reporting period. The Government has been committed to a number of reforms and revisions to existing legislation and to the adoption of a National Drugs Plan with clear aims and objectives.

The national context has been developing with legislation to amend the Constitution to devolve greater powers to the Regions and Autonomous Provinces, as well as to the City of Rome as the capital, progressing through Parliament. The intention is to create a more federal state in which less direct responsibility for what are primarily locally delivered services – health, education, etc. – is held by the central administration.

Within this context, the Government has stated its clear intention to give a different direction to drug policy, clearly focused on the prevention of drug use and interventions aimed at achieving and sustaining abstinence from illicit drug use and re-entry into the social and work environments. Whilst recognising that the development and implementation of drug demand reduction activities is primarily the responsibility of the Regions, central government has the role of providing guidance and co-ordination in line with its international obligations.

The rationale for the revision of the existing drugs legislation and for the contents of the National Drugs Plan are several fold. First, the legislation needs to be revised to take account of changes in the structures and systems for co-ordinating and responding to drug-related problems. Second, there is a need to reduce or remove the variability of responses to drug misuse and of the availability of interventions. Third, there is a need to develop and improve knowledge about the drug problem, the scientific basis of prevention and treatment responses and a separation between the purchasers and deliverers of services to allow equality between public and private provision.

The key structural change has been the establishment of the National Department for Drug Policy. Based in the Prime Minister's Office and under the direct responsibility of the Deputy Prime Minister, it provides the reference and co-ordination point for all aspects of drug policy – demand and supply reduction. A secondary change is planned to strengthen the role of the Central Directorate for Anti-Drug Services (DCSA) (based in the Ministry of the Interior) as the co-ordinator of law enforcement activities aimed at reducing drug supply. There may also be some consequent adjustments to the responsibilities of other Ministries, the Regions and local authorities.

Variability of responses concerns, for instance, different definitions of what constitutes the administrative offence of possession of a controlled drug, different focuses for prevention and treatment responses between Regions and the need to make available a balanced range of treatment options from which a drug dependent can make an informed choice.

The contents of the revision of the drugs law and of the National Drugs Plan are discussed in detail in the following sections. To provide a national focus for monitoring, planning, policy and co-ordination, the National Department for Drug Policy has been established, and the responsibilities and resources previously held by the Directorate for Drug Dependency and the National Drugs Observatory in the Ministry of Employment and Social Policy have been transferred to the new Department. The role of Extraordinary Commissioner has been discontinued and the functional tasks have been absorbed into the Department.

In terms of expenditure at the national level on direct and indirect responses to drug misuse limited information is available as most expenditure occurs within the normal activities of Ministries and Departments. A national project is currently underway seeking to identify the expenditure at local and national level on drug demand reduction activities. In November 2002, as part of a general review of public expenditure, nationally sponsored



projects supported by the Ministries of Education, Employment and Social Policy, Health and Justice, and which were to be financed by the National Drugs Fund, were deferred for one year. In 2003 the National Drugs Fund allocation to the Regions was merged with the National Social Fund. The total allocation was significantly above inflation and represented a real increase in the amount allocated to the Regions.

Given the major developments proposed to the drug laws and to national policy, there has been considerable debate about the changed approach. There have also been some reservations expressed by the Regions. This has, however, been more related to their concerns that the changes impinge on powers devolved to the Regions not necessarily with the policy intentions which have been expressed.

A particular consequence of the active approach taken by the Government in responding to the continued increase in drug use has been to raise the profile of the topic and make it a central issue of debate. By 2005 it is anticipated that final agreement will have been reached on the revised law and the National Drugs Plan, allowing both to be brought fully into action.

## 1.2 Legal Framework

During the year there was one change in the legal framework and significant changes are proposed in a draft law which is due to be considered by Parliament.

On the 9 August 2004 a regulation from the Minister of Health was published in the Official Gazette of the Italian Republic – “Disposizione di sequestro dal commercio dei prodotti contenenti salvia divinorum o il suo principio attivo salvinorina A” (Order for the seizure of products containing salvia divinorum, or its main active ingredient salvinorina A, from premises selling such products).

Based on analysis by the Laboratory of Clinical Biochemistry of the National Health Institute of substances seized by the Health Inspectors Squad (NAS) of the Carabinieri and on the advice of the National Health Institute and the relevant section of the Higher Council of Health on the dangers that salvia divinorum and salvinorina A posed to public health, the Minister of Health ordered that the NAS should have the power to seize any products containing salvia divinorum or salvinorina A from premises selling these products. The order is for a maximum period of six months or until such time as the procedure for including salvia divinorum and salvinorina A in Table I of the unified drug law (Decreto del Presidente della Repubblica 9 ottobre 1990 n.309) is completed.

The draft law – “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.” proposes a number of significant changes to the current legislation and has been the subject of considerable political and professional debate.

### Key elements of the draft revision of the drugs law

- Rationalisation of competencies
- Revision of the tables of controlled drugs
- Verification and updating of controls on cultivation, production, manufacture, dispensing and safe-keeping of substances containing controlled drugs
- Creation of a clear legal definition of what constitutes possession for personal use
- Grading of administrative and penal responses for prevention, repression and recovery
- Provision of increased opportunities to take up treatment alternatives to prison
- Strengthening of investigative tools to counter illicit supply
- Implementation of prevention and information activities in educational settings
- Equality between public and private services
- Orientation of treatment to have the aim of long term abstinence, with pharmacological interventions as a support to achieve this aim



In essence, the draft law is both a response to the National Drugs Plan <sup>[1]</sup> and creates the legal basis for that plan and the structures for its implementation. It has a number of key objectives which are shown in the box. Rationalisation of competencies necessarily follows from the creation of the new Department. Revision of the tables will reduce the present six tables of controlled drugs to two and the legal distinction between “hard” and “soft” drugs is to be removed. The first table will contain drugs which it is considered have no therapeutic use and which cannot be prescribed. The second will contain drugs which can be prescribed, subdivided into five sections according to their dependence creating potential with different levels of control on prescription. Within this framework methadone <sup>[1]</sup> and intermediate methadone <sup>[2]</sup> are included in the first table. Methadone is also included in the most restricted section of Table II, along with buprenorphine and a number of powerful natural or synthetic analgesics. The aim of the changes is to make a clear separation between drugs considered to have or not to have therapeutic value and to grade therapeutic drugs by their dependence and misuse potential. A second aim, in line with the National Drugs Plan, is to favour medical interventions focused on the achievement of long term abstinence. Revision of the controls on cultivation, production, distribution and safekeeping of substances containing controlled drugs reflects concern that pharmacological products have become increasingly available in the illicit market.

Clear definitions of quantities of a listed drug deemed to represent personal use are to be re-introduced <sup>[3]</sup> with possession of a greater quantity considered a criminal rather than an administrative offence. For instances of personal possession, the administrative sanctions will be graded to provide gradually increasing penal responses, advancing from the present administrative sanctions aimed at prevention of continued drug use through to more restrictive responses and punishments where there is a failure to comply with the initial sanction or repeat offending. For criminal offences committed by drug misusers, whether against the drugs law or the criminal code, the intention is to provide increased access to treatment alternatives to prison. These will include both treatment in the community and treatment within “open prison” settings, which may be provided in conjunction with public or private treatment services.

Strengthening the investigative tools available to the law enforcement authorities seeks to draw on recent developments arising from anti-terrorism legislation and to counter tobacco smuggling as well as providing increased capacity to freeze, seize and confiscate assets. It is also intended that before destruction, small quantities of seized drugs should be available for scientific, investigative, epidemiological and training purposes.

The three key drug demand reduction proposals are intended to provide the legal basis for implementation of a central objective of the National Drugs Plan, prevention of drug use and long term abstinence for those who do use drugs. Prevention and research, whilst concerned with drug misuse, are also to be linked with other youth problems amongst which are alcohol misuse, smoking, eating disorders and gambling. Equality between public and private drug treatment services and a focus on non-pharmacological treatments aimed at ending continued drug use through gradual detoxification and rehabilitation are closely linked. Over the years there has been a continuing increase in the number of drug dependents receiving long term methadone maintenance and a gradual reduction in the number referred into drug free rehabilitation programmes. The two amendments therefore seek to allow drug dependents to choose where they will go for treatment and give greater attention to abstinence oriented and drug free treatment rather than maintenance programmes.

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<sup>[1]</sup> Piano nazionale di interventi in materia di prevenzione dell'uso di sostanze stupefacenti e psicotrope, di contrasto al traffico illecito e di trattamenti sanitari e reinserimento socio-lavorativo delle persone tossicodipendenti (2004-2008). Presidenza del Consiglio dei Ministri, Comitato nazionale di coordinamento per l'azione antidroga, Ufficio del Commissario straordinario del Governo per il coordinamento delle politiche antidroga.

<sup>[1]</sup> 6-dimetilamino-4,4-difenil-3-eptanone

<sup>[2]</sup> 4-ciano-2-dimetilamino-4,4-difenilbutano

<sup>[3]</sup> The 1990 law created such a definition which was then removed following a referendum in 1993

A further intention of the draft law is to place public and private treatment services on an equal footing. At present for a drug misuser to have his/her treatment financed by public funds s/he must attend a public treatment service. For treatment in a private socio-rehabilitative service to be publicly funded the referral for treatment must be approved by the relevant public treatment service. The draft law will allow drug misusers to choose the treatment service which they wish to attend, public or private, with the aim of increasing the number of drug users undertaking drug-free treatment in residential treatment centres.

The draft law is complex and is likely to be subject to considerable debate and some amendments in its passage through Parliament. The above, however, provides a summary of the main intentions of the legislation.

### 1.3 Institutional framework, strategies and policies

As noted above, in 2004 a National Drugs Plan was prepared and sent to the Regions and Autonomous Provinces for their consideration and observations. The Plan covers co-ordination, demand reduction, re-entry into society and work, supply reduction, international co-operation and evaluation. It has drawn on and is coherent with the first Triennial National Plan 2002-2004 of the Government and with the international drug control conventions, the European Action Plan on Drugs (2000-2004) and with the motion approved by the Chamber of Deputies in January 2002 (which is included in the Triennial Plan approved in February of the same year).

The National Plan has a number of aims and a series of objectives, although as yet no specific targets have been established. These are likely to be included in the three year action plan which the National Department for Drug Policy is to prepare. The aims and objectives are shown below.

Aims	Objectives
To promote and improve the health of those at risk of or already dependent	<ul style="list-style-type: none"> <li>▪ to guarantee that services are able to provide various pharmacological treatments adequate for different clinical needs, using agonists and anti-craving drugs capable of reducing the risk of relapse and drugs for the treatment of psychiatric disturbances associated with drug dependence</li> <li>▪ to guarantee that public and private rehabilitation services are in a position to provide treatment for those assessed as with 'dual diagnosis', identifying their service for treatment of low, medium and/or high levels of psychopathological problems</li> </ul>
To prevent the use of drugs	<ul style="list-style-type: none"> <li>▪ to strengthen prevention starting from early childhood, involving educational institutes and agencies, primarily through training families and their children and strengthening schools, educational agencies and after-school clubs which meet children and adolescents</li> <li>▪ to challenge the view of drugs as harmless and the atmosphere of 'normality' which is often associated with their use</li> </ul>
To guarantee the most appropriate physical and psychological treatment and re-entry into the social and work environment of current and former drug users and the prevention of relapse	<ul style="list-style-type: none"> <li>▪ to identify new approaches and methodologies which support full rehabilitation and social re-integration of drug users and the prevention of relapse</li> <li>▪ to use substitute treatment only where strictly necessary, within the framework of personalised and integrated treatment programmes aimed at removing dependence on illegal drugs and using available opportunities to suggest different rehabilitation programmes so as to encourage clinical evolution which avoids dependency being a chronic condition</li> <li>▪ to guarantee that public and private services have sufficient qualified staff available to put into practice the most effective psycho-social strategies such as cognitive-behavioural, group and family therapies and psycho-therapeutic support</li> <li>▪ to guarantee that medium and long term rehabilitation has appropriate and protected space to allow, if required, drug using parents to have their children with them on a permanent or occasional basis</li> <li>▪ to develop and update training programmes carried out in</li> </ul>

	collaboration with accredited Institutions and with the participation of the universities, aimed at re-qualifying, training and up-dating of the existing staff in public and private services as well as the institutes for professionals relevant to the dependency sector
To allow drug dependents freedom to choose rehabilitation and where they will receive this treatment	<ul style="list-style-type: none"> <li>▪ to guarantee interventions which involve, on an equal basis, public and private organisations in permanent and effective collaboration, with the equality of the arrangements guaranteed by a third party separate from the purchaser and provider</li> </ul>
To reduce the demand for drugs	<ul style="list-style-type: none"> <li>▪ to increase the number of people successfully placed in treatment aimed at interrupting and overcoming dependence</li> <li>▪ to guarantee drug dependent prisoners right of access to treatment as an alternative to continued detention, ensuring respect for the conditions attached to the treatment order</li> <li>▪ to set up specific 'open prison' structures, which could be managed in collaboration with private social organisations, for drug dependent prisoners wanting to take part in a treatment and rehabilitation programme</li> <li>▪ to reduce the time for the application of administrative sanctions for illegal drug possession by the Prefecture and to guarantee that young people trying drugs for the first time are seen in health or social settings apart from those designed for chronic drug users</li> <li>▪ to support return to the social and work environment for people who have successfully completed rehabilitation</li> </ul>
To tackle illicit trafficking and the availability of drugs	<ul style="list-style-type: none"> <li>▪ to reduce the availability of drugs and the number of drug-related crimes committed</li> </ul>
To optimise use of the available resources with a particular focus on analysis and evaluation of outcomes achieved through earlier investment	<ul style="list-style-type: none"> <li>▪ to identify and apply methodologies and criteria for the evaluation of interventions and their outcomes</li> <li>▪ to develop research activities</li> </ul>
To increase knowledge of the drugs problem through establishing or increasing the number of Regional Drug Observatories, linked to the national observatory (OIDT)	<ul style="list-style-type: none"> <li>▪ to create a permanent observation network to identify and study new drugs, in line with the EU indicators and promoting an active role for Italy in this context</li> <li>▪ to develop a policy of scientifically correct communication and information</li> </ul>

As already noted, the plan is still under discussion before it is formally adopted.

At the Regional level a number of Regions have already established their own plans for responding to drug dependency. Some of these plans are co-terminus with aspects of the draft National Plan. However, there have been reservations expressed by the Regions as a whole to the package of revision of the drugs law and the draft national plan. It is likely that there will be some modifications in the overall package, with Regions seeking a clear understanding of their right, under devolved authority, to make appropriate arrangements at the local level within the general framework of the law and the national drugs plan. This is likely to be the case particularly with regard to treatment and interventions provided through the health system, where full responsibility has already been devolved to the Regions and Autonomous Provinces.

At the national level co-ordination of strategy and policy remains with the National Committee for the Co-ordination of Anti-drug Activities. This Committee involves Ministers from all relevant Government Ministries and Departments and is responsible for approving and promoting overall policy on prevention, demand and supply reduction at both national and international levels. Following the formal establishment of the National Department for Drug Policy with its own Director and an initial budget of €14 million, the position of Extraordinary Commissioner has been discontinued. The responsibilities of the post have been absorbed within the functions of the Department.

The functions of the Directorate General for Drug Dependence in the Ministry of Labour and Social Policy have been transferred to the Department. These include the National Drugs Observatory (OIDT), administration of the National Drugs Fund and organisation of the National Prevention Campaign. The Department also provides administrative and technical support to the National Committee for Co-ordination and has responsibilities for international and national activities, including aspects of supply reduction as well as demand reduction. The priorities, formal responsibilities and annual objectives of the Department were detailed in a decree promulgated by the Deputy Prime Minister in May 2004 <sup>[1]</sup> (see box).

The formal structure of the National Department has now also been agreed. At the head is the Office of the Director, supported by the Scientific Committee, a secretariat and the press and publications section. Under the Director there are four offices:

- ◆ Office for Drug Demand and Supply Reduction  
this has three sections: prevention; treatment and rehabilitation; supply reduction.

- ◆ Office for Interventions to Tackle Drug Problems  
this has two sections: management of the National Drugs Fund; monitoring and control

- ◆ Office for Monitoring

this has three sections: the National Drugs Observatory; studies and documentation; planning and control

- ◆ Office for General Affairs and for International and Community Relations

this has two sections: general affairs; international and community relations

Co-ordination at the Regional level is normally undertaken through the Department for dependency within either the Health or Social Policy Department. Advice is commonly provided by a consultative body involving representatives of both public and private services and formal structures, systems and policy are established by Regional regulations or decisions. The exact arrangements vary from Region to Region and between local health authorities in the same Region. However, it is the case that since

### National Department for Drug Policy

#### Policy Priorities

Based on the 3 year National Drugs Plan adopted in February 2002

#### Competence

support to the National Coordinating Committee, activities to strengthen guidance and coordination at the national level and implementation of drug control strategies, coordinating the activities of all relevant Ministries and Departments;

collaboration with the Regions, local authorities and public and private services active in the drugs field; representation of Italy at the international level and submission of relevant reports/documents;

preparation of a three year action plan, operational plans and modifications as required, including any appropriate draft legislation for consideration by the National Coordinating Committee;

promotion and coordination of prevention treatment and rehabilitation projects, ensuring that Ministries and public and private organizations respect the guidance of the National Drugs Plan;

promotion of information campaigns on the negative effects of drug use and related criminal behaviours;

collection and improvement of data and scientific documents to inform policy and preparation of the annual reports to Parliament and the EMCDDA;

organization of the three yearly national drugs conference.

#### Objectives for 2004

organisation of the national drugs campaign;

promotion of prevention and treatment training programmes;

increased collaboration with private services to create an integrated treatment system;

development of prevention programmes;

strengthened cooperation with European partners;

updating of the National Drugs Plan;

preparation of the annual reports to Parliament and to the EMCDDA.

<sup>[1]</sup> Decreto del Vice Presidente del Consiglio dei Ministri 31 maggio 2004. "Linee di indirizzo amministrativo in tema di promozione e coordinamento delle politiche, per prevenire e contrastare il diffondersi delle tossicodipendenze e delle alcooldipendenze correlate." Gazzetta Ufficiale N. 132 del 8 Giugno 2004.

devolution of responsibility for health care to the Regions there has been gradual establishment of regulations and directives, based on the agreements approved by the Permanent Conference between the State, the Regions and the Autonomous Provinces in 1999<sup>[2]</sup> and subsequent modifications.

#### 1.4 Budget and public expenditure

Data on the true level of public expenditure allocated for activities directly related to drug misuse and associated problems remains sketchy. At the national level, the main dedicated funding relates to the National Drugs Fund. 75% of this fund is allocated to the Regions and 25% is retained for projects proposed by different Ministries. In late November 2002 a decree from the Finance Minister, as part of a broader review of public expenditure, postponed the financing of projects approved for 2002 by the Ministries of Justice, Education, Health and the Employment Department of the Ministry of Welfare until 2003. The table below shows the number of projects approved and funding by year and Ministry. It should be noted that funding may be for projects intended to operate for more than one year and that in consequence actual expenditure in any year may be significantly higher than the amount listed as approved for the year.

Ministry / Department	Financing Period										Total	
	1997-1998- 1999		2000		2001		2002		2003			
	No.	Amount (€ x 100)	No.	Amount (€ x 100)	No.	Amount (€ x 100)	No.	Amount (€ x 100)	No.	Amount (€ x 100)	No.	Amount (€ x 100)
Social Affairs	0	0	5	44560	17	105166	-	-	-	-	22	149726
Defence	4	27595	5	4886	3	1283	0	0	0	0	12	33764
Justice	15	187029	8	41270	5	28147	0	0	4	41780	32	298226
Interior	13	31052	18	28464	19	26929	15	21073	0	0	65	107518
Employment	9	55391	3	12076	7	30946	11	93539	2	14617	32	206569
Education	8	243179	7	43930	4	56810	0	0	1	103730	20	447649
Health	40	146338	9	64580	6	54305	0	0	5	31779	60	297002
TOTAL	89	690584	55	239765	61	303588	26	114612	12	191906	243	1540455

Table 1

Source: Directorate General for Drug Dependency, Ministry of Welfare

Expenditure directly related to drug misuse or drug related problems from the regular budgets of the different Ministries cannot be readily itemised. Some limited data is available on very specific aspects. For instance, €10 million was allocated to UNODC in 2003 with 35% for general funds and the remainder to specific projects agreed with UNODC. Within Italy, the Ministry of Justice reported that €15.5 million was spent to assist drug dependent prisoners in 2002, representing 0.6% of the total prison budget. Additionally, the Ministry specifically mentioned an allocation of €1 million for social reinsertion projects for drug and alcohol dependents serving their sentence in the community and €138,625 for training of prison commanders and prison inspectors with special reference to drug dependent prisoners. No other detailed data is available.

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. A project promoted by the National Department for Drug Policy is seeking to identify the resources expended on drug demand reduction by the Regions/local health authorities.

The table on the following page shows expenditure identified by Regions for the activities of the Ser.T. (public drug treatment services) and for client placement in residential or semi-residential services. These latter are primarily provided by not-for-profit organisations and are predominantly drug-free treatment services. The data for the year

<sup>[2]</sup> The agreement of 21 January 1999 dealt with the organisation and responsibilities for drug treatment services. The agreement of 5 August 1999 dealt with the minimum standards which should be expected in different types of drug treatment service.

2000 is based on the national project whilst the data for 2001 – 2003 is that provided by the Regions for inclusion in the Annual Report to Parliament (Welfare 2001, Welfare 2002 and Welfare 2003). Using the 2000 data for treatment expenditure as the basis, this would suggest that allowing for inflation and a continuing increase in the number of clients within the treatment system, that in 2003 treatment costs were a minimum of €524.3 million.

For the National Drugs Fund, in 2003 the allocation to the Regions was incorporated into the National Fund for Social Policy. This fund is intended to finance and promote a range of social policies and objectives. In total, some €896.82 million was allocated to the Regions in 2003, compared to an allocation of €665.92 million from the Social Fund and €91.95 million from the Drugs Fund in 2002 (total €775.76 million). This represented a 16.25% increase over the amount allocated in 2002 and in effect there was a real increase in the allocation to the Regions of around €18 million after allowing for inflation.

In terms of actual expenditure during the year from the 2003 allocation, it is likely that most of this will occur in 2004. On notification of their allocation Regions establish the basis for inviting project submissions and technical arrangements for determining which project proposals should be expected. The data for 2000 relates to actual expenditure in that year based on the national project mentioned above. Data for 2001 – 2003 relates to expenditure reported by the Regions for that year and not to the allocation made to the Region from the National Drugs Fund for that year.

In addition to expenditure for the provision of specialist drug services, there is a complex funding structure through other Regional Departments, the Provinces, Communes and Municipalities dealing with vocational training, social reinsertion, sheltered accommodation for various disadvantaged populations, prevention of drug use, alternative activities, etc. There is currently no mechanism at the national or regional level which would allow the full range of expenditure dedicated to specific drug-related activities to be collated.

### Expenditure on Drug Demand Reduction by Year and Region (€x 1000)

	Ser.T.				T.C.s				Nat Drug Fund				Prison		TOTAL			
	2000	2001	2002	2003	2000	2001	2002	2003	2000	2001	2002	2003	2002	2003	2000	2001	2002	2003
<b>Piemonte</b>	38139	38139	38139	40269	11508	11508	11508	23103	6092	7606	7615			426	55740	57254	57263	63798
<b>Valle d'Aosta</b>	1184	1312	1033	1378	928	928	1087	1214	137	158	158				2248	2398	2277	2593
<b>Lombardia</b>	61497	67577	62256	63453	22548	22548	24520	24153	11088	22945	12618		2336	1549	95132	113070	101731	89155
<b>Trentino A.A.</b>	5801	6540	7468	8822	4842	4842	4852	4121	819	911	923	1619			11463	12293	13243	14561
P.A. Bolzano	3577	3995	4885	6270	3254	3254	3239	2980	591	722	723	940		100	7422	7971	8847	10290
P.A. Trento	2225	2545	2583	2552	1589	1589	1612	1141	228	189	200	679			4041	4322	4395	4371
<b>Veneto</b>	30920	47987		47987	15494	15494	15506	16790	5683	7225	7234	8445	362	500	52097	70705	23102	73723
<b>Friuli V.G.</b>	8483			12261	1196	1196			1414	1840	4925				11093	3036	4925	12261
<b>Liguria</b>	15617	15617	15804	16000	6896	6896	6576	6859	2452	2814	2817	2000	185		24965	25327	25382	24859
<b>Emilia Romagna</b>	24057		41052	35471	10726	10726	10416	11632	4809	6385	3542	4000			39592	17111	55010	51103
<b>Toscana</b>	32866	48838	24585	44154	10329	10329	12268	9694	4723	6023	3942	2818	217	235	47918	65190	41012	56901
<b>Umbria</b>	9252				5357			4838	1018	1415	1417				15627	1415	1417	4838
<b>Marche</b>	12215	8527	8720	8530	5784	5784	5350	4751	1985	2335	2338	1690			19984	16646	16408	14972
<b>Lazio</b>	36433				4643				6157	8063	8073				47234	8063	8073	0
<b>Abruzzo</b>	9095			2880	4693		4284	2060	1624	1951	1953	1000			15413	1951	6237	5939
<b>Molise</b>	734				1447				347	459	459				2527	459	459	0
<b>Campania</b>	14907	15000	19351	58314	8273	8273	8431	2099	6575	8981	8992	4852		236	29754	32253	36773	65501
<b>Puglia</b>	15483				7317				5992	7435	7444				28792	7435	7444	0
<b>Basilicata</b>	2260	2260	2301	2501	430	430	310	319	615	799	800	250		52	3305	3489	3410	3122
<b>Calabria</b>	13673				4784				2410	2877	2880				20867	2877	2880	0
<b>Sicilia</b>	11875				3906		3223	3476	5301	6985	6993				21082	6985	10217	3476
<b>Sardegna</b>	15318		10471	10500	3099	3099	3443	3500	2471	2828	2832	2800			20887	5927	16747	16800
<b>ITALY</b>	<b>359809</b>	<b>251797</b>	<b>231180</b>	<b>304532</b>	<b>134199</b>	<b>102053</b>	<b>111773</b>	<b>118609</b>	<b>71710</b>	<b>100033</b>	<b>87956</b>	<b>29474</b>	<b>3100</b>	<b>2998</b>	<b>565718</b>	<b>453882</b>	<b>434009</b>	<b>503600</b>

Table 2

Sources: 2000. Interim report of the national project to identify expenditure on drug demand reduction in Italy

2001 – 2003. Reports from Regions for inclusion in the Relazione Annuale al Parlamento sullo Stato delle Tossicodipendenza in Italia



## 1.5 Social and cultural context

The main debates and discussions about drugs and drug misuse have centred on the new policy being promoted at the national level and the proposed revisions to the drugs law. There has been vigorous debate in the media involving both proponents of the changes and opponents. The main objectives presented by the proponents can be summed up as follows:

- increasing prevention measures starting from the early childhood, through the schools and educational agencies, promoting family and teen-ager training, supporting school programmes as well as other educational organizations which host children and adolescents;
- increasing the number of drug-addicts which have successfully undergone a treatment aiming at enabling drug-addicts to definitively stop drug consumption and overcome pathologic dependence from drugs;
- detecting a new approach and new methods in order to ease full rehabilitation and social reintegration of drug addicts and to prevent relapse;
- combating the culture of the harmlessness of drugs and psychotropic substances as well as the feeling of “normality “ about drug use that contributes to increase consumption;
- using treatment based on opiates only when really needed, within personalized and integrated programmes, in view of definitively stopping the state of dependence and pave the way– in the due times and manners - to the adoption of different and personalized rehabilitation programmes able to foster final recovery.
- ensuring that treatment centres are able to provide different pharmaceutical tools , each proving adequate to the various clinical cases, such as anticraving and antagonist substances, able to reduce the relapse risk as well as drug-related psychiatric disorders and other drug-derived diseases;
- ensuring that both private and state operators implement the best psycho-social strategies, such as cognitive behaviour therapy, psychological support, group therapy and family therapy, through an adequate number of competent personnel;
- ensuring that both private and public centres are able to treat the so-called “double diagnosis” cases, and adequately equipped for tackling low, medium and high intensity psychological disorders;
- ensuring a long-term and effective cooperation between private organizations and public agencies. These must operate on a plan of parity, which is to be ensured by a third party ;
- ensuring that in- and out patient rehabilitation centres can offer an adequate and safe environment, so as to give the children of drug-addicts the possibility to stay with their parents in treatment , if necessary.
- reduce the availability of drugs as well as the number of drug-related offences;
- ensuring to the drug-addicts in prison who ask for, the right of access to alternative measures, while verifying the respect of the established conditions;
- creating “ad hoc” structures of “mitigated conviction” for the offenders who chose to undergo treatment and rehabilitation programmes; these centres should be managed also in cooperation with private operators;
- easing the social reintegration of people who have successfully undergone a rehabilitation programme;
- reducing the implementation time of administrative sanctions and ensuring that the young having experienced drugs for the first time can receive counselling in social

- and healthcare centres in places different from those dedicated to chronic drug-addicts;
- detecting and applying valuable assessment criteria and methods to both action carried out and results obtained;
- promoting research;
- building a permanent network for the detection and study of new drugs and psychotropic substances, according to EU directives and promoting an active role of Italy in this field;
- developing evidence-based communication and information policies;
- with the participation of the universities, developing and updating targeted training programmes for operators of both the private and public sector and integrate new professionals in the sector of pathologic dependences.

Regarding the opponents there have been some reservations expressed by the Regions. This has, however, been more related to their concerns that the changes impinge on powers devolved to the Regions not necessarily with the policy intentions which have been expressed. In response to the views which have been expressed about the proposed changes, the Director of the National Department for Drug Policy has indicated a willingness to discuss the issues and to explore ways of building common ground.

## 2 Drug use in the population

### 2.1 Overview

Data on drug use in the population is available from a number of sources. Two general population surveys have been conducted, in 2001 and 2003, and these provide a basis for assessing changes over time. Italy has carried out the European School Survey Project on Alcohol and Drugs (ESPAD) every year since 1999, providing a valuable data set over time. Additionally the Ministry of Defence has data on drug use in the armed services and the Ministry of Justice has data on drug use among offenders, in particular, young offenders received into the juvenile justice system.

All the data collected suggests that there has been an increase in the prevalence of drug use in the general population.

The general population survey shows an increase in the percentage of young people (15 – 24) reporting use of any illicit drug in their life time, the last year and the last month. This increase is most marked in the female population. Life time and last year prevalence for cocaine use has risen in both males and females, with a substantial increase in the female population using the drug.

The school population survey, which covers young people aged 15 – 19 in secondary school, also shows increases in drug use amongst this population. In particular, last month prevalence of cannabis use amongst the male secondary school population shows a marked increase over 2001 and a lesser increase over 2002. There has also been an increase in recent (last 30 days) ecstasy use to the level recorded in 2001. As comparable data for earlier years is not available, it is not clear at present whether the reduced level of use reported in 2002 was an anomaly and no trend can be assumed.

Drug use detected amongst those enlisted in the armed services has continued to fall. This reduction may largely be attributed to the change from conscription to voluntarily enlisted armed services. Nevertheless the trends remain broadly consistent showing cannabis to be the most commonly used drug followed by cocaine. Detected use of all other drugs has declined substantially since the ending of conscription. Where data is available on frequency of use, most were infrequent or occasional users.

Data on drug use amongst offenders is limited for adult offenders and can only show that the percentage of all new prison admissions assessed as drug dependent has continued to decline from the peak in 1997. There is much fuller data on young offenders.

### 2.2 Drug use in the general population

In 2003 the second survey on drug use in the general population was undertaken for the Italian Observatory on Drugs and Drug Addiction (OIDT) by the Institute of Clinical Physiology of the National Research Council. (Standard Table 01). As on the previous occasion this survey used a postal questionnaire and was distributed to 36,979 people between the ages of 15 and 54 using stratified random sampling based on the resident population. Around 2,500 questionnaires were returned because the address was insufficient, did not exist or the person had moved. Of the remaining 34,489, 11,869 (34.4%) were returned completed, 2,394 (6.9%) people declined to participate and 20,226 (58.6%) people did not respond. The final response rate showed variations between Regions, age groups and the sexes but was still adequately representative of the surveyed population. It is noticeable that in both the 2001 and the 2003 general population surveys the response rate fell by age group with the older groups having the highest response rate and the youngest age group (15-19) having the lowest response rate.

Figure 1 shows the prevalence of any use of illicit drugs as reported in the two general population surveys. As can be seen from this, life time, last year and last month prevalence rates in 2003 were all higher than those reported in 2001. It is not surprising

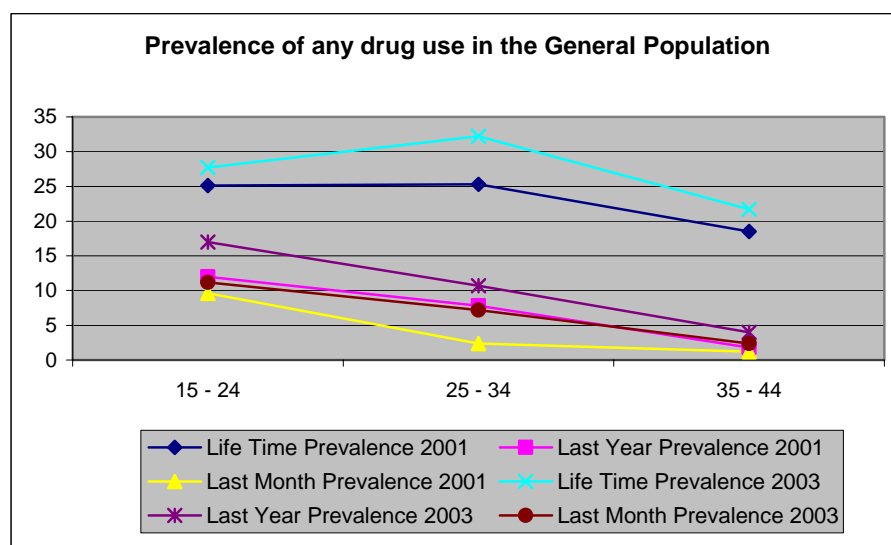


Figure 1 Source: Institute of Clinical Physiology, National Research Council

that life time prevalence is high for the 25 – 34 age group nor that it is relatively high for the 35 – 44 age group. What is more interesting is that last month prevalence for all the age groups in the 2003 survey is close to the last year prevalence rates for the 2001 survey. In the case of the 35 – 44 age group last month prevalence in 2003 exceeds last year prevalence in 2001. It is also noticeable that there has been a greater increase in last year prevalence for the 15 – 24 age group than for the other two age groups. This might suggest that whilst there has been no decrease in experimentation with illicit drugs amongst this age group, it has not progressed to more regular use.

When the drugs used are considered it is clear that use of cannabis was the most prevalent illicit drug use in Italy in both 2001 and 2003. For life time, last year and last month prevalence rates there was a rise in the percentage of people reporting use of cannabis between 2001 and 2003. In both of the general population surveys cocaine was the next most prevalent illicit drug used. As for cannabis, prevalence for life time, last year and last month use rose between 2001 and 2003. The percentage of respondents reporting any illicit drug, cannabis or cocaine use is shown in Table 3 below.

	Prevalence of illicit drug use among young adults (15-34)					
	Life time		Last year		Last month	
	2001	2003	2001	2003	2001	2003
Any illicit drug	24.7	30.4	9.4	13.2	6.9	8.9
Cannabis	24.5	29.9	9.2	12.8	6.6	8.6
Cocaine	4.0	6.3	1.7	2.3	1.1	1.2

Table 3

Source: Institute of Clinical Physiology, National Research Council

This data suggests that there has been a continuing increase in the use of illicit drugs amongst young adults. It might also suggest that continued or current use of cocaine is not rising as rapidly as

cannabis use in this population.

When examined by sex and age group, the data suggests that there may be a significant change occurring in illicit drug use amongst women in the 15 – 24 age group. Life time, last year and last month prevalence for any illicit drug use rose significantly for this age group with last year prevalence almost doubling (from 8.9% to 15.7%) and last month prevalence rising from 6.8% to 10.1%, as can be seen from Figures 2 and 3 below. It is also interesting to note that male prevalence rose in the older age groups, especially for last month prevalence. It is not yet clear if these are significant trends over time but they may suggest two different patterns. For females it may represent changes in a broader social context of increasing independence and self-confidence amongst young women with a greater willingness to engage in higher risk behaviours. Their drug of choice remains pre-dominantly cannabis. For males it may represent an increase in the use of

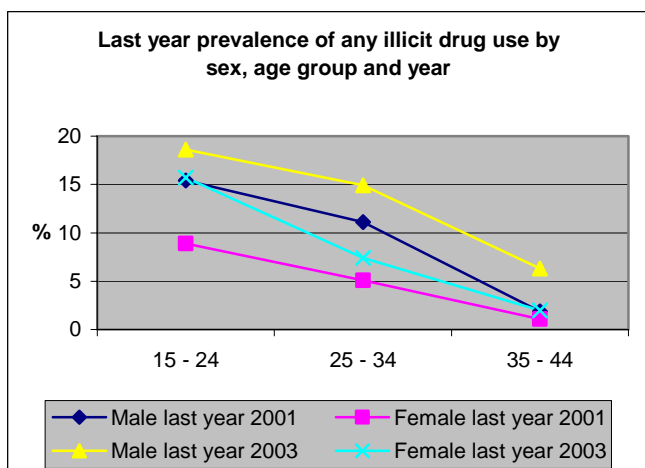


Figure 2 Source: Institute of Clinical Physiology, CNR

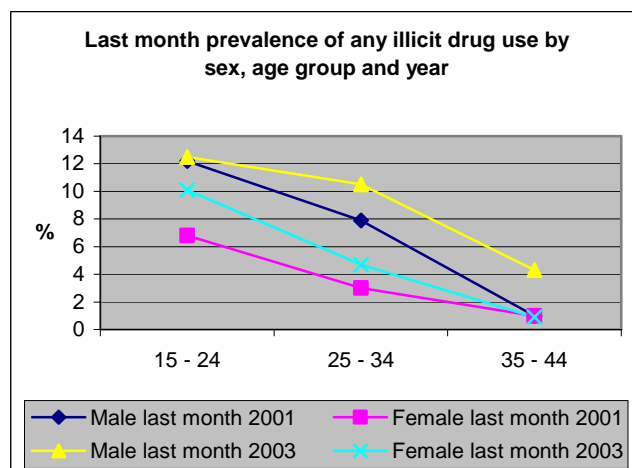


Figure 3 Source: Institute of Clinical Physiology, CNR

drugs as a response to work-related stress either to relax or to overcome fatigue. This hypothesis gains some support from the fact that the main increases have been in the use of cannabis and of cocaine whilst there has been no increase in the use of other substances. Figures 4 – 7 below provide a graphic representation of these developments.

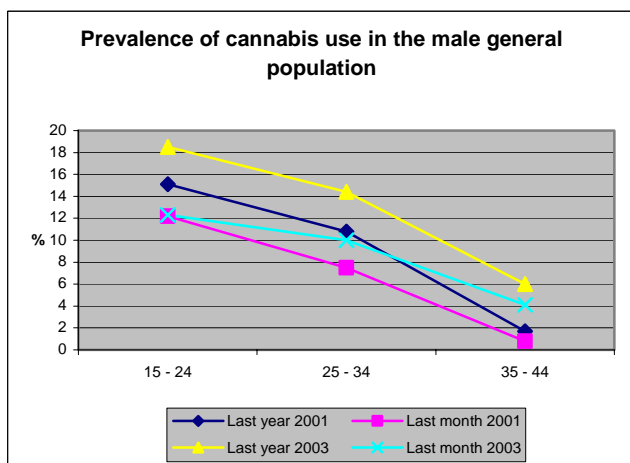


Figure 4 Source: Institute of Clinical Physiology, CNR

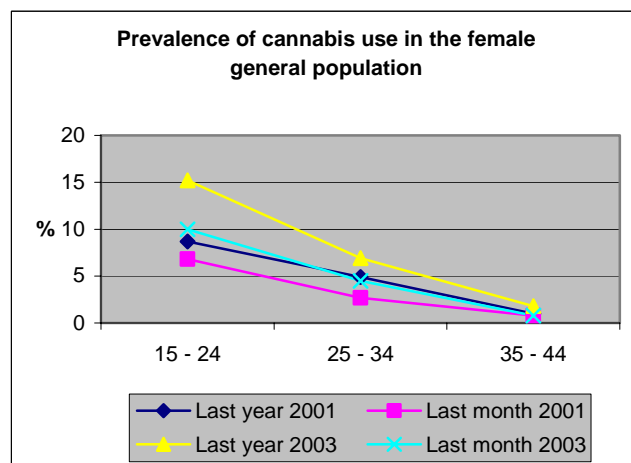


Figure 5 Source: Institute of Clinical Physiology, CNR

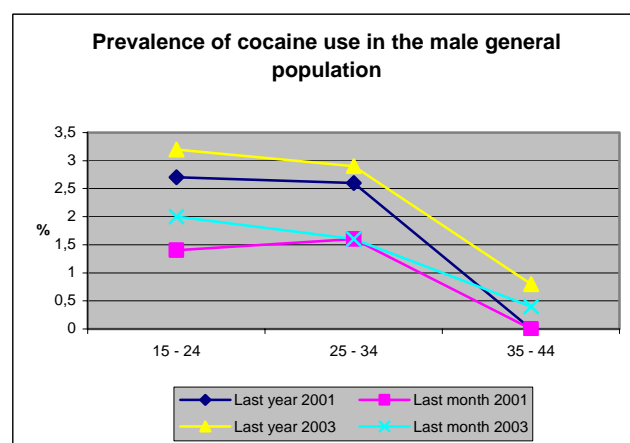


Figure 6 Source: Institute of Clinical Physiology, CNR

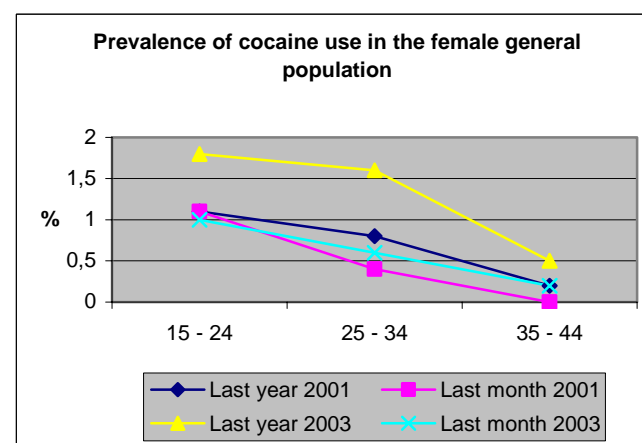


Figure 7 Source: Institute of Clinical Physiology, CNR

Extrapolating from the data obtained from the two general population surveys it is possible to estimate prevalence rates for use of any illicit drug by sex and age group. Table 4

confirms that there has been a substantial increase in female recent drug use in the young adult population whilst in males there has been a much smaller increase in the same age group. Overall, the rate of recent drug use per 10,000 population in the 15 – 44 age range has shown a marked increase between 2001 and 2003.

**Last 30 days prevalence for any illegal drug use:  
rate per 10,000 population**

	Male		Female		All	
	2001	2003	2001	2003	2001	2003
15 - 24	1220	1250	680	1010	956	1120
25 - 34	790	1050	300	470	548	720
35 - 44	100	430	100	90	100	240
15 - 44	610	872	340	473	476	649

Table 4

Source: Extrapolation from CNR data

A caveat must be entered, however, because of the inevitable limitations of the general population survey. Both the 2001 and 2003 surveys used a postal survey methodology reliant on people completing and returning the questionnaire. The response rate was relatively low and, whilst broadly representative of the population, women and older age groups were more likely to respond than men and the younger population. Nevertheless, the rate per 10,000 population is not inconsistent with the estimates of problem drug use (Standard Table 07).

One local survey published during the year (Mele et al 2003) reported on a survey in the Province of Taranto which examined the lifestyles, attitudes, substance use and risk behaviour of 300 people between the ages of 15 and 35. 60.3% were male and 39.7% female with a media age of 22.33 and the majority (83.3%) were between 19 and 26 years of age. Almost 96% of those surveyed were single with almost two thirds resident in Taranto and a further 25% resident in the Province. The average of the parents was the early 50s and the majority of those interviewed came from a family with a good level of education, medium to high socio-economic conditions and in which 74% of fathers and 84% of mothers were in employment. Examining risk behaviours, most declared that they never took any of the risks listed – living on the edge of criminality; risks with health; games and gambling; driving recklessly or after drinking alcohol; unsafe sex and; taking part in dangerous sports or activities. Nevertheless, some 49% did on occasions practice unsafe sex and around 40% took health risks, drove recklessly or drove after drinking alcohol. In terms of drug use, 57% reported using cannabis at least once, 14% use of cocaine, 11% use of poppers and 6% use of ecstasy. The lifetime prevalence of both cannabis and cocaine is double that reported in the general population survey. This may be a consequence of the different methodologies used (postal survey and direct interview) and might also be influenced by the location of the interviews (42.7% were conducted in bars and the majority in public locations including the street, discotheques and games rooms). Cannabis use in the last month was significantly higher than in the general population survey, with 29% reporting use. However, last month use of cocaine and ecstasy (2.3% and 0.3% respectively) seem to reflect the general population survey data. Of particular interest is the level of reported use of poppers. Previous reports have noted a relatively high level of use of this drug (Gatti 2001) and increased use amongst young people, especially in combination with other substances, may well have both a short term and possibly longer term impact on individual and public health.

### 2.3 Drug use in the school and youth population

Again in 2003 the ESPAD Italia survey was undertaken by the Institute of Clinical Physiology of the National Research Council, providing a series for each year since 1999. In 2003 the population surveyed consisted of 28,395 young people between the ages of 15 and 19 attending secondary education. Between 8 and 12% of young people were absent from school at the time of the survey and the overall response rate was 96.5% with a slightly higher response rate from males than from females. For 2003 prevalence of use in the last month was available for all drugs. For earlier years it was only available for cannabis, ecstasy and solvents.

In general there have been slight increases in the prevalence of illicit drug use for life time, last year and last month use. Cannabis remains the most prevalent drug followed by volatile inhalants and cocaine. The patterns of use are, therefore, consistent with the patterns of use observed through the general population survey. There have been



increases in prevalence of any illicit drug use and in the use of most other drugs with the exception of life time prevalence for cannabis amongst male students and last year prevalence for smoked heroin amongst female students. Of particular note is last month prevalence for the use of cannabis (Fig. 8), ecstasy (Fig. 9) and solvents, data which is available for several years, where there have been increases for both male and female

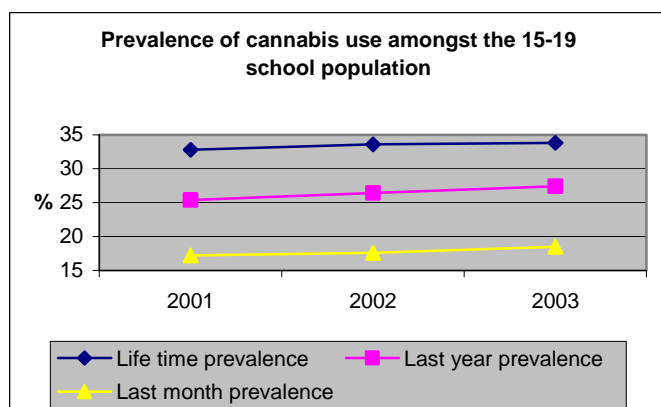


Figure 8 Source: Institute of Clinical Physiology, CNR

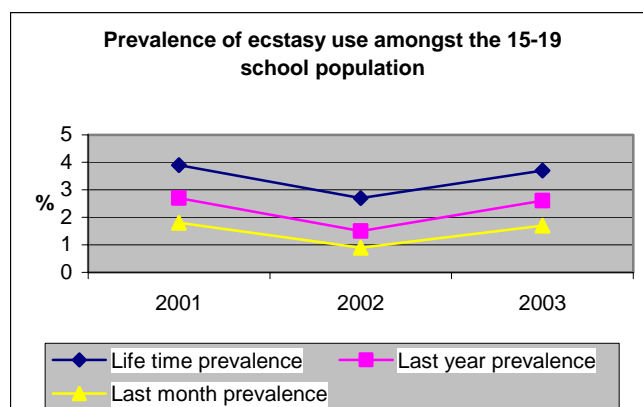


Figure 9 Source: Institute of Clinical Physiology, CNR

students. Data held by the National Research Council also suggests that between 2001 and 2003 use of cocaine in the last month has risen in this population.

As might be expected, the likelihood of illicit drug use increases with age. At age 15, around 14% of the 15 – 19 year old school population has used cannabis at least once. By age 17, almost 1 in every 2 males and 2 out of 5 females has used cannabis on at least once occasion. Similar patterns can be found in lifetime prevalence for the use of cocaine and ecstasy and for last year prevalence of these three drugs. In terms of last month prevalence, male cannabis use (Fig. 10) was slightly higher for most age groups than it was in 2002 whilst female cannabis use (Fig. 11) has risen in 15 and 19 year olds but fallen for 16, 17 and 18 year olds.

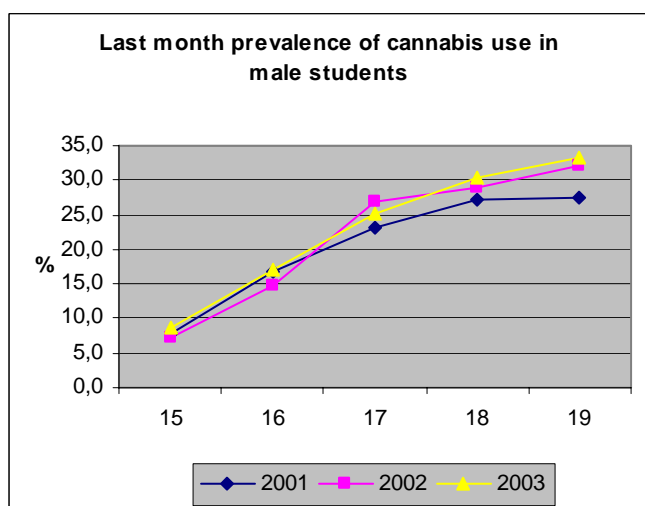


Figure 10 Source: Institute of Clinical Physiology, CNR

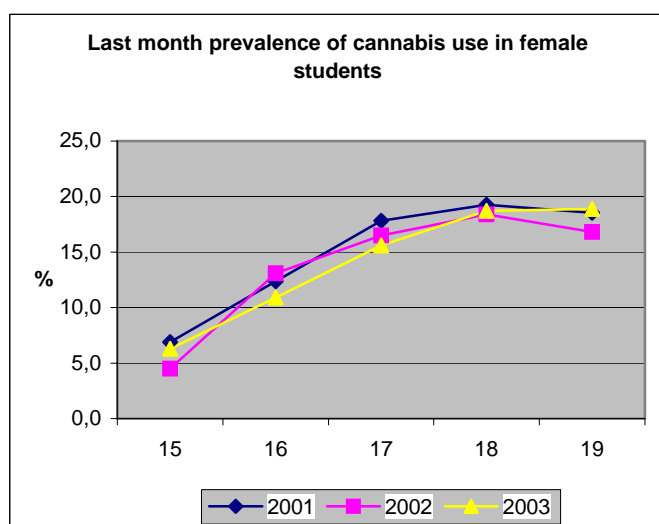


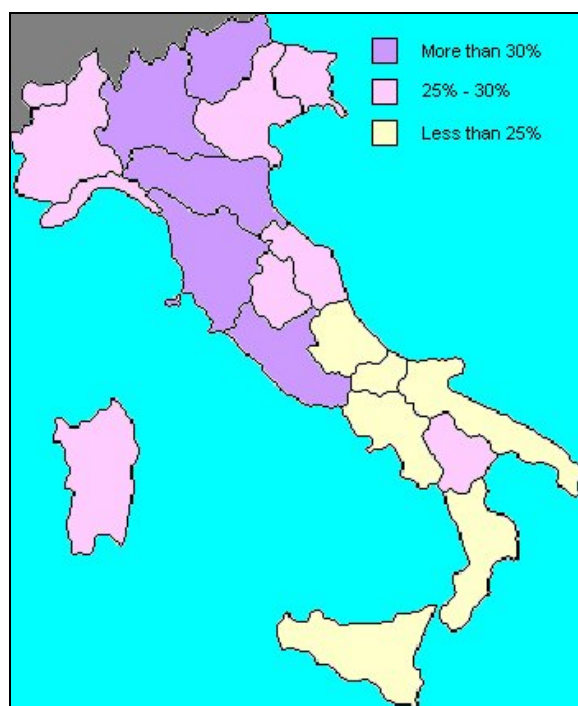
Figure 11 Source: Institute of Clinical Physiology, CNR

For 2003 the Institute of Clinical Physiology has been able to prepare data on frequency of use for some substances and on the geographical distribution of prevalence of use.



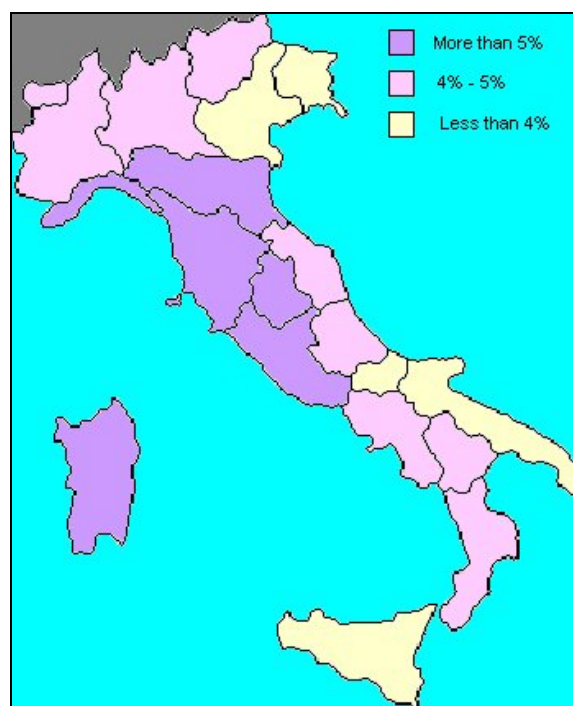
In terms of frequency of use, males are much more likely to have used cannabis (marijuana or hashish) more than five times in the previous 12 months than were females. Whilst use of cannabis sporadically (less than 5 times in the previous 12 months) was broadly similar for males and females <sup>[1]</sup>, a significant difference occurs with regard to

**Prevalence of cannabis use in the last 12 months**



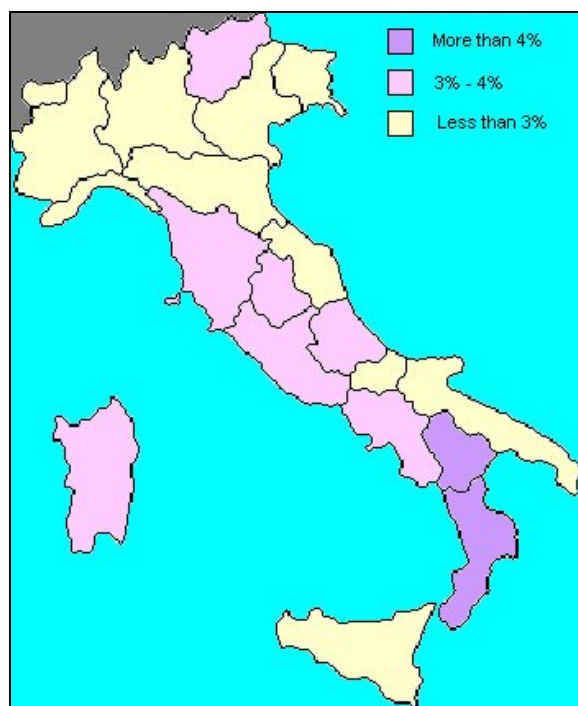
Map 1 Source: Institute of Clinical Physiology, CNR

**Prevalence of cocaine use in the last 12 months**



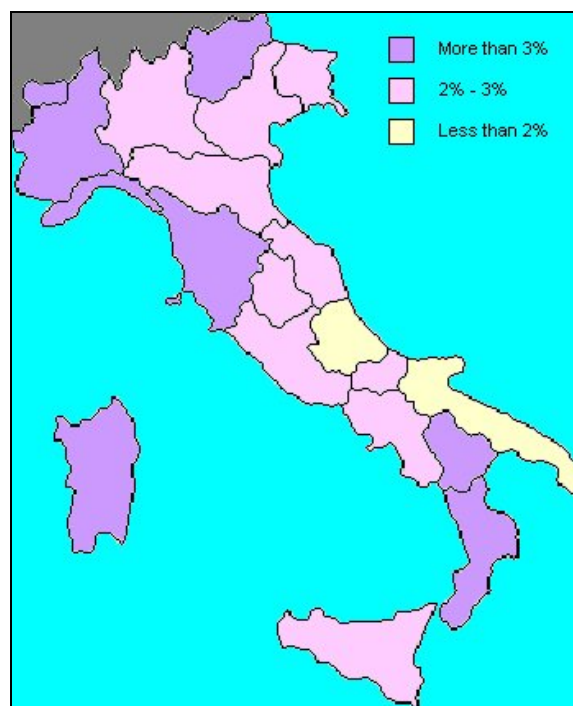
Map 2 Source: Institute of Clinical Physiology, CNR

**Prevalence of heroin use in the last 12 months**



Map 3 Source: Institute of Clinical Physiology, CNR

**Prevalence of ecstasy use in the last 12 months**



Map 4 Source: Institute of Clinical Physiology, CNR

more frequent use of cannabis. Where at age 15 only 3.2% of females reported using

<sup>[1]</sup> At 15, 6.4% of females and 7.3% of males used cannabis less than 5 times in the previous 12 months rising to 15.5% of females and 16.3% of males at age 19.

cannabis more than 5 times in the previous 12 months, 5.9% of 15 year old males reported using cannabis on more than 5 occasions. By age 19, 16.2% of females reported more frequent use but 29.8% of males reported more frequent use. For cocaine use the difference between males and females in terms of frequency of use is even more marked. However, where with cannabis for both males and females at age 19 the percentage reporting use on more than 5 occasions exceeds the percentage reporting use on less than 5 occasions, for cocaine it is sporadic use which predominates for both sexes and all age groups. For heroin use there is a slightly different frequency of use pattern. For males and females the peak frequency of use occurs at age 17 for sporadic use. For more frequent use, however, the peak age for males is age 16 and for females age 18. Finally, for ecstasy frequency of use increases with age for females with 1.5% reporting sporadic and 1.1% more frequent use. For males, at ages 15 and 16 sporadic and more frequent use of ecstasy are at the same level. However, at age 18 sporadic use peaks (3.4%) and more frequent use is at its lowest level (1.2%) whilst at age 19 sporadic use declines to 2.8% but more frequent use peaks at 2.6%.

The geographical distribution of those reporting use of these four drugs during the last 12 months shows interesting variations. As can be seen from Map 1, cannabis use is most prevalent in the northern and central regions, with 5 reporting prevalence rates in excess of 30%. Three of these regions also have the highest prevalence rates for cocaine use (Map 2), with occasional or sporadic use concentrated in the central part of the country. By contrast, sporadic or occasional heroin use (Map 3) is most prevalent in two southern regions whilst ecstasy use (Map 4) is more widely distributed around the country. Taken as a whole, the six regions appear to have the overall highest prevalence rates for illicit drug use in the last 12 months – three central regions (Lazio, Toscana and Umbria), one northern region (Trentino) one southern region (Basilicata) and one island region (Sardegna).

One paper published during the year reported on local research on drug use among students in a local area. Prosa et al (2003) reported on a survey of drug use amongst the student population of Casale Monferrato (Piemonte). The survey used the same questionnaire as was used to evaluate the national drugs campaign in 2000. The survey population was 392 young people, 248 aged 16 and 144 aged 17 and the questionnaires were completed individually and anonymously during school hours. Two thirds of respondents reported having seen drugs circulating in areas they frequented with the discotheque, school and amongst their friends being the most common locations. A third felt they knew enough about drugs, 40% that they knew the drugs scene a little and 17% felt that they were well informed. Cannabis and alcohol were considered to be the drugs most frequently used (87% and 92.1% respectively), followed by ecstasy (67.4%), cocaine (25%) and hallucinogens (24%). These responses broadly match those of the ESPAD survey but must be treated with some caution because they combine knowledge and assumptions on the part of young people and may reflect popular images rather than local reality. 38% of respondents felt that it was easy or very easy to get drugs and a further 38.3% felt it was easy enough. 22.2% did not know or did not respond to this question. Curiosity, for pleasure and group pressure were considered the most common reasons for drug use. This largely matches the responses given by members of the armed services reported for drug use (Table 7). The survey also asked about factors which protected against drug use. The three main reasons proposed were that people could enjoy themselves without using drugs, that they knew the dangers of drug use and that they were able to resist peer pressure (68.9%, 53.3% and 42.4% respectively). Interestingly, only 17.9% felt that lack of opportunity was a factor. Overall, strong sense of self and of personal values were the most important factors.

## **2.4 Drug use amongst specific groups**

The only data series on drug use amongst specific groups is that for members of the armed services. Additionally there is some data from the prison system and the juvenile justice service on drug use amongst offenders.

**Armed Services**

The number of reports of drug use within the armed services has fallen consistently since 1998, with the largest falls occurring in 2000 and 2001 as conscription was phased out. The data is now, therefore, less representative of the wider young male population but rather represents drug using behaviour amongst a specific population who have chosen a career within the services. Table 5 shows the number of reports of drug use and the percentage of reports represented by each group of drugs. As can be seen from this, whilst the numbers have fallen, the percentages have remained consistent and suggest a

<b>Type of Drug</b>	<b>Number</b>						<b>%</b>					
	1998	1999	2000	2001	2002	2003	1998	1999	2000	2001	2002	2003
Heroin / Other opiates	288	185	126	64	55	26	10,1	7,4	7,1	7,2	6,7	3,4
Amphetamine / Ecstasy	89	49	52	19	3	2	3,1	2,0	2,9	2,1	0,4	0,3
Cocaine / Crack	206	221	117	56	70	72	7,2	8,8	6,6	6,3	8,5	9,3
Marijuana/Hashish	2097	1968	1423	691	690	674	73,5	78,6	79,9	77,9	83,6	86,9
Other drugs	172	80	62	57	7	2	6,0	3,2	3,5	6,4	0,8	0,3
<b>TOTAL</b>	<b>2852</b>	<b>2503</b>	<b>1780</b>	<b>887</b>	<b>825</b>	<b>776</b>	<b>100,0</b>	<b>100,0</b>	<b>100,0</b>	<b>100,0</b>	<b>100,0</b>	<b>100,0</b>

Table 5

Source: Ministry of Defence

broad pattern of drug use in which cannabis is the most commonly used drug followed by cocaine. The percentage of heroin, ecstasy and other drug reports has fallen steadily whilst cannabis and cocaine reports have increased. In this, they are consistent with data from the general population and school surveys.

Data is available for 2003 on frequency of use, reason for use and when drug use began. This is shown in Tables 6, 7 and 8.

<b>Frequency of use</b>						
	A few times a year	A few times a month	A few times a week	Daily	Not recorded	Total
Heroin	3	1	4	7	2	17
Cocaine	29	4	10	5	24	72
Amphetamines	0	2	0	0	0	2
Cannabis	209	144	86	24	211	674
Other drugs	3	2	3	1	2	11
<b>Total</b>	<b>244</b>	<b>153</b>	<b>103</b>	<b>37</b>	<b>239</b>	<b>776</b>

Table 6

Source: Ministry of Defence

<b>Reason for use</b>							
	Group spirit	Psychological pressure	Curiosity	Meetings with dealers	Personal problems	Other	Total
Heroin	2	0	0	0	2	2	17
Cocaine	8	1	10	1	2	2	72
Amphetamine	0	0	0	0	0	0	2
Cannabis	48	0	113	0	9	4	674
Other drugs	3	0	2	0	1	0	11
<b>Total</b>	<b>61</b>	<b>1</b>	<b>125</b>	<b>1</b>	<b>14</b>	<b>8</b>	<b>776</b>

Table 7

Source: Ministry of Defence

In terms of frequency of use (Table 6), data is not available for almost one third of all cases. Nevertheless, the patterns of use are interesting. Cannabis and cocaine use, where data is reported, occurs most commonly as a sporadic activity with 52% of cannabis and 46% of cocaine cases where use was a few times a year or a few times a month. For use a few times a week or daily use the respective figures were 16% and 21%. For heroin, amphetamines and other drugs the percentage of cases where data is not recorded is much lower than for cannabis and cocaine. This may suggest that more of

these cases were detected as a result of a medical or health intervention whilst the cannabis and cocaine cases arose as a disciplinary procedure. For the former, patterns of use would be more important whilst for the latter it is the fact of drug use which is important.

The data on reasons for use (Table 7) is interesting but it is difficult to draw any conclusions from it because there is such a high level of un-recorded cases. It is not surprising, however, that in a close knit community such as the armed services, group spirit/pressure and curiosity should be the main factors reported.

The information on when drug use began (Table 8) seems to have some correlation with data on the reason for use. It would not be surprising if no data was recorded on reason for use if initiation into drug use occurred before entering the services. The close correlation between the

	<b>First use of the drug</b>			<b>Total</b>
	<b>Before joining up</b>	<b>After joining up</b>	<b>Not recorded</b>	
Heroin	7	6	4	17
Cocaine	39	24	9	72
Amphetamine	1	0	1	2
Cannabis	474	174	26	674
Other drugs	5	6	0	11
<b>Total</b>	<b>526</b>	<b>210</b>	<b>40</b>	<b>776</b>

Table 8

Source: Ministry of Defence

number reporting initiation before entering the services and the number where no data was recorded on the reason for use suggests that the information in Table 6 may largely concern those who began drug use after joining up.

It is not surprising that the majority of those reported for drug use began to use drugs before they entered the services. This broadly fits the pattern of relatively high prevalence rates amongst teenagers and younger adults identified in the general population and school surveys. Proportionately, cannabis users were much more likely to have used cannabis before joining up whilst users of all other drugs had an increased likelihood of initiating drug use after enlisting. This could suggest progressive use of different drugs with the possibility that they had used cannabis, for instance, before entering the services although they were reported for use/possession of a different drug.

#### Adult Offenders

In terms of drug use amongst offenders, data on adult offenders can only show the number of people assessed as drug dependent on admission to prison. In 2003 out of a total of 81,793 new admissions into prison, 23,709 (29%) were assessed as drug dependent. This represents a general downward trend since 1997 when 33.1% of all new prison admissions were assessed as drug dependent.

#### Juvenile Offenders

There is fuller data on drug use amongst young offenders. Of 18,440 admissions into the juvenile justice system, 1,168 (5.96%) were drug users. This was a fall of 1% from 2002.

There is detailed data on 938 young offenders available from the Juvenile Justice Department of the Ministry of Justice. Figure 12 shows the drug use of young offenders on admission

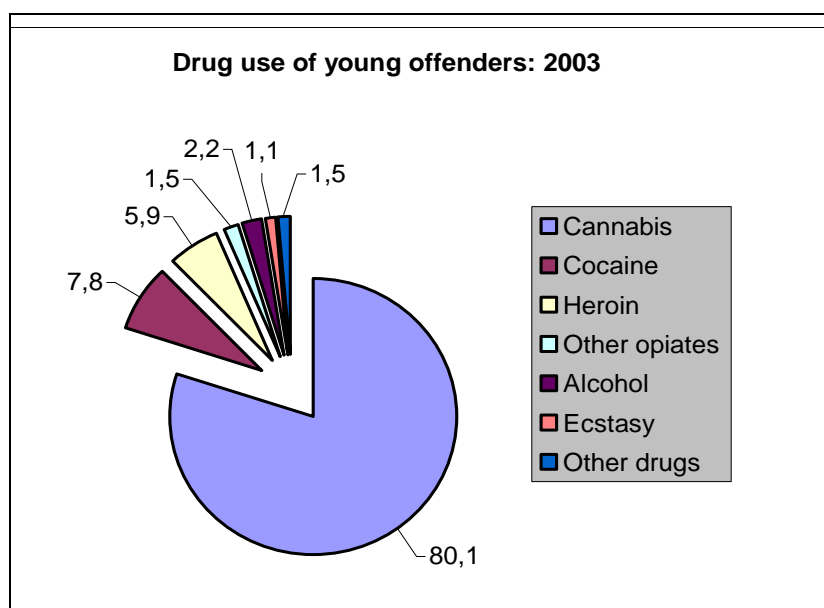


Figure 12

Source: Ministry of Justice

into the juvenile justice system. Cannabis was overwhelmingly the most commonly used drug followed by cocaine and heroin. This pattern of use reflects that in the armed services and in the general population and school surveys. Of those identified as drug users, 67% were as a result of a declaration by the offender, by his or her parents or by a third party and 33% were as a result of clinical examination.

With regard to frequency of use, Table 9 shows data for 2002 and 2003. As can be seen from this table, there has been a trend away from occasional or sporadic drug use towards

	2002					2003				
	Occasion-ally	Once or twice a week	Several times a week	Daily	Several times a day	Occasion-ally	Once or twice a week	Several times a week	Daily	Several times a day
Cannabis	37,1	14,6	20,4	8,4	19,4	29,0	12,9	26,2	11,6	20,2
Cocaine	34,5	16,1	25,3	12,6	11,5	38,4	13,7	24,7	9,6	13,7
Heroin	16,7	11,1	25,9	16,7	29,6	9,1	1,8	32,7	27,3	29,1
Other opiates	12,5	12,5	18,8	25,0	31,3	21,4	7,1	35,7	14,3	21,4
Alcohol	34,8	19,6	23,9	10,9	10,9	19,0	28,6	42,9	0,0	9,5
Ecstasy	28,6	42,9	21,4	7,1	0,0	40,0	10,0	40,0	0,0	10,0
Other drugs	23,1	23,1	46,2	7,7	0,0	57,1	7,1	21,4	0,0	14,3
<b>All Drugs</b>	<b>34,8</b>	<b>15,2</b>	<b>21,5</b>	<b>9,7</b>	<b>18,8</b>	<b>28,8</b>	<b>12,5</b>	<b>27,1</b>	<b>11,8</b>	<b>19,8</b>

Table 9

Source: Ministry of Justice

use for cannabis and there has been a slight increase in daily or several times a day use for heroin. For cocaine occasional and several times a day use have increased but regular or daily use has declined. There is no comparable data available from other surveys and it is not possible, therefore, to say if this data is representative of the wider youth population or of a specifically delinquent population.

Data on length of use (Table 10) of particular drugs shows an increase in the percentage reporting long term (more than 2 years) use of cannabis and in those reporting recent use (in the last 6 months) of heroin. Otherwise, although there are some shifts there have not been any major changes in length of reported use between the two years.

	2002							2003						
	< 6 months	< 1 year	< 2 yrs	< 3 yrs	< 4 yrs	< 5 yrs	5 + yrs	< 6 months	< 1 year	< 2 yrs	< 3 yrs	< 4 yrs	< 5 yrs	5 + yrs
Cannabis	16,5	42,3	26,1	7,5	4,6	2,1	0,9	15,2	41,8	26,2	10,5	4,1	1,5	0,7
Cocaine	26,4	41,4	18,4	6,9	2,3	2,3	2,3	17,8	42,5	26,0	5,5	6,8	1,4	0,0
Heroin	18,5	42,6	27,8	3,7	3,7	1,9	1,9	30,9	23,6	32,7	9,1	3,6	0,0	0,0
Other opiates	21,9	25,0	25,0	12,5	6,3	3,1	6,3	14,3	57,1	28,6	0,0	0,0	0,0	0,0
Alcohol	21,7	52,2	13,0	4,3	2,2	4,3	2,2	19,0	61,9	14,3	4,8	0,0	0,0	0,0
Ecstasy	28,6	35,7	35,7	0,0	0,0	0,0	0,0	20,0	50,0	0,0	20,0	0,0	0,0	10,0
Other drugs	23,1	61,5	7,7	7,7	0,0	0,0	0,0	35,7	50,0	7,1	7,1	0,0	0,0	0,0
<b>TOTAL</b>	<b>18,0</b>	<b>42,3</b>	<b>24,9</b>	<b>7,2</b>	<b>4,2</b>	<b>2,2</b>	<b>1,3</b>	<b>16,7</b>	<b>41,7</b>	<b>25,8</b>	<b>9,8</b>	<b>4,1</b>	<b>1,3</b>	<b>0,6</b>

Table 10

Source: Ministry of Justice

## 2.5 Attitudes to drug use and drug users

Data from the ESPAD Italia survey on the attitude of young people to use of drugs is currently not available. The data which was provided in the last National Report, therefore remains valid.



## 3 Prevention

### 3.1 Overview

Under the National Drugs Plan prevention of drug misuse is one of the central themes with teenagers as the primary target and a focus on three main areas: the general population; the psycho-behavioural condition, and; behavioural problems in children and adolescents.

For the first area it is considered essential that educational agents (family, school and social network educators) involve young people themselves in implementing strategies which allow them to give full autonomy, to bear frustrations and to control their impulses through experiences of relationships which are tried and verified. Linked to the primary objective of reducing the number of adolescents who use drugs there will be programmes based on: the acquisition of correct information about drugs and their risks for health; knowledge about the mechanisms of dependence and the nature of addictive disturbances, and; understanding that use of psychoactive substances impairs capacity to socialise, interpersonal communication and anxiety control. The knowledge and understanding is to be acquired through active programmes of group study, peer education, activities of the school Counselling and Information Centres, etc.

For the second area the issues to be addressed are incapacity to enjoy the ordinary and daily living, separateness from the enjoyment of affective personal relations, incessant searching for novelty, sensation and the extraordinary without ever being satisfied and a propensity to impulsiveness and immediate gratification. In this area, therefore, the family and school have a responsibility to give particular attention to behaviours which, in children and adolescents, even if not within recognised pathologies, require consideration and educational strategies, even where there is no resource to specialist input. Educational strategies have to be able to educate for daily living and to test out ordinary emotions arising from relationships and every day life. They must also increase the sense of belonging to the family, school and the wider community as these are protective factors against the use of drugs.

For the third area, attention is to be focused on psychopathological conditions and serious behavioural problems in children and adolescents which, if ignored or not dealt with at an early stage, can be characterised as predictive of drug use and misuse. Examples of the type of problems which might be observed include: behavioural problems; hyperactivity and attention deficit; anxiety accompanied by mood disorders; bulimia and psychogenic obesity; personality disturbances; interpersonal communication problems; post-traumatic stress disorders; panic attacks. In responding to these issues there is to be both the general approach (universal prevention) aimed at improving inter-personal relations, autonomy and responsibility through ethical and social training and specific approaches (selective/indicated prevention) focused on risk conditions which are associated with introduction into drug use.

Central to all prevention is the family as the basis for establishing from early childhood protective and supportive structures which aid the development of social and cognitive competence, healthy relationships and planning for the future. The improvement of parenting skills, which has been a growing feature of approaches to improve the impact of primary prevention, is to be given high priority within the overall prevention system engaging all those involved in the education of young people.

The actual delivery of prevention remains at the local level with responsibility for establishing the objectives, evaluation systems, financial resources, specific programmes and providers of prevention. In practice, many Regions have now adopted Regional Plans on the prevention and treatment of dependence and with the targeted resources of the National Drugs Fund are in a position to implement some of the elements identified in the national plan. Many Regions have established or are establishing networks for prevention involving the N.O.T., the Ser.T., the Counselling and Information Centres, private social organisations and other appropriate organisations and linked with educational institutions and youth facilities.

In particular, training for universal primary prevention has been given higher priority at the national level and also by many Regions. Previously training has been more centred on interventions aimed at selective prevention or at preventing progression to problematic drug use or at re-qualifying staff of specialist treatment and rehabilitation services.

### 3.2 Universal prevention

The revision to the drugs law, the National Drugs Plan which is out for consultation with the Regions and the Decree establishing the priorities for the National Department for Drug Policy all give high priority to universal prevention in educational settings (see box).

The planning and delivery of prevention is a local responsibility shared between a number of bodies at present, as reported in the last national report. There remains no national data available on prevention expenditure. However, between 1999 and 2003 some €44,764,897 has been allocated to projects sponsored by the Ministry of Education, primarily for prevention work. Additionally other Ministries have undertaken prevention projects such as the Ministries of Defence and Health and a national prevention campaign has been undertaken annually.

#### School Programmes

Prevention programmes tend to be ad hoc or one off rather than integrated within the normal school programme.

At the national level, since the National Drugs Fund was re-instituted in 1999, the Ministry of Education has initiated a series of projects, usually with a Region or not-for-profit organisation acting as the lead or co-ordinating organisation. .

#### Key element of the draft revision of the drugs law:

- Implementation of prevention and information activities in educational settings

#### Aims and Objectives of the draft National Drugs Plan:

##### Aim:

- To prevent the use of drugs

##### Objectives:

- to strengthen prevention starting from early childhood, involving educational institutes and agencies, primarily through training families and their children and strengthening schools, educational agencies and after-school clubs which meet children and adolescents
- to challenge the view of drugs as harmless and the atmosphere of 'normality' which is often associated with their use

#### National Department for Drug Policy

##### Competence:

- promotion and coordination of prevention and treatment projects, ensuring that Ministries and public and private organizations respect the guidance of the National Drugs Plan
- promotion of information campaigns on the negative effects of drug use and related criminal behaviours

##### Priority for 2004:

- organisation of the national drugs campaign
- promotion of prevention and treatment training programmes
- development of prevention programmes

### Ministry of Education sponsored projects financed by the National Drugs Fund

Title of the Project	Cost (€1000)	State of completion <sup>[1]</sup>		Description
Family	2065.8	Phase I Phase II Phase III	Complete 93.5% 87.6%	Interventions and training aimed at the acquisition of knowledge about child and adolescent behaviour and the creation of a solid and permanent agreement between educational staff, parents and social workers in coping and finding personalised responses to problems
Training	2065.8	Phase I Phase II Phase III	Complete 86.4% 71.4%	Training courses aimed at teachers and school directors to give knowledge about the orientation of educational research on health education and to promote planning centred on the student

<sup>[1]</sup> Phase I is the preparatory and planning phase within the central offices of the Ministry. Phase II is the identification of participating educational institutes, allocation of resources and arrangement of controls on project implementation by Regional educational offices. Phase III is implementation of the project by the educational institutes which are participating in it.



New technology in communication	671.4	Phase I Phase II Phase III	Complete Complete 86.5%	A project aimed at stimulating adolescents to reduce or avoid risk behaviours through the medium of new technology (Rome)
Prevention in disadvantaged areas	3165.2	Phase I Phase II Phase III	Complete Complete 6.5%	Primary drug prevention in disadvantaged areas which are considered to be at high risk in three cities (Turin, Bari and Naples).
Students	9296.2	Phase I Phase II Phase III	Complete 91.4% 83.6%	Interventions focused on the school population and aimed at prevention of adolescent problems and drug dependence,
Life skills and Peer education	955.4	Phase I Phase II Phase III	Complete 94.7% 87.3%	Research and action to prevent and reduce dependence, deviance and psychopathology in the school. The project is being evaluated by the Inter-University Centre for research on the genesis of pro and anti-social motivation of La Sapienza University, Rome.
Information and consultation centres	5164.6	Phase I Phase II Phase III	Complete 87.0% 77.5%	A service for students, families and educational staff provided in conjunction with the public drug treatment service to consolidate the use of information and counselling as resources for the personal and social growth of young people
Education in life skills	878.0	Phase I Phase II Phase III	Complete 63.4% 58.6%	A three year training and action programme to put a prevention dimension in education and to promote health. It aims to develop personal competences such as: problem solving; creative thinking; effective communication; self-awareness; management of emotions. The direct target is 2,400 young people aged 11-13, 300 school directors, teachers and educational officials. The project is to end with a national conference in Orvieto and the full documentation for the project is to be made available.
Peer education	1136.2	Phase I Phase II Phase III	Complete 87.0% 77.5%	A research and action programme to prevent and reduce dependency, deviancy and psychopathology in the school.
Student oriented school	413.2	Phase I Phase II Phase III	Complete 94.5% 90.7%	17 upper secondary schools have practiced student participation and sharing of the curriculum and school rules to guide individual schools towards personal well-being and educational success. After defining in the school regulations the area of the rules, the areas to be improved through proposals and planning by the students have been identified.
Provincial councils	826.3	Phase I Phase II Phase III	Complete 44.1% 25.5%	10 Councils have each been allocated around €31,000 for health education activities to be carried out with schools in their area. A portal has also been opened where the Councils can enter information about the prevention initiatives which they have undertaken.
Prevention	622.8	Phase I Phase II Phase III	Complete Complete 42.6%	A project between the administrative services of Modena and CeIS di Modena to create synergies in the area for communal actions aimed at "looking after oneself" rather than having to cope with emergencies.
Local energy and reinsertion	361.5	Phase I Phase II Phase III	Complete Complete 0.0%	A teacher training programme organised by the Centre for administrative services of Rome and Comunità Incontro to develop competence for the prevention of problems.

But what does it all mean?	154.9	Phase I Phase II Phase III	Complete Complete 0.0%	Organised by the Centre for administrative services of Rome it provides short films and CDs to stimulate questions from young people about the effects and risks of drugs
Information and consultation centres as the local focal point for prevention	2582.3	Phase I Phase II Phase III	Complete 0.0% 0.0%	The project aims to organise the Information and consultation centres as the means of entrance and co-ordination in study, research and training and as a reference point for the school and health fields to facilitate communication on available operational and methodological tools for tackling situations which are symptomatic of personal and group problems.
Teacher training	1032.9	Phase I Phase II Phase III	Complete 0.0% 0.0%	To be undertaken in fifty upper schools and linked with the middle schools the project provides training courses involving all the teaching staff and seeks to overcome the isolation of the teacher with responsibility for health education. A scientific/technical committee will co-ordinate the project, organise a national seminar at the end of the project and prepare a CD ROM to disseminate the experience.
The statute of students rights and responsibilities	1032.9	Phase I Phase II Phase III	Complete 0.0% 0.0%	Aimed at tackling youth problems, especially dependence through the building a new relational climate between the different educational components, the promotion of responsibility and a culture of respect for the law in the younger generation.
The student citizen for the effort against drugs in the new generation	1032.9	Phase I Phase II Phase III	Complete 0.0% 0.0%	The aim of the project is to implement innovative training courses using peer education methodology in schools in Sicily and Veneto. Active student participation is planned for every phase, along with teachers, heads of the educational establishments, parents and local associations so as to guarantee their right to learn and to take responsibility within their own community.
Centres for meeting and to promote youth participation	10373.0	Phase I Phase II Phase III	Complete 0.0% 0.0%	The project was developed from a wish to change radically the modalities which were normally used to tackle the difficulties experienced by young people living in disadvantaged situations. The project intends, with complementary interventions between the main educational agents (school, family and private social organisations) to create youth meeting centres, with a high educational value and managed through innovative socio-cultural networks which are autonomous and functionally structured. The project is aimed at the 13 – 18 age group and plans to open 20 centres spread evenly around the country and concentrated in urban areas with the highest risk of marginalisation. The aim of the project is to: provide integrated training for young people, teacher, those working in the social sector and parents; support the need of young people to communicate and to build intense and significant relations; create a network involving all the participating areas which can

				support disadvantaged and insecure young people; make adults aware of the dialogue; offer real opportunities for orientation towards and entry into professional training.
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Table 11

Source: Ministry of Education

There is little new data on universal prevention in addition to that included in the last national report. Those national projects listed above, due to be completed shortly, will have their final reports published in time to be utilised for the next national report.

One example of universal prevention comes from Milan. In March 2001 a training project for educators, both teachers and social workers, carried out by teachers of the University Bicocca started. Within the project the educators have developed an important role in supporting young people as they search for their own identity and in the creative laboratories. The creative laboratories were places for prevention, analysis of youth culture, identification of different possible identities and where people could find themselves. The laboratories were developed through 6 meetings. Thirteen upper secondary schools and 29 work classes with around 600 young people and 28 teachers were involved in the project.

### 3.3 Selective/indicated prevention

There is substantial activity in selective and indicated prevention, much of which is financed through the National Drugs Fund and implemented at the local level through a range of organisations, both public and private. To facilitate co-ordination and an integrated approach to primary, secondary and tertiary prevention, the Regional Councils in most Regions have adopted formal decisions to provide local arrangements for the establishment, organisation and operation of all activities in the dependency sector. In many cases this involves a technical or advisory committee to advise on strategy, planning and projects and on the evaluation of activities as well as a Department for Dependence which provides the operational support for implementing and monitoring the strategy and programmes and projects funded through resources available to the Region. Commonly representatives of interested sectors in the public and private social services serve on the advisory committee.

#### *Recreational Settings*

As has been reported in previous years, this has been a major focus of prevention activity conducted by both public and private services. In most Regions projects have been established to work in discotheques, youth and sports facilities and on the streets, combining both drug prevention and services to reduce harmful consequences of drug use.

At the national level there has been a major project aimed at training discotheque staff. The project has been carried out by the National Health Institute involving 17 Regions and discotheques nominated by the Union of Dance Hall Operators (SILB). The training has had as its principal aim the empowering of discotheque staff to be agents for the prevention of drug use amongst young people. The Regions involved have worked to a common protocol and procedures so that the training plans in all the Regions were harmonised. Over a three year period some 160 trainers have prepared 934 discotheque and dance hall staff, more than double the number proposed at the start of the project. As well as being directed at prevention of drug use, the project also identified the importance of prevention of sexually transmitted diseases in leisure settings. As a consequence of the close collaboration between SILB, the Regions, the police and local authorities and organisations, a wide range of events have been held and publications produced, including videos, information material, interviews on radio and television and in papers, magazines and journals. There have also been information campaigns and awareness raising activities aimed at different target groups. The formal report from the project is in preparation and more detailed results should be available for the next national report.

At the local level, there continues to be a substantial focus on prevention of the use of synthetic drugs, especially in discotheques. No new evaluative reports about this work have been published since the last National Report. A further and more recent focus has

been on the use of drugs in sports settings, including both organised sports and independent gyms. This has taken two forms. On the one hand there has been preventive work aimed at discouraging the use of drugs – both performance enhancement and psycho-active substances, and on the other hand there has been a focus on sport as a healthy alternative to drug use. One example of this is a project to promote sport financed by the National Drugs Fund and implemented by Associazione La Ricerca. The project began in February 2002 with the aim of providing training courses for all sports associations interested in adding an educational and preventive dimension to their sport. The general objective is to promote sporting activity and it is being implemented in five locations – Piacenza, Turin, Viterbo, Pistoia and Florence. Specific objectives include supporting psychological and physical well-being, recovering the educational value of sport, proper sporting values and the spirit of sport and learning to be and live with a team. Different approaches have been developed in the different cities according to the local situations. In Piacenza the activities developed with various sports associations have been reviewed. Two associations in particular have seen a noticeable benefit for internal relations and improved dialogue which has allowed them to prepare events such as tournaments and festivals. In Turin planned activities with the Gugliasco Sports Association have been completed and work has now started with Sporting Torino. Following the success of the first phase of the local activity, there has been great interest expressed in the project with strong support from a group of managers. In Pistoia both sporting federations and the Commune have been participants. In Florence, after some initial difficulties, there has been great interest expressed by young people wanting to go further into the themes of the project. At Viterbo a team has been built to be involved with prevention, education and training within each sports association. Training has planned to give in-depth exploration of educational models and integrated training between the different teams is also planned.

#### *At risk groups*

There is a strong focus on preventive work with young people who drop-out of school or who are involved in the criminal justice system. Services are also provided for young people who are identified as having behavioural problems.

Law 285 of 1997 provides resources for the development of projects for children and adolescents with a particular focus on supporting families and young people in order that they can participate and benefit fully from the formal education system and on the prevention or resolution of problems and responding to the needs of socially disadvantaged populations. In the first three years since the law came into force some 2,800 projects have been supported with some 25% concerned with prevention. These have included creative laboratories (art, theatre, music, dance, etc.), youth centres, support for parents, recreational centres, staff training and day education centres. Milan provides examples which can be found repeated around the country. In Milan one office deals with all activity in the drugs field with a specific division for drug prevention. This division brings together school based activities, activities in public and recreational settings and works in close co-operation with a wide range of associations and not-for-profit social co-operatives. Its stated aim is to see prevention as developing a culture of understanding and giving greater value to the processes of growing up, not only emergency management of problems which have already developed. Examples of the prevention projects developed include the following.

- *100 years of adolescence*: developed with financing from the Cariplo Foundation, this is a social communication activity, a cultural event to promote adolescence and an activity to prevent youth problems. Involving young people it seeks to build a self-portrait of contemporary adolescence.
- *Short films about drugs*: this has involved young people in the production of a series of short films on the theme of drugs. The aim has been to strengthen creativity and expressive capabilities.

- *Notturmo andante*: an action research project in Milan discotheques to increase knowledge about drug use and other at risk behaviours and to help target prevention work.

Work has been underway to develop an internet site into which information about recent and effective prevention projects in Italy will be placed. It was expected that this site would be on-line by late 2003 but this has not proved possible. The projects developed under Law 285/97 have all been collected into a single publication prepared jointly by the Ministry of Education and CNCA. Although many of these projects are not specifically concerned with the prevention of drug misuse, nearly all deal with areas which have been identified as important in terms of future drug misuse or other social problems.

In addition to the Law 285/97 projects, the Regional allocation of the National Drugs Fund has financed many projects aimed at primary prevention of drug use or at avoidance of progression into regular drug misuse. Most of these projects are local and tend to have quantitative rather than qualitative evaluation, based on the number of people contacted, the types of intervention provided, the number of leaflets, etc. distributed and the like. In general reports from these projects are not published but are submitted to the Region as a report on the utilisation of the funds provided. There continues to be a dearth of published qualitative evaluations of prevention, however, increasing focus is now being given to this area. The Emilia Romagna Region has prepared a document on the monitoring and evaluation of primary prevention and harm reduction projects (Tassinari and Bartoletti 2003) and held a conference on this topic in June 2003 to promote monitoring and evaluation. The Veneto Region has approved <sup>[1]</sup> the establishment of a Regional prevention network through which all the local health authorities have been linked for the purpose of health promotion and to support prevention of dependency. This initiative is linked to the European network of "Health promoting schools" and to the national project for the development of life skills and aims to create new alliances and partnerships in support of healthy living and drug prevention.

#### *At risk families*

Work with at risk families is provided in the context of the educational system through the provision of home support to give educational support. It is provided by the Commune and directed towards at the nuclear family in its complexity and through the presence of an educator it offers individual educational support to the young person within the family, involving the parents and assisting the parents and children to explore and finds ways of improving their relationships. There are also programmes aimed at providing training to parents (see, for instance, the "Family" project in Table 11), parent self-help and support groups for those with children at risk. Although many of these projects are not drug specific, they are directed at behaviours and situations which are known to be indicators of possible resort to drug misuse. Placed within an educational and social support system they can avoid stigmatisation whilst at the same time offering intensive support as a means to avoiding problems becoming entrenched.

These services are available throughout Italy. Many are financed through Law 285/97 with others financed through the National Drugs Fund and through the regular budget of the local authority.

## **4 Problem drug use**

### **4.1 Overview**

Estimates of the prevalence of problematic drug use have been calculated using between three and five estimate methodologies for each of the last five years and there is also data available for 1996. In 2003 estimates were also made for the incidence of initiation into heroin use with national data calculated back to 1975 and incidence data by Region available for 2003. Prevalence data suggests that there may be a levelling off or even a reduction in problematic drug use in Italy. From the incidence estimates, at a national level incidence of initiation into heroin use appears to have risen sharply from 1981 and to

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<sup>[1]</sup> Decision n. 2341 of 30 July 2004

have peaked in 1990 with a gradual reduction to 1997 and then a slight increase levelling off in recent years. There are, however, substantial Regional variations in terms of both historical and current incidence rates.

National data on the profile of clients in treatment is limited. There is information on sex, age, primary and secondary drug use, and use by injection. Several Regions now have TDI data collection systems but at the time of writing TDI data was only available from two Regions. Several Regions also have Drug Observatories which collect and analyse data from both treatment and non-treatment sources. Along with reports from specific studies, all of these sources have been used to give an overall profile of problematic drug users in Italy.

From the available data, the average age of drug users in treatment has continued to rise with increases for both the average age of clients still in treatment from the previous year and clients entering treatment during the year. At the same time, there has been an increase in the percentage of new clients, both male and female, entering treatment during the year. Males outnumber females by a large margin in both new and continuing clients but the male to female ratio is much closer for the younger age groups. A higher percentage of new female clients are in the younger age groups than is the case for male clients, suggesting that females may enter into treatment at an earlier stage in their drug using career. Heroin remains the primary drug for the majority of clients, but while the percentage of clients with primary heroin use has been falling, the percentage with primary cannabis or cocaine use has been rising. There has been a continuing reduction in use by injection of the primary drug. Where data is available, new clients seem more likely to be unemployed although it is not clear whether this is a consequence of drug dependence, wider economic/employment circumstances or a combination of both. There also appears to be a slight increase in the percentage of new clients who are homeless or who have insecure housing. Self-referrals for treatment are most likely for heroin and cocaine misuse whilst referrals from judicial sources were most likely for cannabis and ecstasy. Drug dependents in treatment with the Ser.T. for dependence on non-opiate drugs were younger than opiate dependents and more likely to be employed and to have stable employment.

There is substantial data at the local and Regional levels on problematic drug users outside treatment. This data is not standardly collected and collated at the national level. From the available information this population of drug dependents was more likely to be homeless and unemployed than the 'in treatment' population. Heroin was the primary drug but poly-drug use was reported in around three-quarters of this population (where the data was recorded). The male to female ratio was the same or slightly higher than for the population in treatment but there was a higher percentage of people in the younger age groups. This is in line with other data which suggests a time lag between regular drug misuse and first entry into treatment of around four years. It is noticeable that the number of drug dependents contacted by outreach services, where comparable data is available over a period of years, has been falling annually. The implication is that the incidence of problematic drug use may be stabilising or falling but that those still outside treatment may be the most problematic group requiring specific attention.

This view may be supported by data from Liguria on hospital admissions of drug dependents. This shows that whilst heroin overdose admissions have been falling, there has been an increase in admissions for drug-related psychiatric conditions there continues to be a large percentage of admissions for physical health problems.

#### **4.2 Prevalence and incidence estimates**

Prevalence of problematic drug use has been estimated every year for the last five years using three or more different methodologies. In addition, for 2003 the incidence of initiation into the use of heroin has been estimated for every Region of Italy and incidence has been calculated for every year from 1975 to 2003, allowing a mapping of the heroin misuse epidemic in Italy by year and region.

In terms of the prevalence of problematic drug use, Table 12 shows the estimates by year and methodology. As can be seen from this, the lower estimate is at the highest level

since 1999 but the upper estimate is the lowest it has been whilst the media figure is slightly below that of 2002. On the basis of this data it would suggest that the prevalence of problematic drug use, if not declining has at least stabilised. A longer period of consistency in the data is needed, however, before firm conclusions can be drawn.

**Estimates of problem drug 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
2003	n.a.	285,838	275,698	298,892	n.a.	275,698 - 298,892

Table 12

Source: Institute of Clinical Physiology, CNR

In terms of the incidence of initiation into heroin use, based on back calculation methodology the Institute of Clinical Physiology has estimated that in 2003 between 23,027 and 24,381 people first used heroin with a media of 23,704. The curve of incidence for Italy as a whole between 1975 and 2003 (Fig. 13) shows a sharp rise between 1980 and 1990 followed by a slow decline to 1997 and then a shallow rise to 2003. The

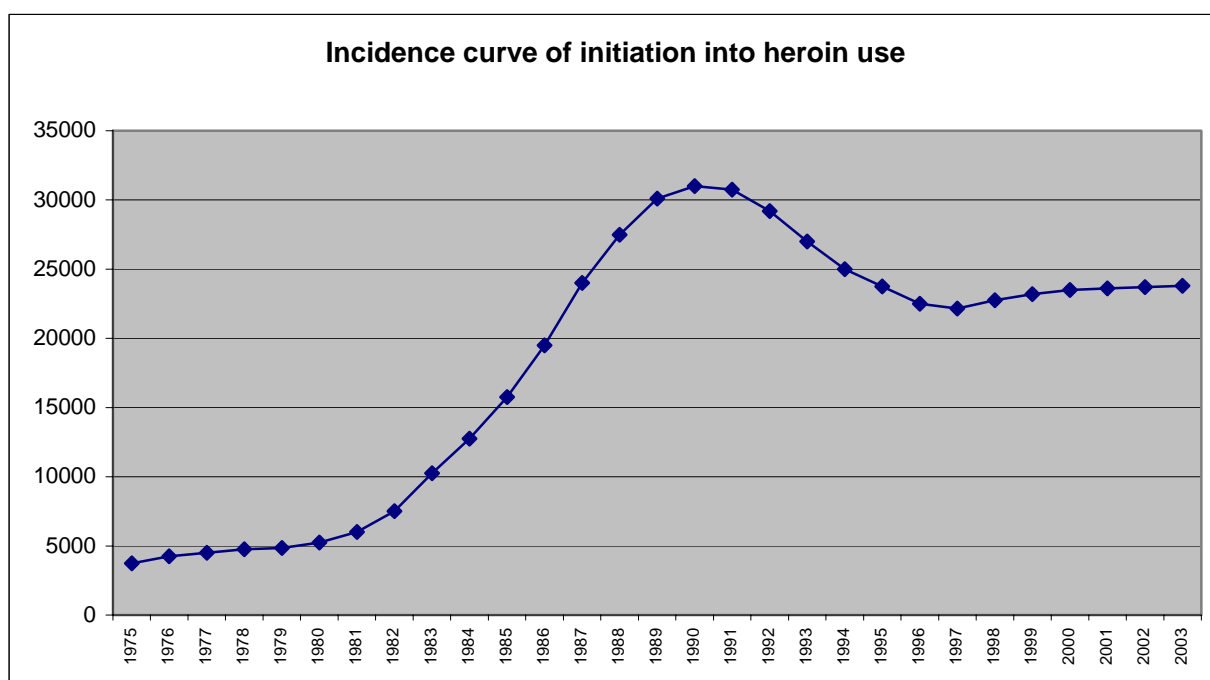


Figure 13

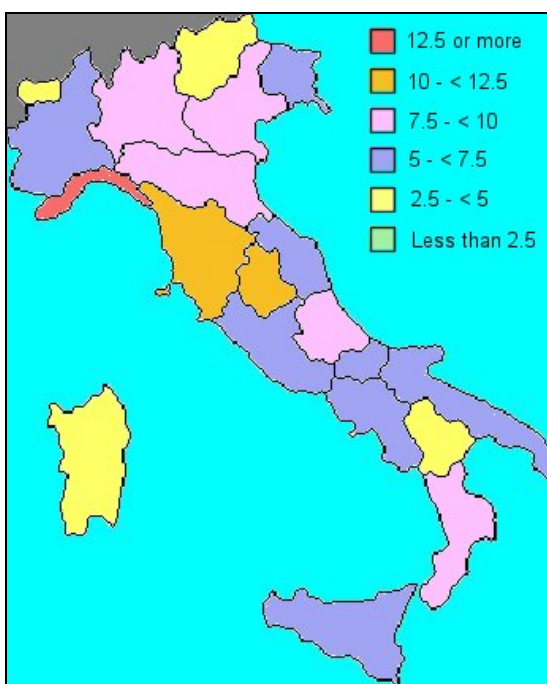
Source: Institute of Clinical Physiology, CNR

incidence curve offers some support to the possibility that the epidemic in problematic drug use has stabilised.



The incidence data by Region has been based on rates per 10,000 population in the 15 – 54 age range. These rates show substantial variations between Regions with some having a marked decline in incidence rates and others showing rising rates. These differences are not geographically based in that Regions in the same area of the country have significantly different incidence rates and incidence curves over time. In general, incidence rates in the northern regions peaked between 1988 and 1990, in the central regions between 1990 and 1991 and in the southern regions between 1991 and 1993. After the first peak in the incidence of heroin use, however, different incidence patterns are found. For instance, taking the northern Regions, whilst incidence rates for Piemonte, Valle d'Aosta, Trentino, and Friuli in 2003 were still below the peak of the late 1980s and early 1990s, for Emilia Romagna the incidence rate has returned to almost the same level whilst for Lombardia, Liguria and Veneto the incidence rates, after a fall in the first half of the 1990s, are now at a new peak. In general, for the majority of Regions the decline in incidence recorded to the mid or late 1990s has either ceased or shown a slight increase in recent years, with some Regions having more substantial rises. Map 5 shows the incidence rates for initiation into heroin use per 10,000 population in 2003.

**Incidence of initiation into heroin use 2003**



Map 5 Source: Institute of Clinical Physiology, CNR

As can be seen from this the highest rates are now found in three adjacent Regions, Liguria, Toscana and Umbria. The overall position appears to be that some 13 of the 20 regions have shown a continuing decrease in incidence or a stable rate suggesting an endemic problem whilst some 7 regions show a rise in rates in recent years suggesting that a new heroin epidemic has occurred or is occurring with consequent impact upon the drug prevention and treatment systems in those Regions.

There is no immediately observable explanation for the wide variations within geographical areas. They do not seem to be related to population density and levels of urbanisation. However, the rates are for heroin use and it is possible that the overall picture for problematic use might change when all problematic use is taken into account. Such a hypothesis is reasonable given that the more densely populated Regions tend also to have higher levels of cocaine, amphetamine and amphetamine analogue use, along with cannabis use based on, for instance, data from the ESPAD research and reports on primary drug use of those in treatment with the Ser.T.

#### 4.3 Profile of clients in treatment

There continues to be limited data available on clients in treatment with the Ser.T. Separate data on clients being treated in residential or semi-residential services operated by not-for-profit organisations is not available but around 80 - 85% of these clients are counted within the Ser.T. client group because their treatment is financed and overseen by the local health authority.

In 2003 there were 33,628 new clients of the Ser.T. and 126,983 clients who continued in treatment from a previous year. This was a slight increase for both new and continuing clients over 2002 although the trend over time has been for new clients of the Ser.T. to represent a decreasing percentage of all clients (Fig. 14).

The male to female ratio nationally was 6.82 : 1 for new clients and 6.51 : 1 for continuing clients, in both cases this was a slight increase over the ratios in 2002. In general, the male to female ratio for clients under 20 years of age is much lower at 3.73 : 1 for new and 3.45 : 1 for continuing clients whilst the 30 – 39 age group has a ratio of around 8 : 1 for new and 7.2 : 1 for continuing clients. The average age of both new and existing clients has continued to rise (see Standard Table 04)

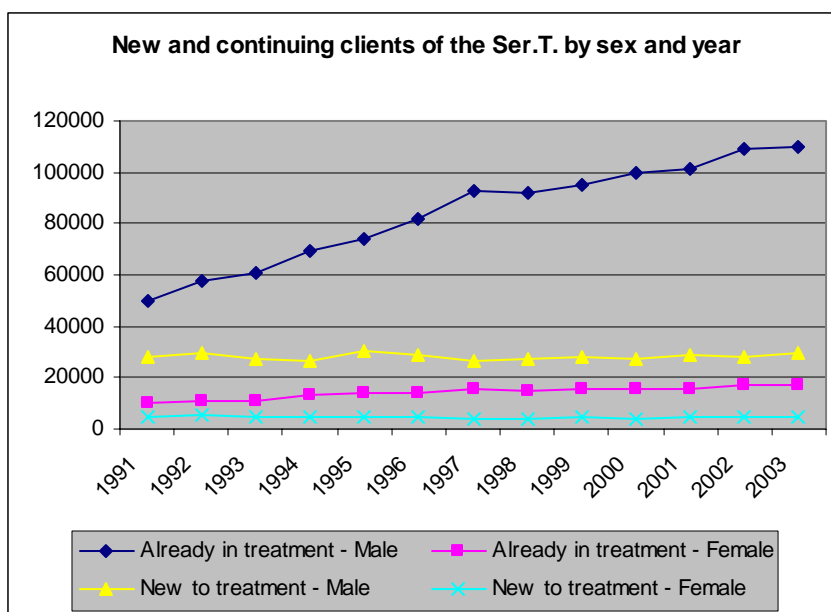


Figure 14

Source: Ministry of Health

although in 2003 there was an increase in the number of clients under the age of 15 with the largest increase being in the number of female clients in this age group. There was a slight fall in the number of clients in the 15 – 19 age group. The percentage of new clients in these two age groups rose from 7.5% to 7.7% for males and from 13.2% to 14.2% for females but both males and females in these age groups represented a smaller percentage of continuing clients. In general, there continues to be an aging population in treatment. In terms of primary drug use, national data is only available for all clients in treatment with the Ser.T. and cannot be broken down for new and continuing clients. In 2003 the decline which has been observed for several years in the percentage of clients using heroin as their primary drug has continued. In 1990 91.9% of clients used heroin as the primary drug. In 2003 this percentage had fallen to 74.8%. There has also been a fall in the percentage of primary heroin users who used the drug by injection, falling from 77.4% in 1998 to 68% in 2003. Whilst the percentage of heroin users has declined, there has been a continuing increase in the percentage of primary cocaine and cannabis users. In the 10 years from 1994 to 2003, the percentage of all clients with primary cocaine use rose from 2% to 8.9% and from 5.1% to 10.3% for primary cannabis use.

More detailed data is available from local and regional drug observatories. In particular, the Liguria and Emilia Romagna Regions both publish extensive data on clients in treatment and additional data is also available from a number of other Regions, notably Veneto and Abruzzo. Some data from the VEdETTe study has also been made available with information on clients in treatment with the Ser.T. during the period of the study.

Data from these sources suggest that around 10% of females and 19% of males in treatment with the Ser.T. had no educational qualifications or the minimum qualifications (Faggiano and Bargagli 2003, Malagoli and Morandi 2004, Curzio et al 2004), around 54% of females and 60% of males completed compulsory schooling and around 36% of females and 21% of males completed upper secondary schooling or a degree course.

In terms of employment, there are some differences between the different studies which may reflect local circumstances. In the VedeTTe study based on clients enrolled between October 1998 and March 2001 from a nationally representative sample of Ser.T., around 23% of females and 36% of males had stable employment, around 23% of females and 27% of males had occasional employment, 11% of females and 4% of males had non-professional employment and around 43% of females and 33% of males were unemployed. The Liguria and Bologna Province data is shown in Table 13. Although there are some differences, it is notable that new clients were less likely to be employed

and for Bologna certainly and probably for Liguria, they were more likely to be unemployed. This may reflect economic conditions in the local area or it may suggest that treatment offers a means of either retaining employment or of allowing the client to re-enter the labour market.

Where the data is available, around one third of clients are living with their parents and

around 23% with a partner either alone or with children. Around 6% are in prison and a further 6% are homeless. The Bologna data shows that new clients were more likely to be homeless than continuing clients. In 2003 only 3.3% of continuing clients were homeless while 18.1% of new clients were homeless.

There is some data on source of referrals to the Ser.T. from Liguria and Modena. The Liguria data shows that around 63% of clients were self-referrals and 29% referrals by judicial bodies (courts, the Prefecture, etc.) with other treatment services being the source of referral for some 5% and families accounting for only 1% of referrals. The Modena data provides data on the referral source by primary drug for new clients. Around 40% of referrals were self-referral, 31% from judicial sources, 14% from other treatment services, 10% from other services and 6% from other sources. When this data is examined by drug, 58% of heroin referrals were self-referrals and 36% of cocaine referrals but only 8% of cannabis referrals. Referrals from judicial sources were most likely for cannabis, where that accounted for 69% of all cannabis referrals and for ecstasy (50% of referrals) and other drugs (60% of all referrals). This pattern of referral reflects patterns of referral to the Prefect for unlawful possession of a controlled drug. The vast majority of referrals are for cannabis and consequently most referrals to the Ser.T. for assessment or treatment will be of those using cannabis. Referrals from the prison service are more likely to be for heroin use and may reflect a changed situation since responsibility for the provision of drug treatment to prisoners passed to the Ser.T.

The national project on synthetic drugs conducted by the National Health Institute in collaboration with all the Regions and two national organisations for socio-rehabilitative services, CNCA and FICT reported on its work in 2004 (Macchia et al). This project collected data on people approaching specialist drug services in relation to their use of synthetic (recreational) drugs. Some 210 services provided data, 78% were Ser.T. and 22% socio-rehabilitative services. The data collected was on the contact, socio-demographic information, drug use and the treatment offered. This latter point is dealt with in section 5.

In 2000 10,594 people were identified as primary users of drugs other than heroin, representing 7.2% of all those in treatment with the Ser.T. The study collected data on 1,911 clients, representing 18% of all non-heroin users in treatment. Some 72.7% of the clients in the study were new to treatment and had never sought help before. Just under 40% referred themselves, suggesting that they had reached a point where they acknowledged they had a problem. A further 30% were referred either as an alternative to prison or by the Prefecture or police and 17% were referred by their family. 38.7% of those approaching a treatment service wanted to give up drug use, 28% were there either as a legal requirement or to avoid sanctions, 14.4% to deal with health or psychological problems and 11.6% to calm their parents.

86.8% of the clients were male and the male to female ratio of 6.6 : 1 was slightly higher than the ratio for all clients in treatment (6.4 : 1). The media age was 27.4 years but there was a significant difference between males and females. The media age for males was

#### Employment status of clients of the Ser.T.

	Liguria Region		Bologna Province	
	New Clients	Continuing Clients	New Clients	Continuing Clients
Employed	34,2	42,0	41,1	50,8
Casual employment			8,8	7,6
Pupil/Student	2,5	2,2	5,8	2,2
Economically inactive	2,8	2,7	0,7	3,6
Unemployed	20,6	32,2	39,0	31,8
Other	0,8	0,5		0,1
Not known	39,1	20,3	4,6	4,0

Table 13

27.7 and for females 25.4 compared to a media age of 28.4 and 27.7 for all new clients in 2000. This was a statistically significant difference for females. Moreover, in general primary users of drugs other than heroin were younger than heroin users with just over 44% of all clients in this group being under 25. In terms of employment status 47.9% had stable employment (50.7% males, 30.5% females), 13.5% had casual work (12.7% m, 18.9% f), 22.9% were unemployed (22.2% m, 26.8% f) and 6.2% were students (4.5% m and 16.9% f). The employment rates were therefore higher for synthetic drug misusers attending for treatment than for all new clients attending the Ser.T. as reported from Liguria and Bologna (Table 13). It is also noticeable that females were four times more likely to be students than males. This may reflect earlier observations that females might attend for treatment at an earlier point in their drug using career, as noted in the VEdeTTE study and by the larger percentage of young females attending for treatment. It is also possible that young women have older partners who introduce them to drug use and that they approach for treatment when they feel their drug use is adversely affecting their studies. This hypothesis is supported by the fact that whilst under 5% of males used drugs with their partner, one in five of females did so.

Information on the drug use of this population shows that 71.2% use cocaine (73.5% m, 55.3% f), 19.9% ecstasy (19.5% m, 23.8% f) and 4.5% psychopharmaceuticals (3.3% m, 12.3% f). Most commonly drugs were taken with friends (c. 58%) or alone (c. 33%), with females more likely to use in the home (40.7%) than males (30.1%) and males more likely to use in public areas (38.5%) than females (30.8%).

#### **4.4 Main characteristics and patterns of use from non-treatment sources**

Some data is available on characteristics and patterns of use of problem drug users outside treatment. A number of Regional or local observatories do collect some data but at the time of writing only the reports from the Liguria and Bologna observatories have been published with relevant data. There is also some data from local services such as Magliana 80 in Rome and SOS Stazione Centrale in Milan and from some specific projects aimed at specific populations.

The Bologna data comes from the low threshold services. 256 drug dependents were contacted through these services in 2003 out of a total of 401 people contacted. 33% were already with the Ser.T., 35% were not known to the Ser.T. and 32% had previously been clients of the Ser.T. The majority of people contacted were male (86.3%) and living in Bologna, with 60% living on the streets. 88% were unemployed. Almost 94% were heroin users and 73% cocaine users and poly-use was assessed in 74% of people. These were all percentage increases over the previous year with the largest increase in those using cocaine. Those who had never been in treatment with the Ser.T. were much less likely to have undertaken testing for HIV or Hepatitis C infection. Data from the social support service shows that there of 502 clients 230 (45.8%) were drug dependent with the majority being male (89.1%) and a media age of 31.7. Of the 31 non-Italian drug dependents, 61% were illegal immigrants. Most were living in Bologna with 79.6% living on the streets and 91.7% unemployed. 45.2% had arrived in Bologna in the previous month and 63.1% had arrived within the last 12 months. Just over two thirds (67.4%) had completed compulsory schooling. 88.3% were heroin users, a reduction from previous years, 62.2% were cocaine users, a continuing increase, and 66.5% were assessed as polyusers. Around two thirds had never, or not within the last six months been tested for HIV or Hepatitis C.

The data from Liguria refers to hospital admissions with a drug-related diagnosis. This shows that between 1997 and 2003 there has been a continuous drop in the number of such admissions with the exception of 2001. In 2003 there were 247 such admissions recorded. Of these, 73.5% were for opiate related problems, either alone or in combination with other drugs, 9.5% were for cocaine and 12% were for drug mixtures or where the substance was not specified. Drug dependence was the most common diagnosis (54.3%) followed by drug misuse without dependence (23.1%) and drug psychosis (19.0%). The data indicates also shows that there has been a steady reduction in the number of admissions for heroin overdose, falling from 5.8% in 1997 to 2.4% in 2003 whilst there have been slight increases in poisoning associated with hallucinogens



and psycho stimulants. This is in line with data on drug-related deaths and the continuing reduction in the number of drug-related deaths reported both locally and nationally and with data from local studies and reports on drug use in the youth population.

The data from these two sources is in line with data from previous years. It suggests that drug users outside treatment have much higher levels of social problems and are much more likely to experience serious drug-related health and personal problems than those in treatment. The Bologna data also suggests that there is a particularly problematic client group already in treatment with the Ser.T. who continue to use street drugs or have serious social and personal problems which may require more specific and targeted interventions.

SOS Stazione Centrale reports on 7,130 contacts with 876 persons during 2003. In fact during the year there were 12,710 contacts but registered data is only available for 7,130. Of those contacted, 361 (41.2%) were drug dependents producing 57% (4,072) of all contacts. 82.3% were male and 17.7% female, a slightly higher male to female ratio than for all those in treatment with the Ser.T. However, the northern Regions of Italy have usually had a higher percentage of females in the drug dependent population, perhaps reflecting the more urban, industrialised and cosmopolitan nature of some of these Regions, especially their main cities. 14 (3.9%) of those contacted were non-Italians. Data is not yet available on age groups or housing status, although data on new contacts between May 1990 and December 2000 is available. Over this period 1.5% were under 18, 25.3% between 19 and 25, 70.4% between 26 and 40 and 2.7% over 40. It is noticeable, however, that over time the percentage of people in the older age groups has been rising with 74% between 26 and 49 and 10.7% over 40 in 2000. In terms of accommodation, over the period 82.5% were without secure housing but, as with the age groups, there has been a continuing diminution in the percentage of people in this situation. It is also noticeable that over the period 1990 -2000 drug dependents represented a decreasing percentage of all new contact made by the service, from a high of 67.1% (Oct. '93 – Sept. '94) to 45.7% in 2000.

Magliana 80 has reported on the work of its outreach service (unità di strada) for the period 1994 to July 2004. During this time it made 187,000 contacts with drug dependents. Data is not provided on the number of people involved but some 2,667 persons were referred to specialist drug services. In this period there was a significant increase in the percentage of cocaine users, rising from 3% in 1994 to 9% by 2004. This largely reflects the pattern observed in the data from the Ser.T. The drug most commonly used was cannabis but there was also an increase in poly-drug use. Of the 1,948 homeless people contacted by the service, 11.6% were drug dependent. It was also noted that among the 334 Italians contacted in 1996 who were involved in prostitution, 67 (20%) were drug dependents. However, this data on involvement in prostitution is similar to that identified by the On the Road project which has been working in the area of prostitution for many years.

## **5 Drug-related treatment**

### **5.1 Overview**

Data collected by the Ministry of Health provides information on clients whose treatment is financed by the local health authority. Treatment may be provided directly by the Ser.T. or by an private socio-rehabilitative organisation which has an agreement with the Ser.T. to provide drug services. However, this data cannot distinguish between those who are only receiving drug-free treatment and those who are attending both a medically assisted and a drug free treatment service. Data on the private socio-rehabilitative services is maintained by the Ministry of the Interior. This only provides information on people in treatment on a specific day of the year. Moreover, it classifies services by only three typologies – residential, semi-residential and ambulatory. The residential and ambulatory services may include emergency housing, street services, drop-in centres and the like as well as therapeutic programmes. At the national and regional levels efforts are being made to overcome these problems with a significant number of projects funded by the National

Drugs Fund and sponsored by the Ministry of Health, the Directorate General for Drug Dependency of the Ministry of Welfare (now transferred to the National Department for Drug Policy) and the Ministry of the Interior all aimed at improving national data collection systems and at the development of Regional drugs observatories to collect and analyse data based on European guidelines. Despite these qualifications, the national data collected at present does provide a data set for 15 years able to show trends and developments over time.

## **5.2 Treatment systems**

The treatment system within Italy consists primarily of public drug treatment services provided through the national health system and private socio-rehabilitative services usually managed by not-for-profit organisations. Historically, those seeking treatment for a drug problem are admitted for treatment by the public drug treatment service (Ser.T.). They may subsequently receive treatment in either a public or a private treatment service but technically remain a client of the public treatment service and their treatment is paid for by the national health service.

Parallel with this arrangement drug misusers may be referred for assessment and/or treatment by the Prefecture or may be allowed to undertake a treatment and rehabilitation programme as an alternative to imprisonment or to continued imprisonment. In such cases funding of treatment is through the law enforcement and criminal justice systems.

In all cases the local health authority and the Ser.T. have been the central point for managing the provision of drug treatment. However, significant changes are now occurring with the creation of Departments for Dependency and a separation between the commissioner and the provider of services. In the past the commissioner of services was commonly also one of the providers. This seems to have resulted over time in increasing concentration of services in the public sector and longer retention of clients in medically assisted treatment and a reduction in the use of other treatment providers, particularly those providing drug free treatment.

The major changes planned in the drug treatment system are detailed in the National Drugs Plan and the draft law, both of which have been described in earlier sections of this report.

## **5.3 Drug-free treatment**

Drug-free treatment is available in both the public and private services, with the latter having drug-free treatment as its main approach whilst the former is evenly balanced between drug-free and medically assisted treatment. In-patient treatment is usually within a residential therapeutic community. Out-patient treatment may be semi-residential, where the drug dependent is expected to be present at the treatment service every week day and /or for a total of 40 hours per week or ambulatory where the drug dependent attends for intensive treatment sessions by appointment. Within the Ser.T., integrated treatment is usually provided with the client receiving both medically assisted and psycho-social treatment and with just under half of all clients receiving drug-free treatment alone. For the purposes of this report, and given the difficulties of making a clear distinction between drug-free and medically assisted treatment, drug-free treatment is focused on socio-rehabilitative services and medically assisted treatment on the work of the Ser.T.

In 2003, the Ser.T reported that 21,231 clients were placed in socio-rehabilitative services. In absolute numbers this was an increase over 2002 of 11.2% and reversed the steady reduction in the number of clients in this type of service which had been occurring over the last 5 years. The increase as a percentage of clients registered with the Ser.T. is more modest at 1.2% over 2002 and is still below that in 1998 when 14% of those registered with the Ser.T were in treatment in a socio-rehabilitative setting.

Moreover, there are substantial variations between Regions in the percentage of clients being treated in socio-rehabilitative services. In Valle d'Aosta one third of clients were being treated in such settings and in Toscana (28.3%), Calabria (24.7%) and Veneto (20.7%) a significant percentage of clients are placed in socio-rehabilitative services. At the other extreme, Lazio (3.7%), Friuli (5.3%) and Sicilia (7.4%) appear to make low use



of such services. The reason for these variations is not clear as there is no obvious correlation between the availability of socio-rehabilitative services or in primary drug use patterns and the types of service into which clients are placed. This would suggest that referral patterns may be affected by historical clinical practice, inadequate networking between the different services and also by financial considerations. As the local health authority finances drug treatment within both the public and the private services from the same budget, if more clients are referred into socio-rehabilitative services this may limit the number of clients who can be brought into primary treatment with the Ser.T.

In terms of the treatment provided within socio-rehabilitative services, the data available seems only to relate to treatment which may be provided either in a public or a private service. Whilst over 21,000 clients are identified as receiving treatment in a socio-rehabilitative service only 12,539 treatment interventions are reported suggesting that information on at least 40% of clients is missing and that this percentage may be higher if clients receive more than one type of treatment intervention. With this reservation, there has been a trend in recent years for an increasing percentage of clients in such services to receive medically assisted treatment and for longer term methadone treatment to be provided rather than short term, detoxification focused treatment. In 1998 25% of treatments in socio-rehabilitative settings were medically assisted, 3.8% using long term (over 6 months) methadone treatment. In 2003 32.3% of treatments were medically assisted with 7.7% using long term methadone. It is not entirely clear what this trend represents in terms of the pattern of treatment provision. It may be an indication of increasing use of residential services to provide social and health support for drug dependents in a form of crisis intervention. It may also represent the increased use of residential treatment assessment services with subsequent referral into either in or out patient treatment. There is some support for this interpretation as there has been an increase in the number of such services in Italy in recent years based on the quarterly census of socio-rehabilitative services undertaken by the Ministry of the Interior Directorate for Documentation. It is also possible that the use of residential detoxification as the first stage of admission into a therapeutic community has increased which would account for the use of short term (less than 1 month) methadone prescribing in such settings. This would also account for the use of other drugs (5.7%) with 15.4% of all medically assisted treatments in such settings being focused on detoxification.

Although there has been a noticeable increase in the use of medically assisted treatment within socio-rehabilitative services, the predominant treatment modalities are psycho-social. In 2003 67.7% of clients registered with the Ser.T. and placed in a socio-rehabilitative service received psycho-social treatment, primarily through social work support (54%) and psychological support (22.8%).

The data from the Ministry of the Interior provides information on capacity and occupancy of residential and semi-residential socio-rehabilitative services on 31 March 2003<sup>[1]</sup>. On that date there were 811 residential treatment services providing 18,831 bed spaces. The total number of residents was 12,142, giving an overall occupancy rate of 64.5%. In six Regions there is public provision of residential treatment services and all Regions have such services provided by private social organisations. The overall occupancy rate in the public services was 87.2% (226 places, 197 residents) whilst in the private services the occupancy rate was 64.2% (18,605 places, 10,239 residents). There was a slight reduction from 2002 in the number of residential services available, from 817 to 811, and a reduction in the number of residents from 12,537 to 12,142.

For semi-residential services, such facilities were provided by public services in seven Regions with 206 places and 193 clients, giving an occupancy rate of 93.7%. Private social organisations provided semi-residential services in 17 Regions with 3,833 places and 1,862 clients, giving an occupancy rate of 48.6%. The number of semi-residential

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<sup>[1]</sup> The census of socio-rehabilitative services is undertaken four times a year on the last day of March, June, September and December. Summary reports are provided for each census but the only detailed report available at present is for March 2003.

services in 2003 was the same as in 2002 but there was a slight increase in the number of clients placed in these services from 2,005 to 2,055.

In April 2003 Studio VEdeTTE presented the results of its research to a conference in Rome (Jarre et al 2003). This research project involved the collection and analysis of data from 106 Ser.T. in 13 Regions with 11,905 clients registered with them. There was a higher representation of Ser.T. from the central, southern and island Regions but just over one third of clients came from the 5 northern Regions participating in the study. This is reasonably representative of the distribution of treatment demand in Italy.

For the purposes of the study, detailed data was available for analysis on 10,454 drug dependents, 1,249 of whom were new to treatment, 1,981 who re-entered treatment and 7,224 who were in treatment throughout the period of the study. The population included in the study received 48,902 treatment episodes, a treatment episode being defined as a specific treatment intervention. The study also examined the treatment combinations provided based on the predominant treatment methodology being used. 1,053 clients were placed in a therapeutic community with 56.2% having no other treatment intervention. Clients new to treatment and placed in a TC were most likely to receive a methadone detoxification treatment followed by support and assistance and counselling. Clients returning to treatment and placed in a TC were least likely to receive another intervention but around 18% received support and assistance and 11% methadone detoxification. By contrast, clients in treatment throughout the study and placed in a TC had a greater likelihood of receiving methadone maintenance (11.3%), psychotherapy (8.5%) and/or support and assistance (21%).

There were substantial differences in the average length of completed treatment/treatment ended by mutual agreement between Regions, with an average length of 122 days in the Province of Trento up to 917 days in Sardinia and an average length of treatment of 553 days (18.4 months) for Italy as a whole. The data also suggests that new clients and clients returning to treatment remained in a therapeutic community for a substantially shorter time than clients who were in treatment throughout the study. It also showed that clients who received no other intervention than the therapeutic community programme were more likely to leave treatment prematurely.

The Parsec Association published the report from its mapping of services for women drug dependents with children during the year. It noted that treatment was still primarily focused on male drug users and that this seemed to deter women drug users from entering or continuing in treatment. In total in Italy it identified 80 services for female drug users, around half of which were provided by private or religious organisations and with 64% based in the northern, 27% in the central and 9% in the southern Regions. This pattern of provision does reflect the difference in the male to female ratio of drug dependents in treatment between the different geographical areas and lends some support to the view that specific service provision impacts on the level of service uptake. In terms of the programmes available, data was only available for 55 services. There were 8 centres for women drug users, 29 for women drug users and their children, 7 for women drug users with children which also accepted non-drug dependent women, 7 residential assessment centres and 4 communities which accepted women drug users with children as residents. The project also focused on the specific needs of pregnant women drug users and prepared a protocol for the treatment of this client group. The protocol drew on international literature but also on experience and best practice identified within Italy.

#### **5.4 Medically assisted treatment**

In Italy medically assisted treatment is provided almost exclusively by staff attached to the public drug treatment services. It is uncommon for any other doctors to be involved directly in drug treatment and only in Trieste has there been a system where general medical practitioners play a significant role in drug treatment.

In 2003 there were 160,611 drug dependents registered with the Ser.T. of whom 33,628 were clients entering into treatment during the year and 126,983 were clients who were already in treatment at the start of the year. Of this total population, 23,231 were placed in

socio-rehabilitative services (primarily drug free oriented) and 28,144 were temporary clients of the reporting Ser.T. The total number of drug dependents in direct treatment with the Ser.T. in 2003 was, therefore, 139,380.

The data currently collected nationally does not provide a distinction between the treatment provided to clients entering treatment during the year and those already in treatment at the start of the year. It is only possible, therefore, to provide information on the overall pattern of treatment within the Ser.T. Additional data is available from the VEdeTTE study. At the time of writing TDI data was only available from two northern Regions and cannot be considered representative of Ser.T. based treatment nationally.

In recent years there has been a continuing reduction in the number of people receiving methadone treatment in the Ser.T. (Fig.15). Until 2001, whilst the number of people receiving short term (less than 1 month) methadone had been falling and the number receiving medium term methadone (1 – 6 months) had been stable, the number receiving long term (over 6 months) methadone had been rising. Since 2001 the number of people receiving long term methadone has been falling and in 2003 the percentage of clients of the Ser.T. receiving a medically assisted treatment with methadone fell to 53% from a high of 56.5% in 2000. Of those receiving methadone based treatment, 64.7% were in methadone maintenance, with 22.6% receiving medium term and 12.7% short term methadone. These percentages have barely changed since 2001. The general move towards longer term methadone prescribing and away from short and medium term methadone reduction treatment was largely completed by then. Where in 1998 only 54.1 % of those receiving methadone treatment were on a long term regime, with 21.1% on a short term and 24.8% on a medium term regime, the corresponding percentages for 2001 were 64.7%, 13% and 22.3%.

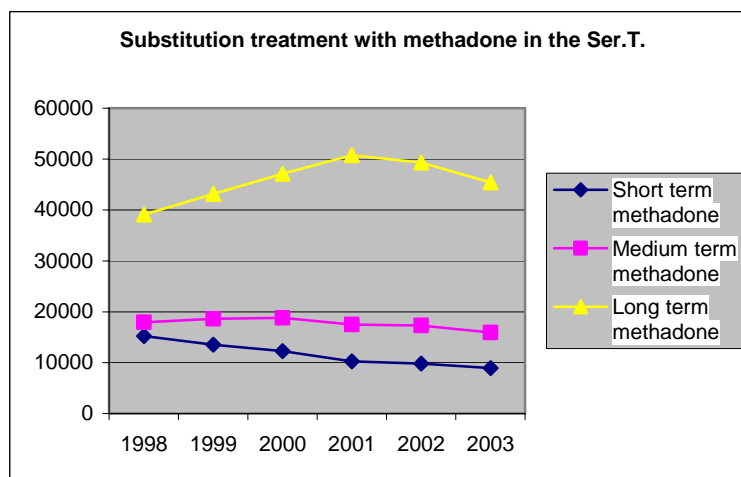


Figure 15

Source: Ministry of Health

If the data is examined by geographical area, the northern Regions, which have the largest number of clients, also have the largest percentage of clients receiving methadone maintenance whilst the central Regions have higher percentages receiving short and medium term methadone treatment.

Treatment with buprenorphine is the subject of one of the key issues and will not be discussed fully in this section. There is some data available on this treatment methodology and statistical information has only recently become available. In 2003 7,113 people were reported as receiving buprenorphine, a 41% increase over 2002. It is not entirely clear whether this represents a real increase in the number of people being treated with buprenorphine or improved reporting by the Ser.T. The latter may be a partial explanation because the average number of clients per reporting Ser.T. in buprenorphine treatment has risen annually from 20 in 2000 to 51 in 2003 and the percentage of all clients receiving this treatment in the reporting Ser.T. has also risen from 6% in 2000 to 15.1% in 2003.

In total 85,307 clients treated at the Ser.T. received a medically assisted intervention. In addition to methadone and buprenorphine, the most commonly used drugs were naltrexone and clonidine, with 2,390 and 1,631 clients respectively receiving treatment with these drugs. There has, however, been a substantial reduction in the use of these substances in the treatment of drug dependence with use of naltrexone falling by 70.5%

and of clonidine by 67.6% since 1998. In the same period, the use of other drugs has risen slightly, from 10,792 to 11,059 (2.5%). The reduction in the use of naltrexone and clonidine may reflect an increase in the use of buprenorphine where there is increasing international evidence of its efficacy and a reduction in the use of the other drugs where there is less convincing evidence of their value in treatment of dependence.

The general reduction in the percentage of clients receiving a medically assisted intervention may also reflect changes in the primary drug of clients presenting for treatment. Where data is available <sup>[1]</sup>, new clients of the Ser.T. are less likely to use opiates as their primary drug and more likely to be primary cocaine or cannabis users. At the same time the percentage of clients with primary opiate use has been falling for several years whilst primary cocaine and cannabis use has been increasing. These factors together are likely to have had an impact on the number of people receiving such treatment. It is, however, worth noting that there has been an increase in the number of people receiving other medical treatments, for instance in relation to psychiatric comorbidity.

Data from the VEdeTTE study (Jarre et al 2003) casts further light on treatment within the Ser.T. For the purposes of the study it has considered methadone use in terms of methadone maintenance and methadone reduction programmes. As previously described, the study identified treatment episodes by type of treatment and type of client and then the treatments associated with the prevalent treatment typology. A total of 11,381 clients were identified where the primary treatment methodology was methadone maintenance. Almost half (49.5%) had no other treatment intervention than methadone, with 50% of new clients and over 52% of returning clients in receipt of methadone maintenance receiving no other intervention. Where other treatment interventions were provided, the most prevalent for all client groups was support and assistance followed by counselling. Around 7% received another pharmaceutical intervention, 7% psychotherapy and around 4% were placed in a residential community. The average length of treatment with methadone maintenance was just under one year with about 10% of people in treatment for over 2 years. As might be expected, clients new to treatment or re-entering treatment during the study period had lower length of treatment. The study identified two serious issues in terms of medically assisted treatment within Italy. First, it found that drop out from treatment was more likely where no other treatment interventions were associated with the methadone treatment. This was important when just under half of those in methadone maintenance were receiving no other intervention. Second, it found that the daily dose of methadone was substantially lower than the effective dose identified by the meta analysis undertaken by the Cochrane Group. This had identified 60 mg per day as the minimum effective level to maintain clients in treatment and have an impact on other drug use. The average daily dose in Italy ranged from 34 mg in Calabria to 60 mg in Liguria with an average for Italy as a whole of 42.7 mg per day. There was an association between low levels of methadone maintenance prescribing and treatment drop out with the lowest dose levels being associated with the client deciding for him/herself not to continue in treatment. By contrast with methadone maintenance treatment, only 30.5% of the 943 people receiving naltrexone had no other treatment intervention provided. Just under 45% received support and assistance and around 18% received psychotherapy. The different focus of methadone maintenance and naltrexone treatment was evident. Where almost one in five was assisted either to plan or look for work or to retain their employment in naltrexone treatment these approaches did not feature in methadone maintenance treatment. The general implication from these findings is that methadone maintenance treatment in Italy has been focused on achieving stability and retaining the client in treatment whilst other medically assisted treatments have been concerned with cessation of drug use and avoidance of social exclusion. However, even with the limited goals for methadone maintenance the daily dose has been insufficient with a consequent high premature drop out rate.

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<sup>[1]</sup> Comparative information on primary drug use for all clients of the Ser.T. and new clients of the Ser.T. is only available for 5 Regions and 1 Autonomous Province

In addition to the VEdeTTE Study, there has also been a major national research project on quality within the Ser.T. Data from this project was presented at a conference held in Bologna in January 2004. The research was carried out by emme&erre, Padova, contracted by the Emilia Romagna Region as the lead Region for the research. The part of the project concerned with evaluation of quality in the Ser.T. was carried out between 1998 and 2000 and involved 16 Regions, 126 staff of the Ser.T., 25 representatives from the Regions and 49 from private social organisations. To collect data, information and consensus 112 seminars were held at the Regional and 7 at the national level. The part concerned with training staff responsible for the quality system was carried out between 2002 and 2003 and trained 270 Ser.T. staff at foundation level and 35 at advanced level.

The data collected came from 283 Ser.T., around half of all the Ser.T. in Italy. It measured a number of quality parameters including the adequacy of the premises, staffing, training, treatment procedures, treatment planning and monitoring and evaluation of outcomes. While around 75% of the Ser.T. have adequate premises, only 57% had adequate hygienic facilities and only 42% met the building safety requirements of the law. In terms of staffing, less than one quarter of the Ser.T. were staffed as proposed in the Ministerial Decree 444 of the Minister of Health but 32% of staff had training in advance of their basic qualification. Around 28% of services had an admissions procedure and one quarter an individual treatment planning procedure, with 21% having a monitoring and outcome evaluation procedure. Looking at admissions procedure as an example, whilst 93% of the responding Ser.T. said there was a standard procedure, only 53% had a written procedure and only 25% had a detailed procedure which described the responsibilities of the person making the admission.

At the same conference in Bologna Astolfo (2004) presented information on the experience of evaluation in some Emilia Romagna Ser.T. The research considered admissions to treatment in 1998 and 1999 and found that the number of Ser.T. using the instruments developed by emme&erre rose from 74% to 86%, with 32% of all admissions being administered the first 'outcome' questionnaire in 1998 and 35% in 1999. In terms of programme completion, 49% of primary heroin dependents completed, 69% of primary cocaine dependents and 76% of primary cannabis dependents. A number of outcomes were identified by comparing the situation on admission into treatment and the situation 6 months later. For quality of life measures – energy, social isolation, sleep, mobility, unhappiness, there were clear improvements, with the exception of unhappiness, where there was a slight increase. In terms of substance misuse the percentage of people being abstinent for at least one week from heroin use rose substantially and rose slightly for those using psycho pharmaceutical products. For ecstasy and amphetamine use there was virtually no change whilst for cocaine and cannabis use the percentage abstinent for at least one week declined. There was a significant improvement in terms of alcohol use. This data suggests that whilst there was an overall improvement in quality of life, at the time of the study the Ser.T. were much better placed to work with heroin dependents but had more limited capacity to work with those dependent on stimulants or substances where there was no specific medically assisted treatment available.

Macchia et al (2004) have reported on a study of non-opiate dependents brought into contact with treatment services. The study was in the context of a national project on new synthetic drugs undertaken by the National Health Institute (ISS) and involved all Regions and two representative organisations for private social services, CNCA and FICT. In total some 206 Ser.T. and 14 private social services contributed forms for the study accounting for 1,911 clients. Of these 1,389 (72.7%) were new to treatment.

For both new (72%) and already known (69.1%) clients cocaine was the most common primary drug followed by ecstasy (20.3% and 17.8% respectively). Dependency was most commonly associated with cocaine and use of psycho-pharmaceuticals, problematic use with ketamin, ecstasy, LSD and amphetamines and occasional or non-dependent use was associated with ecstasy, LSD and amphetamine. The treatment provided for this client population was related both to the assessment of treatment need, but also to the source of referral. For those whose drug use was assessed as occasional/non-dependent, referral was predominantly from the Prefecture, almost certainly as a result of being found in

unlawful possession of a controlled drug. The main interventions were urine control followed by meetings with a psychologist and socio-educational support. For dependent or problematic use self-referral or referral by the family was most likely and whilst meetings with a psychologist were the main intervention, medical and pharmacological treatments were also much more common, as were psychiatric interventions. The average length of treatment was 318 days. When examined for new and known clients the average treatment time was 313 and 555 days respectively. The shortest treatment time was for clients referred by the Prefecture and the longest for those identified as dependent users. Finally, the study reported on outcome. 52.3% of all clients referred were still in treatment. Not surprisingly, dependent users were most likely to be still in treatment (63.2%) followed by problem users (52.7%) and then occasional/non-problem users (35.2%). Agreed conclusion of treatment occurred for just under 40% of occasional users but for less than 10% of dependent users. Problematic, but non-dependent users were the most likely to abandon treatment or be lost to treatment which confirms previous observations about the difficulty of retaining this population in treatment. A useful document offering guidelines for medically assisted treatment has been published. The Italian Society for the Study of Drug Dependence (SITD) published the report of a consensus panel on clinical principles for the use of methadone (AA.VV. 2002). This dealt with selection of patients, the objectives, methodology and practice, identification of client selection priorities, treatment control and retention in treatment for the optimal time. The statement was developed by a distinguished panel drawn from throughout Italy and has been widely welcomed by treatment professionals in the Ser.T.

Overall, the two major studies on treatment and quality in the Ser.T. have provided valuable information but have also identified important limitations. These have provided the basis for identifying national and regional priorities and have informed the development of the National Drugs Plan.

## 6 Health correlates and consequences

### 6.1 Overview

There have been continued reductions in the number of deaths recorded as a result of drug misuse, specifically drug overdose and in the percentage of clients testing positive for HIV or hepatitis infection. Data on other drug-related health correlates is limited although there is some historical data from Emilia Romagna on calls to the ambulance service for drug-related emergencies, some data from Liguria on hospital admissions and some data on road accidents where drugs were a factor.

The number of direct drug-related deaths has continued to fall, maintaining the almost continuous downward trend since 1996. The number of female deaths has not fallen as greatly as male deaths and in 2003 there was a slight increase in female direct drug-related deaths. Retrospective studies of deaths amongst drug users and drug dependents show a range of causes of death. Whilst in the 1970s and 1980s drug overdose was the main cause of death, by the 1990s AIDS was the prime cause of death. One study concerned with deaths amongst people referred for unlawful possession of a controlled drug also showed that traumatic deaths, including road accidents, were a specific risk for cannabis users.

### 6.2 Drug-related deaths and mortality of drug users

The number of direct drug-related deaths in Italy fell again in 2003 and is now at the lowest level for many years. Figure 16 shows the trend in recorded drug related deaths since 1993. Although the overall number of deaths fell, there was an increase in the number of female deaths and in deaths amongst the 15 – 19 age group.

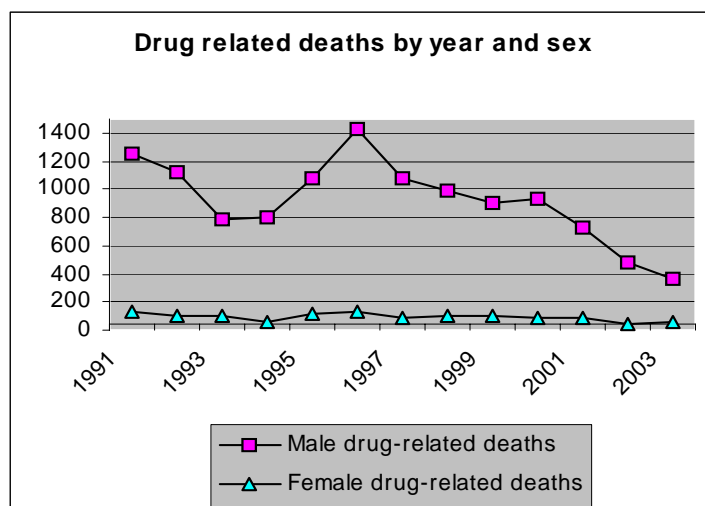


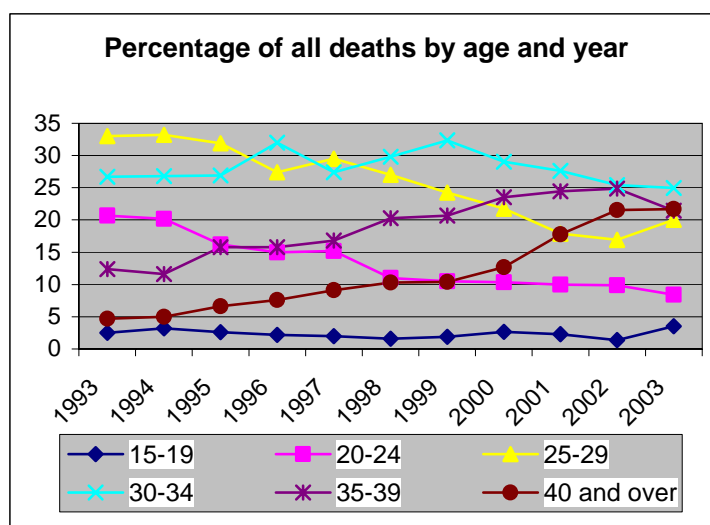
Figure 16

Source: Ministry of the Interior, DCSA



When the data is considered by age group, the percentage of all deaths coming from the 15 – 19 age group (3.5%) is the highest it has been (Fig. 17) and there has been an increase in the percentage of all deaths coming from the 25 – 29 age group from 16.9% in 2002 to 20% in 2003.

An examination of the data by sex and age group shows that whilst the number of male drug related deaths has fallen for all age groups for females it has increased for all age groups. This is seen even more clearly when the percentage of all deaths by sex and age group is considered (Figs. 18 & 19). For males the trend has been for a decreasing percentage of deaths amongst the younger age groups, an increasing percentage of deaths amongst



those aged 40 or over and after a slow increase in deaths amongst the 30-39 male population there has been a fall in recent years.

For females the picture is much less clear. Whilst direct drug-related deaths amongst females still represent a relatively small percentage of all direct drug-related deaths the trend has been upwards. In 1995 female deaths accounted for 8.9% of all deaths but this had risen to 14% by 2003. Like male deaths, an increasing percentage of deaths has come from those over 40 and there has been an upward trend in deaths amongst the 30-39 age group. However, there has been a sharp increase in the percentage of all deaths coming from the younger female age groups.

There are no ready explanations for this development. There has been a small increase in the male to female ratio of drug dependents in contact with drug services but there is no correlation between the male to female treatment ratio and the male to female death ratio. Some Regions with an above average percentage of females in treatment, also had an above average percentage of female

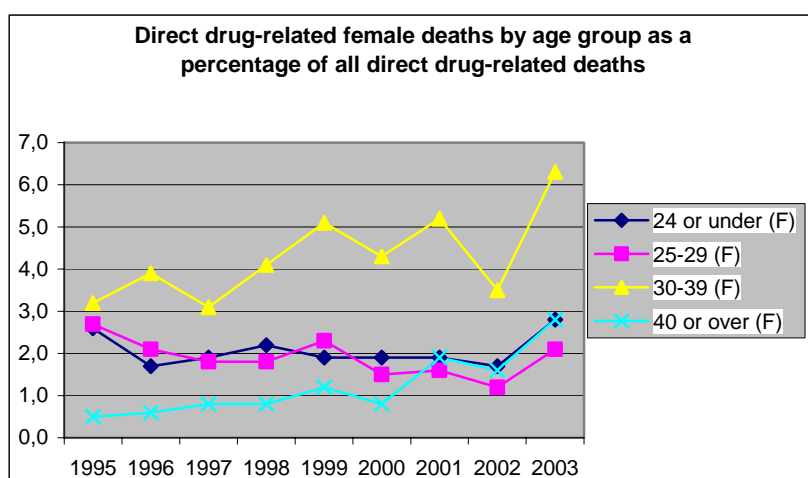
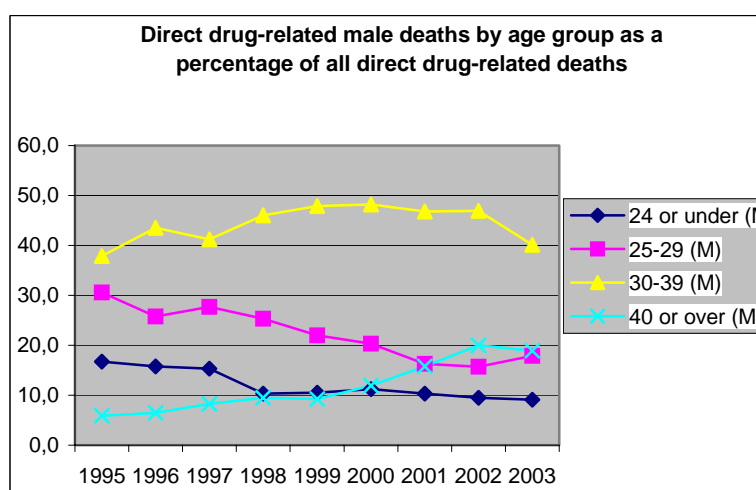


Figure 19

Source: Ministry of the Interior, DCSA

deaths whilst some Regions with a below average percentage of females in treatment also had a below average percentage of female deaths. It is possible, therefore, that some specific local circumstances were a factor.

A second trend which can be noticed is that while the percentage of all drug-related deaths in the north east and north west Regions has been falling since 1999, the percentage of all deaths coming from the central and southern Regions has been rising. Again, there is no certain explanation for this trend. However, in 2003 only three of the eight northern Regions was the percentage of clients known to the Ser.T and using heroin as their primary drug higher than the national average, and two of these Regions have small populations. By contrast, five of the ten southern Regions had percentages higher than the national average, as did one of the two island Regions. This might suggest that in the southern and island Regions heroin continues to be the main drug of misuse with a consequent increased likelihood of accidental overdose.

When direct drug-related deaths are examined as a rate per 10,000 population in the 15 – 64 age range, Liguria and Umbria, which have the highest estimated incidence rates for initiation into heroin use in 2003 also had higher than average death rates for males. However, Lazio, Campania and Marche with medium level incidence rates for initiation into heroin use also had much higher rates of death per 10,000 population than the national rate (0.19 per 10,000 pop.). Lazio, Marche and Liguria also had higher female death rates than the national rate (0.03 per 10,000 pop.). Taken together, the national and regional data suggests that the concentration of direct drug-related deaths is associated with high incidence of heroin use in some Regions and with a preponderance of problem heroin use over other drug use in some other Regions.

Three studies on drug-related deaths and mortality of drug users have been published in the Emilia Romagna Region. Ciccolallo et al (2003) have reported on deaths amongst injecting drug users in the Region. 4,260 drug dependents were enrolled in the study, 906 in the period 1979 – 1995 from the Ferrara Province, 2,518 in the period 1975 – 1995 from the Modena Province and 836 in the period 1978 – 1995 from the Piacenza Province. Follow-up was undertaken based on the situation at the end of December 1995 using the mortality records of the local health authority and ICD9 classification to identify cause of death. Table 14 shows the results of the study. 641 deaths were identified, 521 (81.3%) males and 120 (18.7%) female. The most common cause of death identified was AIDS, accounting for 194 (37.2%) of male and 57 (47.5%) of female deaths. The next most common cause of death was overdose (32.4% male and 23.3% female) followed by traumatism and blood poisoning (15.4% male and 13.3% female). Using standardised mortality rates based on three periods (1975 – 1988, 1989 – 1992 and 1992 – 1995) overdose deaths rose from 3.9 to 10.3 and then fell to 5.9 but for AIDS related deaths there was a very substantial increase in the last period, rising from 4.3 in the second period to 26.5 in the third period. This is perhaps not surprising as high levels of HIV infection amongst injecting drug users occurred in the second half of the 1980s and the first half of the 1990s and a sharp increase in deaths could be anticipated in the 1990s. The study found that mortality rates were higher amongst those who began drug use before the age of 20 compared to those who started aged 20 or older and that mortality rates were higher from all causes for those in the study cohort compared to the general population.

	Male		Female	
	N°	%	N°	%
AIDS	194	37	57	48
Overdose	169	32	28	23
Trauma/blood poisoning	80	15	16	13
All other causes	78	15	19	16
Total	521	100	120	100

Table 14

Pavarin and Prata (2004) have reported on mortality risk amongst injecting drug users in Bologna. The study was based on a retrospective cohort of drug users who had attended the Ser.T. between 1975 and 1998 and consisted on 1,965 people (1,503 male, 462 female). This study found that the overall mortality rate decreased from the early 1990s. Mortality rates as a result of AIDS fell from 1995 whilst mortality rates for drug overdose declined until 1995 and then started to rise again. The study, as with the study referred to

above, found higher mortality rates from all causes among injecting drug users compared to the general population. Mortality rates for women injecting drug users were especially high at 42.78 where for men the standard mortality rate was 21.08. In both males and females life expectation 15 years after initiating drug treatment with the Ser.T. was 44%. There was a significant correlation between higher time lags between starting drug use and entering treatment, poor educational attainment and unemployment. Other than drug overdose and AIDS, the main causes of death for men were traffic accidents, cirrhosis, suicide and tumours whilst for women it was suicide.

Pavarin (2004) has also reported on mortality amongst those referred to the N.O.T. of the Bologna Prefecture having been found in unlawful possession of a controlled drug. The study cohort consisted of those referred between 1990 and 2000 who at the time of the referral were resident in the province of Bologna, even if the referral was made by another Prefecture. Follow-up to ascertain the situation of the cohort was carried out between 1998 and 2000. In the period of the study 5,946 people were referred of whom 92% were male and 91% Italian. 20% of referrals were resident in Bologna, 32% in other parts of the Province, 39% were resident outside the Province and 5% were homeless. Around 75% of referrals were for 'soft' drugs, with 66% for cannabis, 15% for heroin, 5% for cocaine and 1% for ecstasy. The average age was 25.4 with those referred for 'soft' drugs having an average age of 24 and those referred for 'hard' drugs having an average age of 28. The final cohort for the study consisted of 2,908 people, representing 48.9% of all referrals to the N.O.T. in the 10 year period. During the period of the study there were 91 deaths, of which 82 were male and 9 female with 24 deaths amongst those reported for possession of 'soft' drugs, 59 amongst those reported for possession of 'hard' drugs and 8 where the drug was not indicated. 46% of male deaths were from drug overdose, 21% from AIDS and 22% from traumatic injury. In this latter group, 12% were as a result of a road accident, 5% from suicide and 1% from homicide. Amongst the female population 44% of deaths were from overdose, 33% from AIDS and 22% from traumatism (11% of the latter being suicide). Of the 24 deaths amongst 'soft' drug users, 25% were from overdose, 17% from AIDS and 50% from traumatic incidents (33% traffic accidents, 8% suicide and 4% homicide). Amongst the 61 deaths of 'hard' drug users overdose accounted for 52% of male and 43% of female deaths and AIDS accounted for 27% of male and 29% of female deaths. Overall, 3.1% of the total cohort died with 10.5% of heroin users dying compared to 1.5% of cocaine and 1.1% of cannabis users. In numerical terms, however, where there were 51 deaths of heroin users there were 24 deaths of cannabis users. This is an important finding in that whilst heroin users had the highest risk of direct drug-related death (overdose, AIDS), cannabis users had a high risk of traumatic death, especially from traffic accident. This finding was confirmed when compared with mortality amongst the general population. Those found in unlawful possession of a controlled drug had a higher mortality rate, especially amongst female referrals.

Together these three studies have confirmed that injecting drug users have a significantly higher mortality rate than the general population and that women injecting drug users had a particularly higher mortality rate. The studies thus seem to confirm the trends noted in the national data on direct drug-related deaths as reported to the special register maintained by the Central Drugs Directorate of the Ministry of the Interior. They also confirm the data of the National Health Institute which maintains data on AIDS related deaths. This has shown that deaths from AIDS arising from injecting drug use have been falling since the second half of the 1990s. The study of clients referred to the N.O.T. has provided important data on deaths amongst drug users who are not normally clients of the Ser.T. In particular, this study seems to confirm the potentially significant role played by cannabis in fatal traffic accidents and suggest that cannabis might be a contributory factor in other, non-fatal, traffic accidents. This is discussed further in section 6.5

### **6.3 Drug-related infectious diseases**

The number of drug users in contact with the Ser.T. who were recorded as HIV positive or infected with the Hepatitis B or Hepatitis C virus continued to fall in 2003. However, the number of people tested also continued to fall and it is difficult to determine whether the

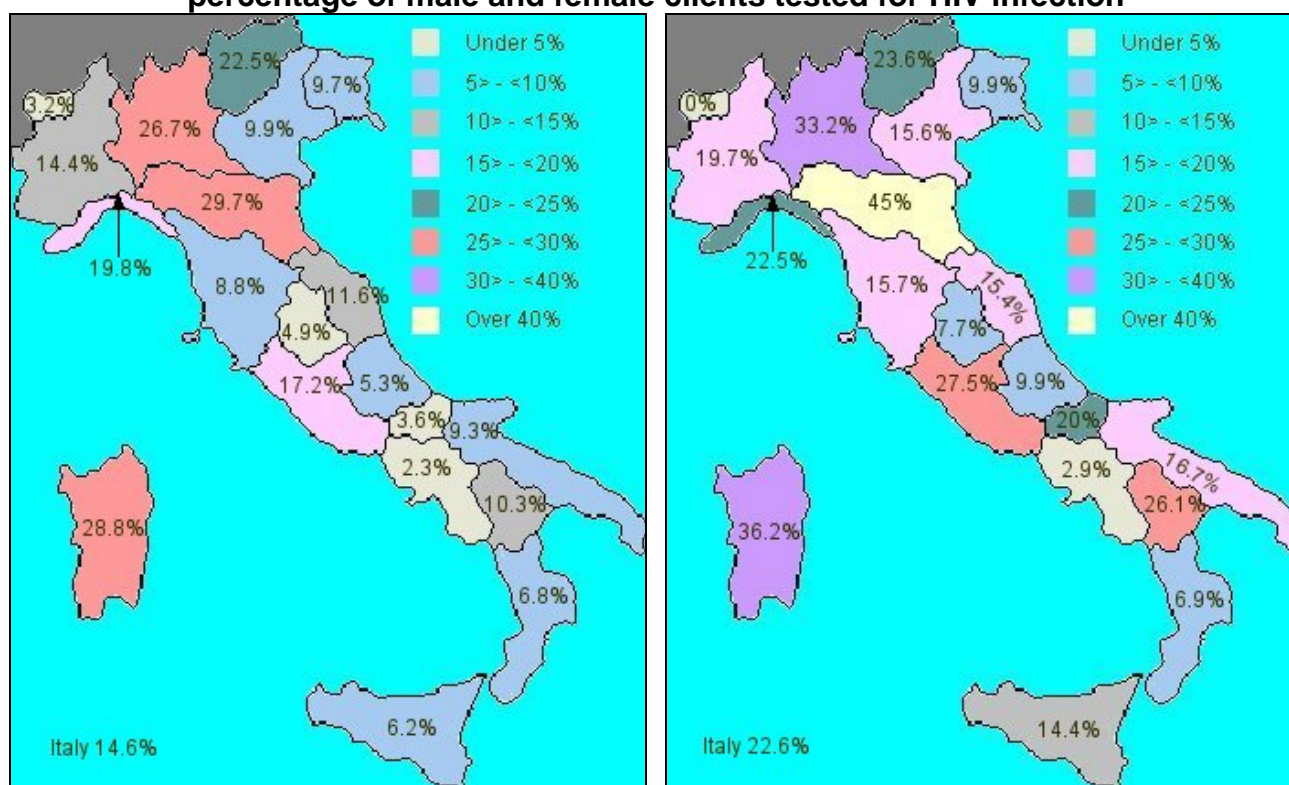
fall is an accurate reflection of the true level of infection within the drug using population in contact with the Ser.T.

In 2003 of 160,611 people in contact with the Ser.T., 84,230 (52%) were reported as using their primary drug by injection. This is a further reduction in the percentage of clients reported as drug injectors but some caution must be expressed about the accuracy of the data. The year by year variations in the same Region and significant under-reporting from some Regions suggest that this data may be of limited utility.

The percentage of clients tested for HIV infection at 44% is the same level as for 2002. Nationally there has been a slight fall in the percentage of clients tested who were positive for HIV infection, falling from 14.8% to 14.2%. However, this decrease masks substantial variations between Regions and between male and female clients (Maps 5 – 12). In almost all Regions female drug users were much more likely to test HIV positive than male drug users and several Regions showed an increase in the percentage of female drug users testing positive. Emilia Romagna, Sardegna, Liguria and Lombardia all had infection rates amongst female drug users in excess of 30% compared to the national infection rate of 21.2% and, with the exception of Lombardia, all registered an increase in the rate of infection over 2002. For male drug users there was an increase in HIV infection in several Regions but these increases were smaller. The same Regions had higher than averages infection rates amongst males as for female infection.

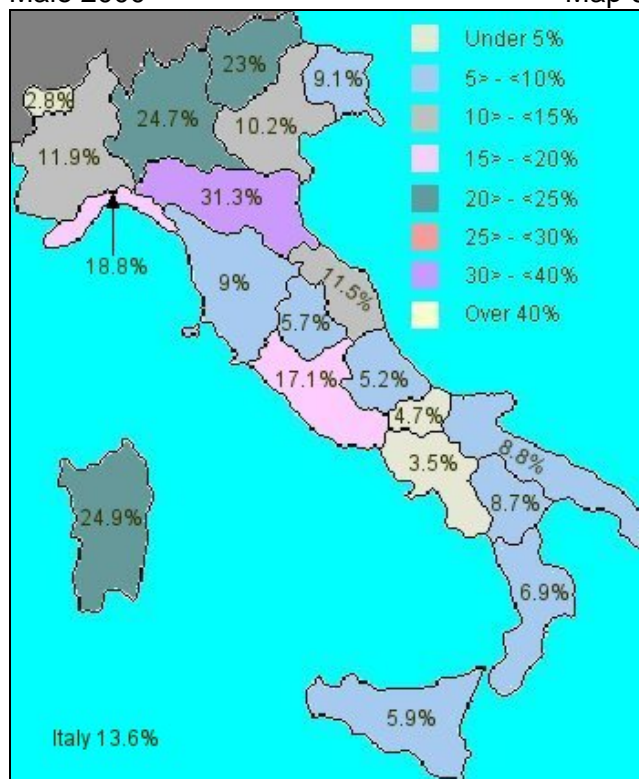
It is not clear how best to interpret this data. The high level of female infection may reflect distinct or interlinked patterns. First, female drug users may have been introduced to drug injecting by male partners and may have continued to share injecting drug equipment with their partner. Second, they may be less comfortable injecting themselves and a friend may assist them, using shared equipment. Third, it is possible that female drug users are more likely to earn money to buy drugs through prostitution where male drug users are more likely to be involved in drug law or other offences to raise money. This might result in female drug users being more open to infection from unsafe sexual practices as well as from injecting drug use. At present there is insufficient data to confirm any of these hypothesis although reports from street services seem to suggest that there is a much higher level of prostitution amongst female drug users than amongst male drug users.

#### Male and female clients of the Ser.T. testing positive for HIV infection as a percentage of male and female clients tested for HIV infection

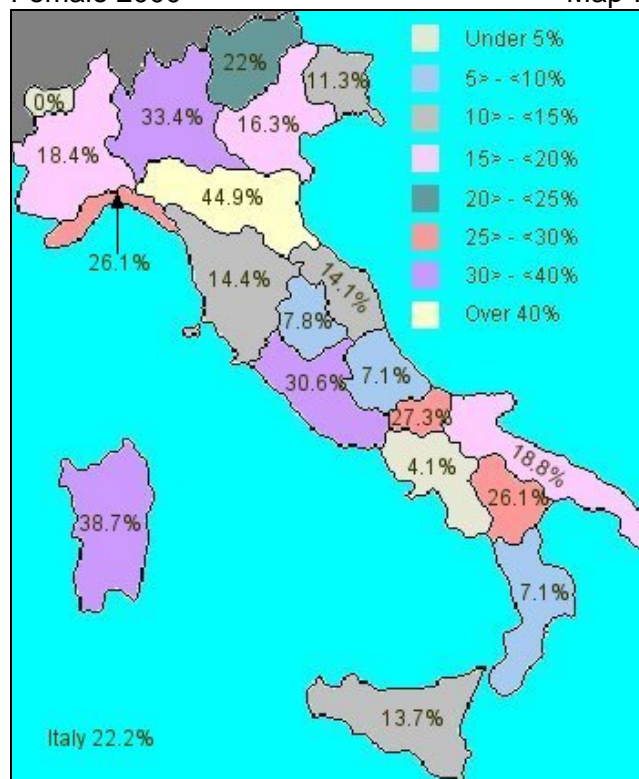




Male 2000

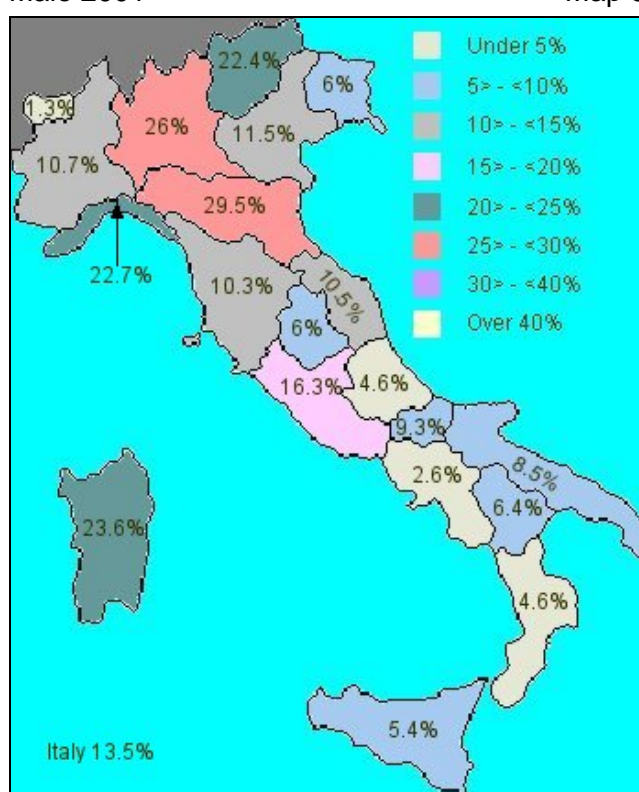


Map 6 Female 2000

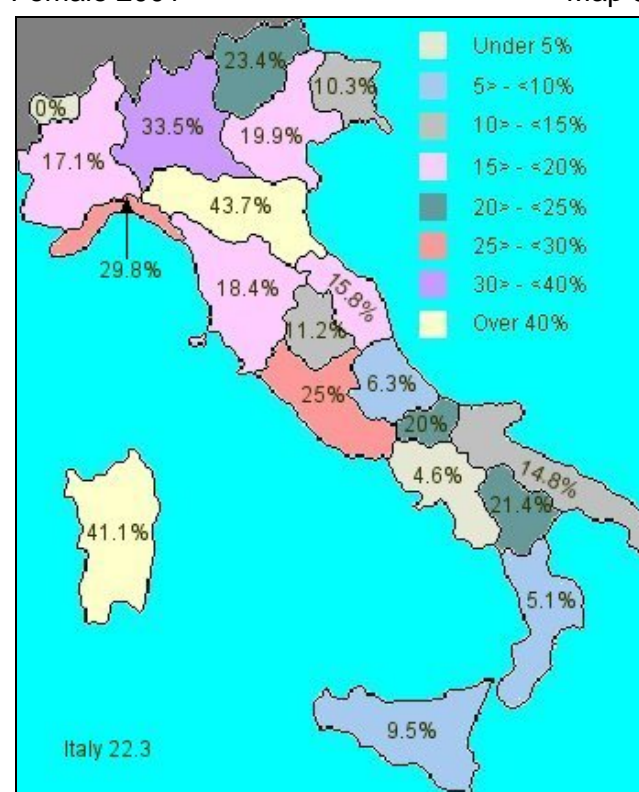


Map 7

Male 2001

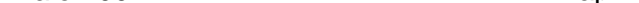


Map 8 Female 2001

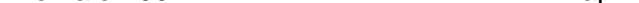


Map 9

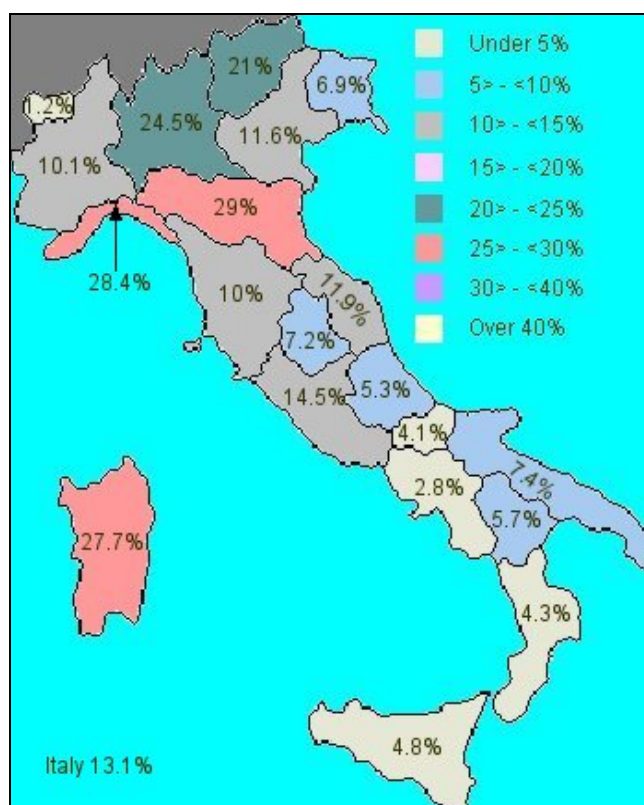
Male 2002



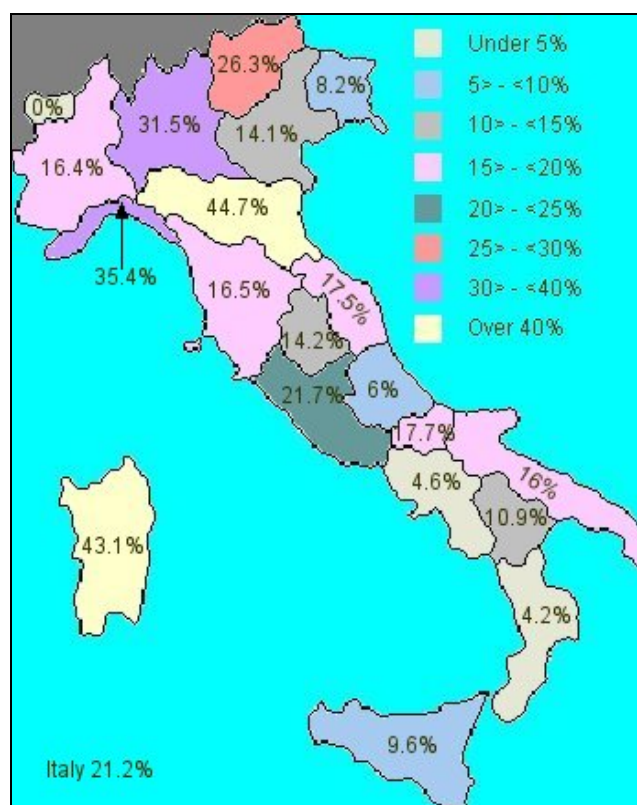
Map 10 Female 2002



Map 11



Male 2003

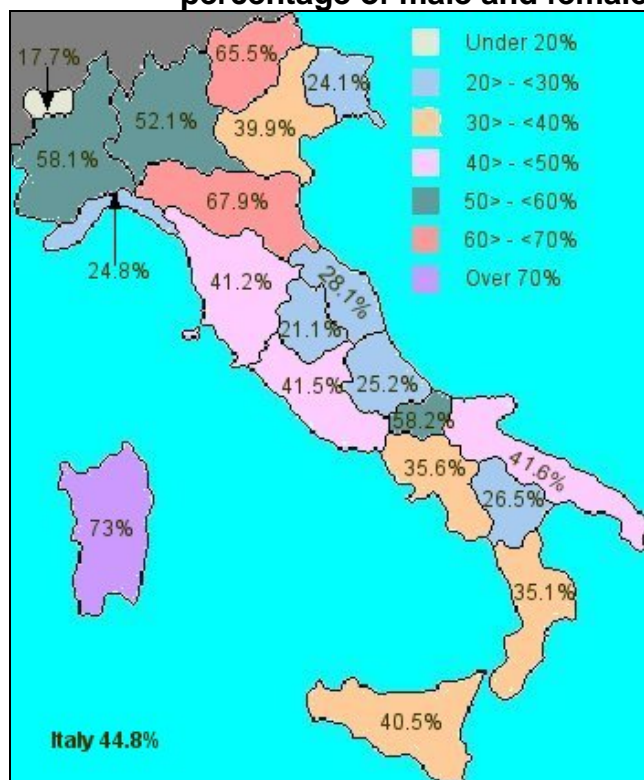


Female 2003

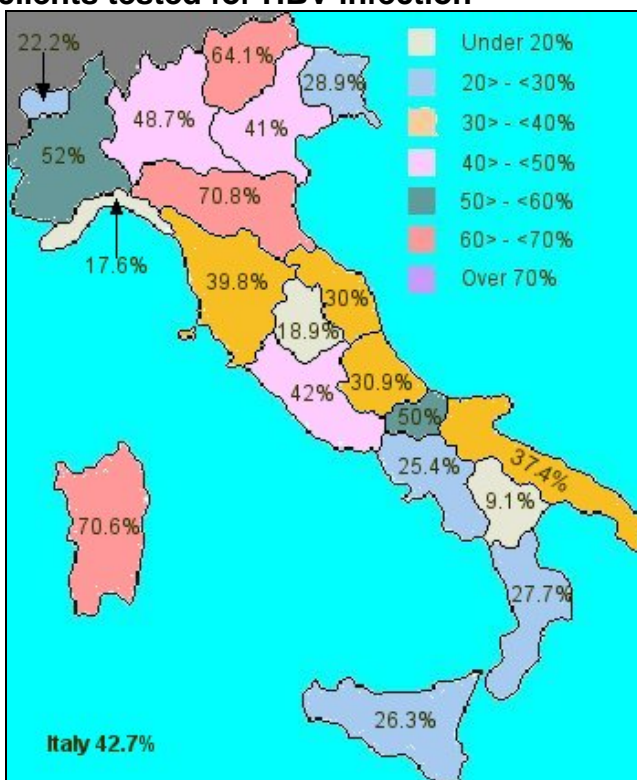
Map 13

For infection with Hepatitis B virus around 39% of all clients of the Ser.T. were tested. This is slightly less than in 2002 and continues the gradual reduction in the percentage of clients tested for the presence of any drug-related infectious disease. The reported level of infection nationally has remained largely stable for the last three years and unlike HIV

### Male and female clients of the Ser.T. testing positive for HBV infection as a percentage of male and female clients tested for HBV infection



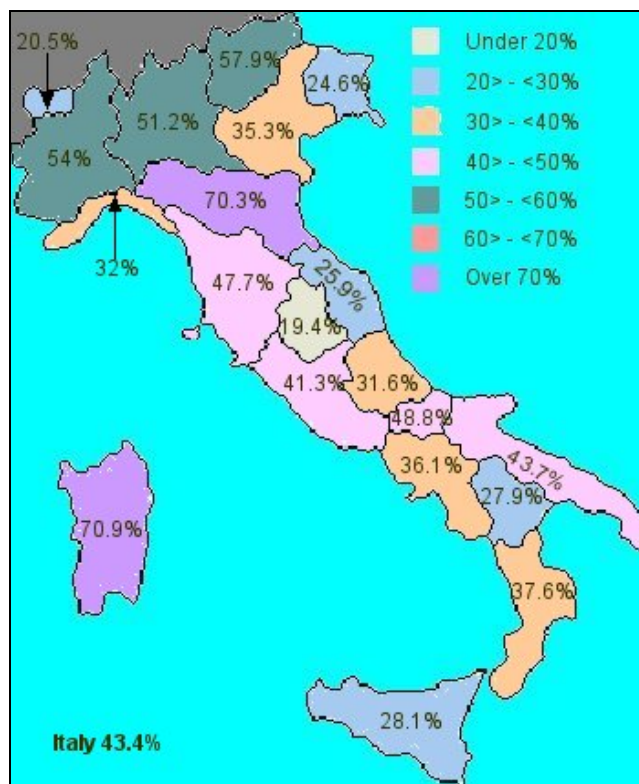
Male 2000



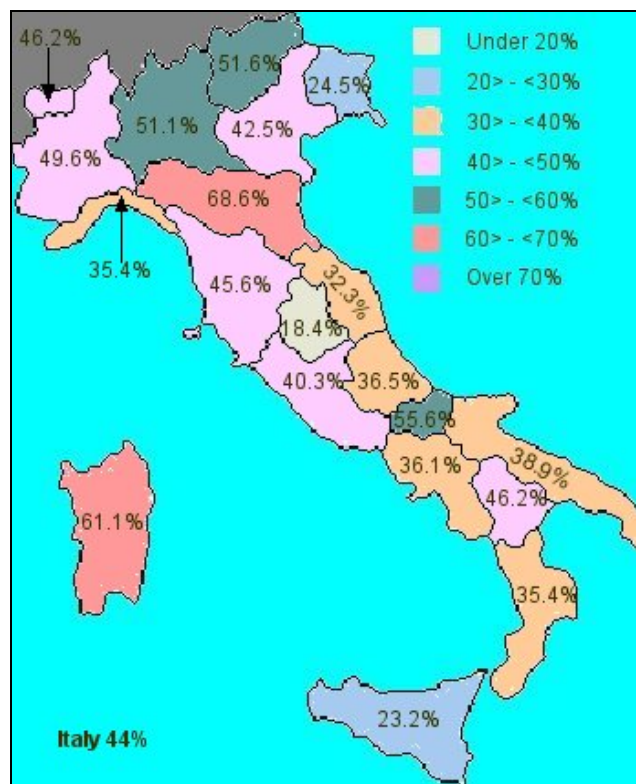
Female 2000

Map 15

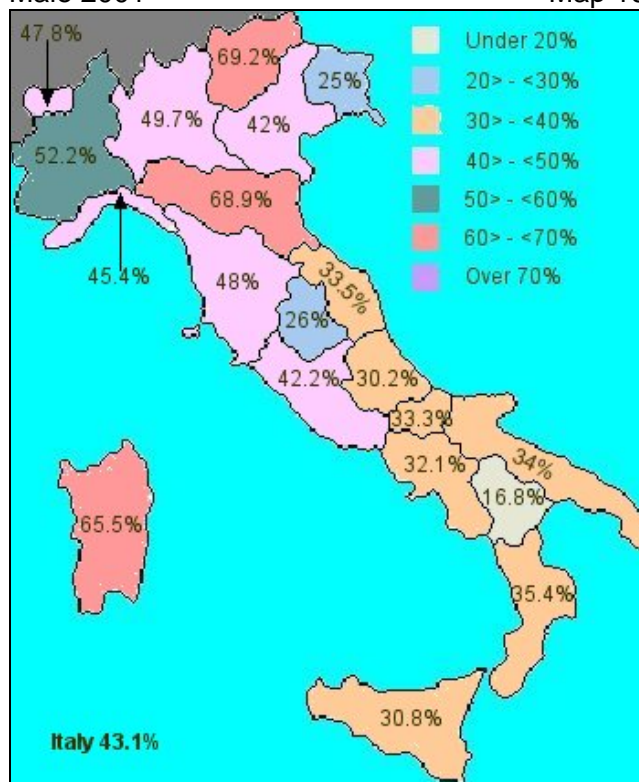




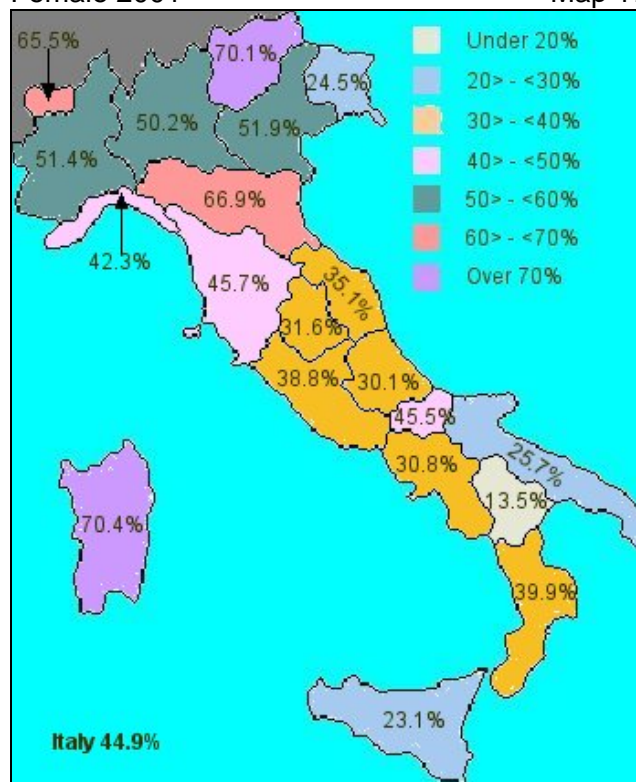
Map 16



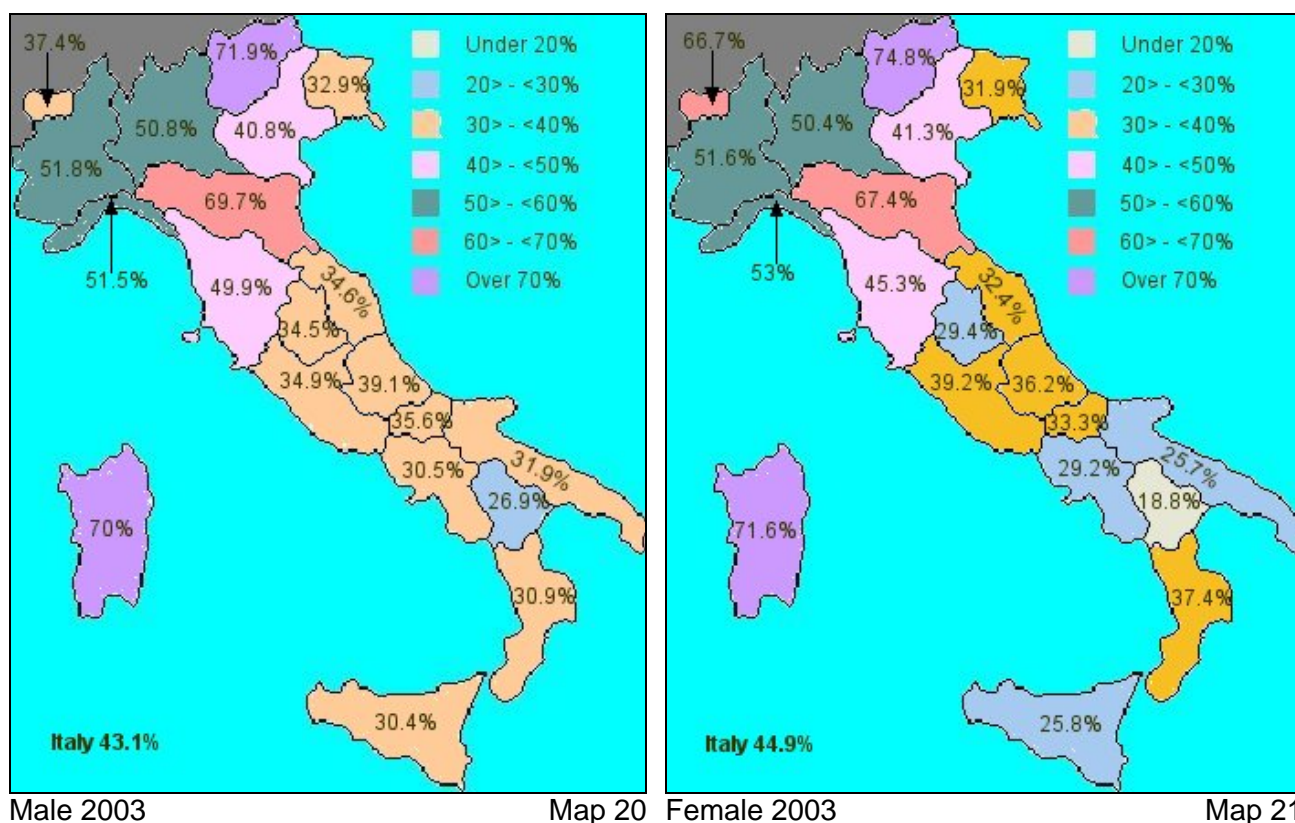
Map 17



Map 18



Map 19

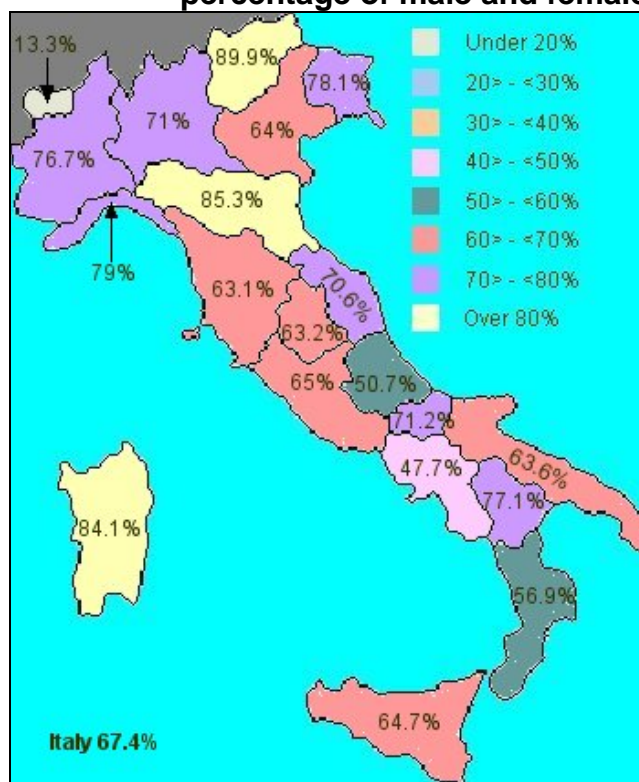


infection rates, the percentage of male and female clients are roughly similar. However, whilst for males since 1998 the trend has been for a slight decrease in infection rates, for females, after an initial decline to 2000, the trend has been slightly upward (Maps 13 – 20). Within this overall national picture there are substantial Regional variations with Valle d'Aosta, Liguria, Trentino and Umbria showing particularly large increases in the rate of female infection between 2000 and 2003, some Regions having high levels of infection (Emilia Romagna, Piemonte and Lombardia) and other Regions having a stable or declining rate of female HBV infection. For male HBV infection the percentage of clients of the Ser.T. testing positive has remained stable but as for female clients, there are considerable variations and different regional patterns. Several Regions (Valle d'Aosta, Liguria, Umbria) have shown large increases between 2000 and 2003 whilst others have remained with a high level of infection (Emilia Romagna, Trentino, Sardegna) and others have shown a stable or downward trend.

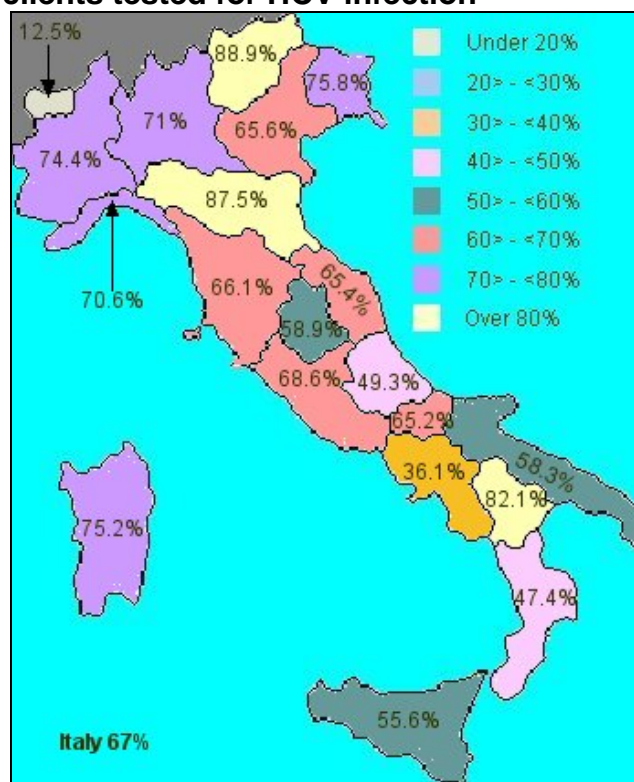
The trends in HCV infection seem broadly to mirror those for HBV infection. Some 49% of all clients of the Ser.T. were tested in 2003, a further decrease from previous years. Broadly speaking the Regions which showed increases over the 2000 – 2003 period for HIV and HBV infection have also shown increases for HCV infection and there has been a slower decline in infection rates nationally amongst female drug users than amongst male drug users. However, compared to the other two drug-related infections in all but three Regions over half of all clients tested are infected and in several Regions 4 out of every 5 clients tested are infected.



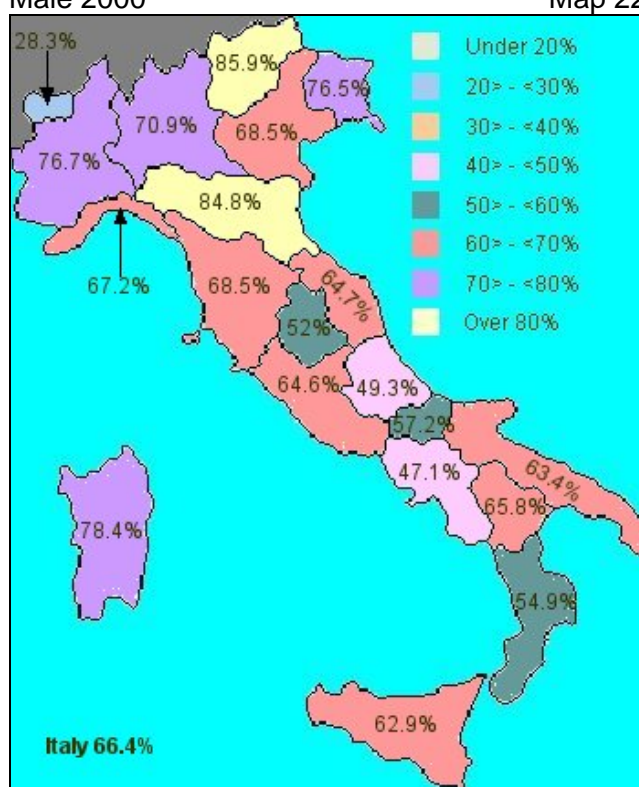
**Male and female clients of the Ser.T. testing positive for HCV infection as a percentage of male and female clients tested for HCV infection**



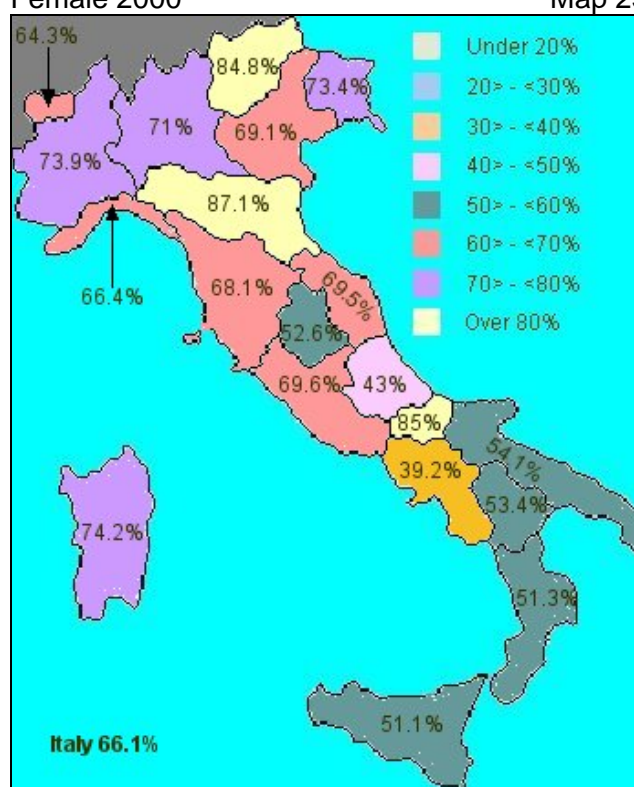
Map 22



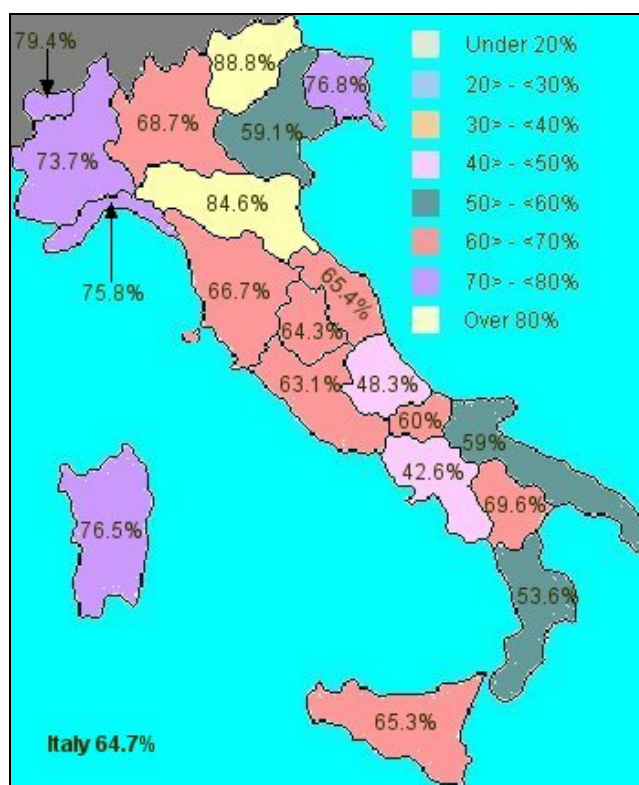
Map 23



Map 24

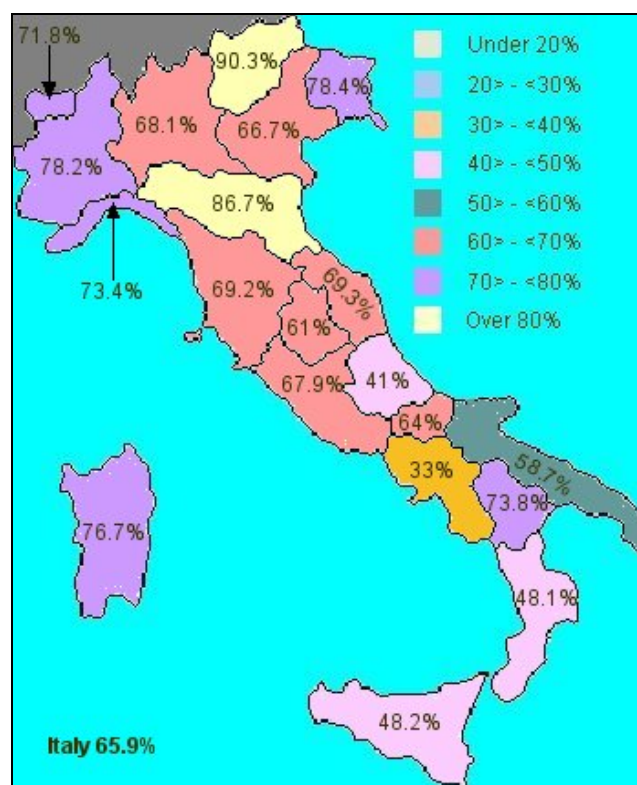


Map 25



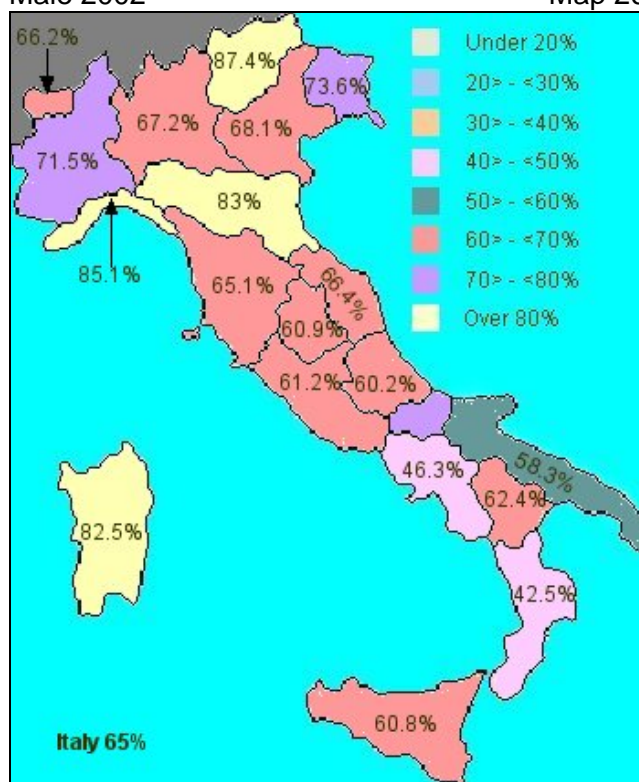
Male 2002

Map 26



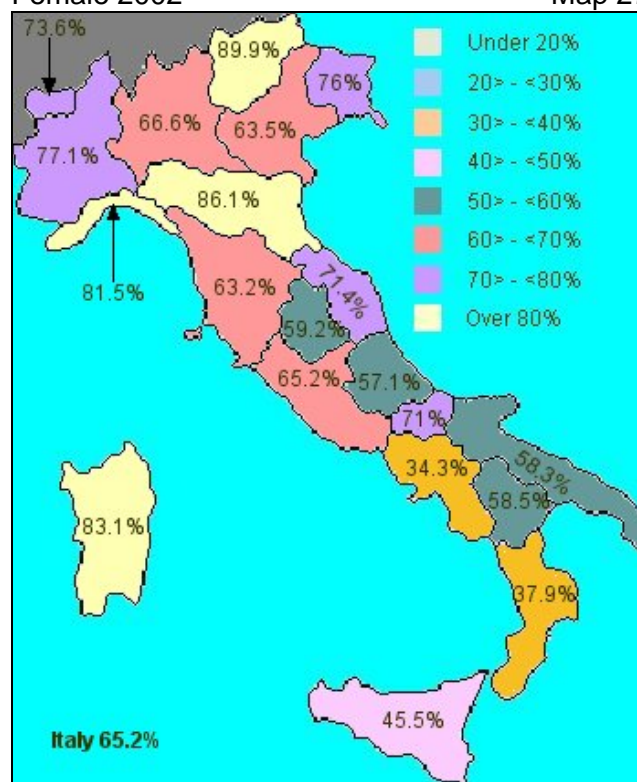
Female 2002

Map 27



Male 2003

Map 28



Female 2003

Map 29

For all three drug-related infections new clients in the year had much lower infection rates than clients who were in treatment at the start of the year. For HIV infection, whilst 4.7% of new clients tested positive, 16.1% of existing clients tested positive in 2003. This pattern was broadly similar for each of the last four years. However, in both new and existing clients females were much more likely to be infected than males. A similar pattern can be found with HBV infection where existing clients were twice as likely to be infected as new clients (47% and 23.9% respectively in 2003), however infection rates between males and females were similar. This pattern was repeated for HCV infection



with 36.7% of new and 69.9% of existing clients testing positive in 2003 and little difference between male and female infection rates. This pattern may suggest that new patients are less engaged in high risk behaviours, especially drug injecting. However, at present it is not possible to provide data on injecting behaviour for any Region and those Regions which are compiling TDI data do not include data on mode of use, past or current.

One explanation for the trends which have been observed may relate to testing policy and that testing of clients has been more focused on those with higher risk behaviours. This hypothesis may provide a partial explanation but as the variability in the percentage of injecting clients tested is so considerable between Regions and year by year this does not seem to be sufficient. A second factor, as has already been mentioned, may be that female drug users have greater double exposure risk from injecting drug use and unsafe sexual practices. A third element may be that clients who have been previously tested and found positive have not been re-tested and included in the annual statistical returns. This could result in the data being a mix of both prevalence and incidence data with no clear cut-off point between the two. In the circumstances the National Department for Drug Policy is currently considering a small validation study to gain greater understanding of reporting practices and to identify ways of further improving annual reporting and the data from which policy priorities are identified.

#### **6.4 Psychiatric co-morbidity**

The first major national conference on the topic was held in Sardinia in October 2002. 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, treatment of psychiatric co-morbidity has a high priority in the National Drugs Plan, and there has been development of a number of specific services around the country.

As reported last year, 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.

## 6.5 Other drug-related health correlates and consequences

There are some studies on calls to the ambulance service for drug-related emergencies and some data on admissions to hospital. There has also been increasing attention focused on the relationship between drug use and traffic accidents.

As has been noted earlier, there is emerging evidence of the role of drug use in fatal and non-fatal traffic accidents. The National Health Institute (ISS) has reported on a study which found that one in five of those who used drugs occasionally were involved in an accident or injured. Out of 1,738 people in the study, 346 had experienced a traumatic incident. 38% had a traffic accident and 22.6% required medical treatment as a result. Almost 15% had attempted suicide, 21.2% had been involved in a fight, 7.2% had had a fall and 30.4% had been unwell. The data from the two studies on deaths amongst drug users (Pavarin 2004, Pavarin and Prata 2004) both show that accidents were an important factor and strongly suggest that there will have been much higher levels of non-fatal injury arising from drug misuse.

The Bologna Observatory in its 2004 report (Pavarin (ed) 2004) has reported on calls to the ambulance service and has data from 1998 (Tab. 15). This shows clearly that there has been a continuing diminution in the number of drug-related emergency

	Bologna Province					
	1998	1999	2000	2001	2002	2003
All emergency calls	72583	72566	76123	77394	78025	80589
Calls for drug users (*)	3044	2294	1992	954	617	616
No. of drug users involved(**)	1129	957	873	330	254	180
Calls to drug users as a % of all calls	4.2	3.2	2.6	1.2	0.8	0.8
Individuals identified as a % of all calls to drug users	37.1	41.7	43.8	34.6	41.2	29.2

Table 15

Source: Bologna Metropolitan Observatory

\* 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

calls although the overall number of calls to the ambulance service has continued to increase annually. Information is also available on the critical level of the call – red for critical and yellow for less critical. Although the data does not cover all calls the trend seen over the years for calls to be to less critical situations has continued. In 2003 39.8% calls were code yellow and 49% code red compared to 30.4% code yellow and 69.6% code red in 1998. It is worth noting that whilst the mean age of those attended by the ambulance service was 30.4 for males and 30.3 for females, the mean age of non-Italians was almost two years younger than the mean age for Italians (30.8 and 28.9 respectively). This might suggest that there is some difficulty in bringing non-Italian drug dependents into treatment which could include both cultural and immigration status factors. It is also noteworthy that the male to female ratio for this sub-group is much lower than the male to female ratio for the treatment population. It is not possible at present to offer a specific interpretation for this situation but it may reflect a higher proportion of female than male drug users outside treatment, drug using patterns and possibly higher reliance on drug using partners for female drug users with increased chance of accidental overdose.

The Liguria Regional Observatory has reported on hospital admissions and discharges related to drug dependents (Curzio et al 2004). Between 1997 and 2003 there were 3,939 admissions where there was a principal diagnosis related to drug dependence, with the number of admissions falling annually from a high of 844 in 1997 to a low of 247 in 2003. In 2003 the main drug-related diagnosis was drug dependence (54.3%) followed by drug misuse without dependence (23.1%), drug psychosis (19%) and other diagnoses (3.6%).



This represented a definite change from 1997 with drug dependence as the main diagnosis falling from 69.2% whilst drug psychosis rose from 11.7% and non-dependent drug misuse rose from 12%. The change seems clearly to reflect the change in terms of drug use with a reduction in the percentage of admissions involving opiates from 79.3% to 73.5% and an increase in cocaine related admissions (2.3% in 1997 to 9.5% in 2003) and in other stimulant and hallucinogen related admissions (1.5% and 1.6% respectively in 1997 up to 2% and 2% respectively in 2003). The implication from this data is that the gradual change in patterns of drug misuse may be resulting in a reduction in drug-related deaths and non-fatal overdoses but may also be leading towards different health problems. This seems to be confirmed when data on the primary, secondary and tertiary diagnosis is examined. Where in 1997 a higher percentage of primary diagnoses were concerned with physical health issues, by 2003 there were increasing primary diagnoses concerned with mental health. Nevertheless, physical ill health remains the most common basis for hospital admission, including hepatitis, HIV infection, other infectious or parasitic illnesses, circulation problems, accidents and the like. The data thus confirms the substantial health related problems arising from drug misuse and dependence and strongly suggests that there are important health correlates associated with both dependent and non-dependent drug misuse.

## **7 Responses to health correlates and consequences**

### **7.1 Overview**

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.

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 are currently operating. These have commonly been financed for three year periods and future changes will depend on policy and priority changes at both national and local levels.

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.

### **7.2 Prevention of drug-related deaths**

As reported in previous years, many outreach services make Narcan available to drug users and on occasions provide a direct intervention in response to a drug-related emergency. Many services provide leaflets or cards on how to respond to a drug overdose and how to use Narcan. There is little evidence of specific training on how to avoid or deal with an overdose, but again this appears to be part of the wider training provided for drug workers. What does seem to be the case is that 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.

### **7.3 Prevention and treatment of drug-related infectious diseases**

There is little published data on the prevention and treatment of drug-related infectious diseases. There is no nationally collected data on prevention of drug-related infections and no Regional data has come to light. There is some data from local or individual projects but it is not possible to say how representative these are of the Regional or national situation. The annual statistical reporting to the Ministry of Health on clients registered with the Ser.T. includes data on the number of clients vaccinated against hepatitis. The National Institute of Health (ISS) maintains data on the treatment of people with AIDS and is able to provide information on treatment broken down into various categories. Additionally, as has been previously reported, vaccination against hepatitis infection at age 12 is compulsory in Italy and has been so since 1990. It is likely, therefore, that an increasing percentage of those registered with the Ser.T. will have already been vaccinated. Depending on the test used, it is possible that some of the data on hepatitis infection may reflect vaccination rather than exposure to active hepatitis virus.

The main interventions aimed at the prevention of drug-related infectious diseases consist of outreach to make contact with drug users who are not in contact with a treatment service or who are engaged in high risk to infection behaviour, efforts to bring drug dependents into treatment and to retain them in treatment and the provision of information, sterile equipment and condoms to those who are not yet prepared to enter treatment or move away from drug injection. The second strand has been vaccination against hepatitis.

Outreach projects and low threshold services exist throughout Italy, although they are more preponderant in urban and northern Regions than in the southern Regions. The 'unità di strada' is a well established part of the overall pattern of drug services. Over time, the facilities provided through outreach have extended and may now include advice and counselling, referral to a range of different services, including drug treatment, provision of information leaflets and guides to avoid or deal with drug-related emergencies, provision and/or exchange of sterile injection equipment, guidance on safer sex and the provision of condoms. More recently in some areas there has been the introduction of mobile methadone treatment services aimed at reaching clients who are not presently able to use the fixed site service. The low threshold services aim to provide ready access to core services as well as offering a range of social facilities. Their primary role has been to provide an entry point into the treatment system and to support clients move forward into the general drug treatment system.

Information from the Milan harm reduction project, from Bologna and from Rome may serve to illustrate the general pattern of activities.

The Milan harm reduction project has provided data for the period May 1999 to December 2000. In that period it made 6,155 contacts, of which 4,903 were drug dependents – 4,130 male and 773 female. In the same period the project distributed 211,381 and collected 89,869 syringes, provided 176,927 ampoules of sterile water, 359,220 antiseptic swabs, 53,391 condoms, 800 doses of naloxone and 1,408 other medications. Additionally, the project directly intervened at 39 overdoses. The Bologna low threshold services met 401 individuals of whom 256 were drug dependent during 2003. There were a total 20,084 contacts of which 13,458 were with drug dependents. In 2003 the service exchanged 58,474 syringes and distributed 5,197 condoms. In addition it had 1,121 support sessions with drug dependents and referred 494 people to other services. In Rome, Magliana 80 has reported on the work of its street unit between May 2000 and July 2004. In this period it made 59,836 contacts of which 2,110 were first contacts and 49,856 were with males and 5,714 with females. 210,487 syringes were distributed and 105,059 collected, an exchange rate of 49.9%. 76,109 ampoules of distilled water were provided and 24,866 condoms along with 14,811 packages of information. Some 1,451 referrals were made to various specialist services.

This data seems broadly representative of the pattern of harm reduction or street services provided in the more urbanised areas of Italy. Whilst there has been a focus on harm reduction through needle and syringe exchange or distribution, the work of these services

has tended to be broader and to include a range of measures including referral to other specialist facilities, crisis intervention, referral to temporary housing and the provision of basic necessities including washing and laundry facilities, a canteen, etc.

At the national level there has been a small increase over the last four years in the percentage of clients of the Ser.T. who have been vaccinated against hepatitis

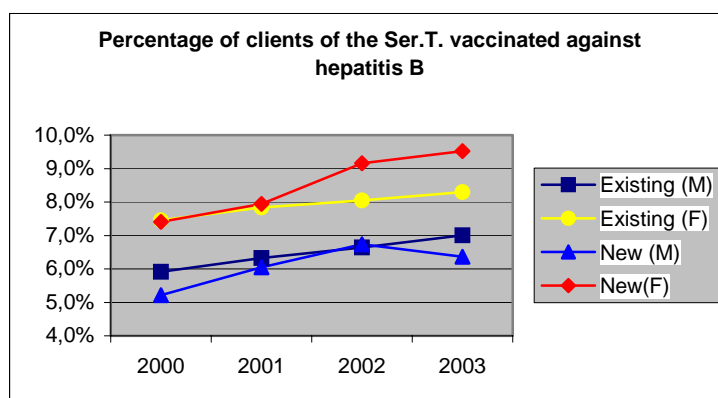


Figure 20

Source: Ministry of Health

(Fig. 20). As can be seen from this, the major increase has been in the vaccination of female drug dependents new to treatment during the year. In general female drug dependents are more likely to be vaccinated than male drug dependents, but there is no published information on how clinical decisions about whom to vaccinate are made or what factors are taken into consideration. Given that the rates of infection between male and female drug dependents are virtually the same, it seems likely that other factors will have guided the decision. These may include a wish to protect the women and her children (now or in the future) from infection and the possibility that female drug users are a greater risk to infection from both unsafe sex and drug injection and are deemed as having a greater need for vaccination. However, as there have been no studies published on the use of hepatitis vaccination for drug dependents and there are no specific guidelines published, it is not possible to provide any more specific explanation.

In terms of treatment for drug-related infections, only data relating to treatment for HIV infection/AIDS is available. 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. At the time of writing data relating to 2003 was not available, but at present there is no reason to suppose that drug dependents do not continue to represent the majority of those receiving this type of therapy in Italy.

#### 7.4 Interventions related to psychiatric co-morbidity

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 CeLS 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.

Clerici and Carrà (2003) conducted a study of 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.

Many Regions have reported that projects concerned with co-morbidity have been initiated but virtually none has given specific information on the interventions provided. The Autonomous Province of Bolzano has reported briefly (Welfare 2004) on a research project involving 54 clients of the Ser.T. who had been in substitution treatment for at least two years. In this population it found that 35.3% had anxiety, 29.7% mood and 7.4% psychotic disturbance. They concluded that there was a need to carry out a thorough diagnostic evaluation of clients in order that the most appropriate treatments might be provided to this specific client group. The Emilia Romagna Region has reported (Welfare 2004) on two services for clients with dual diagnosis, one in Rimini and one in Piacenza. The Rimini service is jointly operated by a private social organisation and the local health authority and provides a diagnostic and brief intervention centre. The service is multi-professional with staff from both the drug and mental health sectors and is designed for

people who need long term observation whilst abstinent. During 2003 40 people were admitted to the service and 38 were referred on to other services – residential or outpatient drug treatment or mental health services. The Paicenza service is operated by Comunità Emmaus and provides 15 residential places for clients with co-morbidity. The programme lasts for around a year and a half with three phases: observation and diagnosis; treatment; re-entry. The community staff are supported by two psychiatrists and a psychologist for the diagnostic phase and by two psychologists in the treatment phase for work with both the clients and their families. Two psychiatrists provide supervision for the programme. In 2003 around two-thirds of clients were referred by health authorities in the Region with the remainder being referred from other Regions, primarily Lombardia. 30 clients were admitted in 2003.

#### **7.5 Interventions related to other health correlates and consequences**

There has been no data published on interventions other related to other health correlates and consequences. As has already been indicated in this report, the pattern of service development has been for outreach or street services and low threshold services to have a broad remit which includes reduction of drug-related overdoses and their severity, reduction in risk behaviour in relation to both health and social consequences of drug misuse and dependence and the provision of a range of interventions and referrals aimed at limiting harm and bringing the drug misuser into treatment.

### **8 Social correlates and consequences**

#### **8.1 Overview**

Available data show that drug dependents are much more likely to be unemployed or casually employed and to be homeless or insecurely housed than non-drug users. The rate of rejected unemployed and homeless addicted individuals is decreasing, being addictive behaviour spreading in all social and professional categories. From the profile of problem drug users provided by both treatment and non-treatment sources they seem also to have lower educational qualifications. Lower educational status may be indicative of early problems and incomplete schooling. There are some indications that clients entering treatment during the year and those outside the treatment system have greater social and health problems than those in treatment, strongly suggesting that entry into and retention in treatment is an effective intervention to prevent or reduce social exclusion.

#### **8.2 Social exclusion**

There has been no new data on social exclusion associated with drug misuse or dependence reported during the year. It is a priority of the National Drugs Plan to give a high level of support to re-integration into the social and employment environments. However, this is a post treatment response designed to achieve affective and lasting re-integration.

As has been reported under the 'Prevention' section, considerable resources and a large number of projects have been made available aimed at supporting families and preventing the development of problems likely to result in social exclusion. These have included the provision of support teachers working with the individual pupil and his/her family to continue education and seek ways of returning to normal education, support to parents, alternative education projects, etc.

It is clear from the data arising from both treatment and non-treatment sources that a significant proportion of drug dependents are already in a state of social exclusion in that they are unemployed or in temporary employment, have no settled accommodation or are homeless and have health and legal problems which limit their capacity to participate in the wider social environment. It is also clear that there is a significant proportion of drug misusers or dependents who are at present employed and have satisfactory accommodation but who are at increasing risk of social exclusion as a consequence of their drug misuse.

#### **8.3 Drug-related crime**

There is substantial data available on offences against the drug laws but little data available on offences committed by drug misusers. The Ministry of the Interior has



information on drug law offences. The Ministry of Justice has information on proceedings against drug misusers and on the types of offence committed by young offenders assessed as drug misusers on entry into the juvenile justice system.

There has been a continuing reduction in the number of people referred to the Prefect for the administrative offence of unlawful possession of a controlled drug. In 2003 21,360 people were referred, a reduction of 34% compared to the previous year and of 43% compared to 2000. Of those referred, 17,397 were referred for the first time and 4,233 had been referred at least once in the past. The Region with the highest number of referrals was Lombardia (2,808) followed by Toscana (2,599), Piemonte (2,473), Sicilia (1,903) and Lazio (1,628). Cannabis was the drug most commonly found, with 18,327 (85.8%) of all referrals for this drug. This was followed by cocaine, heroin, ecstasy and amphetamine. The continuing and rapid decline in referrals for unlawful possession does not reflect any of the other data available on the prevalence or incidence of drug misuse and drug dependence in Italy. The National Drugs Plan has established as one of its targets reduction of the time lag between referral to the N.O.T. of the Prefecture and the assessment and decision on what type of action to take – warning, sanction, referral for assessment/treatment, etc. This, combined with the proposed change to the drugs law to define precisely what constitutes the offence of unlawful possession of a controlled drug may make a difference in the future.

There has also been a reduction in the number of people referred to the Judicial Authority for drug law offences. In 2003 29,393 people were referred for drug law offences compared to 33,174 in 2002, an 11.4% reduction. The reduction in referrals was most noticeable for non-Italians – from 9,859 in 2002 to 8,061 in 2003 - and young offenders – from 1,381 in 2002 to 1,053 in 2003. However, a higher proportion of those referred were held in custody in 2003 compared to 2002, suggesting that either the offences were considered more serious than in the previous year or that those referred had been referred on previous occasions and were considered unsuitable for release on bail. In terms of the drugs involved, the downward trend in arrests involving heroin has continued, there was virtually no change in cocaine related referrals from 2002 although the overall trend has been upwards, there was a slight increase in referrals for amphetamine or amphetamine analogue offences and a sharp drop in cannabis arrests, although the trend has been upward in recent years. Most offences were for drug trafficking. It is not possible at present to distinguish between large scale trafficking operations and small scale user-dealer trafficking. Unfortunately it is not possible to identify how many drug law offences were committed by drug dependents and how many by non-drug dependents.

The Ministry of Justice data shows that at the end of December 2003 there were 45,191 penal proceedings in process for offences of drug trafficking involving 88,980 adults and 8,633 juveniles. During the year 13,870 proceedings were completed with 12,936 adults and 4,687 juveniles found guilty. The relatively rapid processing of cases against juveniles seems to represent lower level offences and a desire to complete proceedings rapidly with the aim of rehabilitation. This interpretation seems more likely given that a large proportion of young offenders are placed in community or treatment settings rather than prison settings.

The vast majority of those found guilty of offences against the drugs law were male (8,351 male and 650 female) with the largest proportion being in the 20 – 29 age group. This might include many of those assessed as drug dependent as this would be a prime age for drug law offences pre-entry into treatment but probably already dependent and involved in drug law offending to support their drug misuse. However, at present this is a hypothesis based on the a review of different data sets which suggest such a possibility. Without more precise examination of the data, however, no definitive view can be stated.

Data from the Juvenile Justice Service of the Ministry of Justice provides the only data available on offences committed by those assessed as drug dependent. In 2003 there were 938 drug dependent young offenders passing through the services compared to 1,100 in 2002. Of these, 667 were Italian and 271 non-Italian. Data on the main offence with which they were charged shows that for 52.2% it was a drug law offence and for

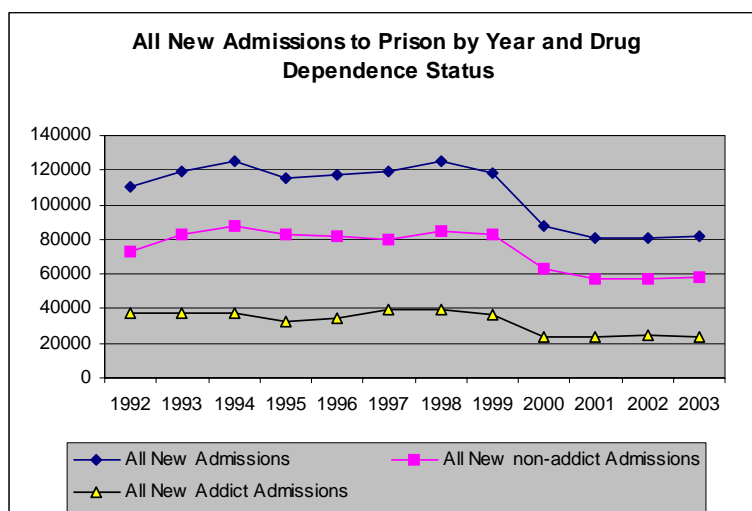


40.9% an offence of theft or robbery. 1.5% were charged with murder with a further 3.1% charged with violence or threat against the person. This data would suggest that for this group of drug misusers they were most likely to be involved in drug law offences or opportunistic offending. However, given the limited reliability of the drug dependence assessment, little further significance can be drawn from the available data.

#### 8.4 Drug use in prison

There is no specific data available in Italy on drug use in the prison setting. There is some data available on seizures of controlled drugs by the Penitentiary Police. However, as their responsibilities also include people serving sentences outside the prison, and the quantities involved are so small, it is not possible to say what this represents. It may well relate to drug use outside prison and resulting in the individual being recalled to prison to complete his/her sentence. There is information available on prisoners assessed as drug dependent on admission as well as on treatment provided to drug dependent prisoners.

In 2003 there were 81,793 new admissions into prison of whom 23,709 were assessed as drug dependent. This was a slight increase in the total of new admissions compared to 2002 but a slight decrease in the drug dependent new admissions (Fig. 21). The increase is almost entirely due to an increase in the number of non-Italian new admissions.



Of the drug dependent

Figure 21

Source: Ministry of Justice

prisoners reported as being admitted during 2003, the Ser.T. reported providing medically assisted treatment to 8,801 prisoners. These treatments included long, medium and short term methadone, naltrexone and clonidine as well as other non-substitution pharmacological interventions. It is possible that this number of treatments is greater than the number of prisoners treated as a single prisoner may have received more than one type of medically assisted treatment. It is also possible that more prisoners received assistance from the Ser.T. but that this is continued treatment on release from prison either as an alternative measure, or on bail or on completion of the sentence. Treatment would then be recorded as the last treatment or current treatment. It is not possible at present, therefore, to give more precise information about either unlawful drug use in prison or medically assisted treatment to drug dependent prisoners.

#### 8.5 Social costs

No new information on the social costs of drug misuse and drug dependence has come to light in 2003/4. The data provided in the last National Report therefore remains current. Work is progressing to gain a better understanding of the overall social costs but it is not yet possible to provide any specific detail.

### 9 Responses to social correlates and consequences

#### 9.1 Overview

Prevention of social exclusion and reintegration into the social and work environment is a priority for the National Drugs Plan and has been a priority of Government policy for a number of years. A number of legislative provisions exist aimed at avoiding social exclusion and supporting re-integration. Those concerned with avoiding early drop-out from school and alternative education have already been described under the 'Prevention' chapter. There is also specific legislation which provides for an employee identified with a

drug problem to receive treatment with a guarantee to be able to return to his/her employment on completion of treatment. The maximum allowable absence from work is 3 years. Legislation also exists to provide support and assistance to those most vulnerable to long term unemployment and to support, amongst others, drug and ex-drug dependents enter employment.

Nearly all residential treatment services and many semi-residential services provide employment training or support to enter the employment market, as do many out-patient services. Additionally, social co-operatives provide a sheltered training and employment environment in preparation for re-entry into the general employment market. Substantial resources are available for this activity through funds from the European Commission, the Ministry of Labour and Social Policy, the National Drugs Fund, the Regions, Provinces and Communes.

Prevention of drug-related crime is based on several complementary approaches. First through prevention and alternative activities within the overall drug prevention programme. Second through public security measures including improved policing and control of public areas and environmental improvements. Third through prevention of re-offending by drug misusers through referral into treatment and the use of alternative and treatment options rather than imprisonment and treatment in a secure environment where the conditions for alternative measures cannot be met. The issues of alternatives to imprisonment and public nuisance are discussed more extensively in the 'Selected Issues' section.

## **9.2 Social reintegration**

As has been reported in previous National Reports, social reintegration is considered a normal part of the treatment and rehabilitation process and a large number of projects have been financed through the National Drugs Fund for this purpose. These range from the provision of educational services, vocational training, occupational guidance and support groups and systems in the period following treatment completion.

Most Regions in Italy provide some supported or sheltered accommodation for drug dependents on completion of treatment and to aid re-integration. This may also be provided as a low threshold intervention. Moreover emergency or temporary accommodation may be provided as a means of basic care and if possible referring people into treatment.

Most residential treatment services and many outpatient services provide vocational guidance and employment training. The latter may be part of the therapeutic programme and an increasing number of services now have a commercial or semi-commercial outlet for their products. The income is then used to finance the continuing work of the service and to supplement the income from the health authority. They may also be specific projects funded from a range of different sources – local, provincial or regional authorities as well as from the European Commission. These projects normally seek to develop skills and provide a recognised qualification which will provide a basis for future employment.

The provision of employment is commonly made through social co-operatives. These are of two types: one is primarily concerned with offering sheltered employment to disadvantaged populations and they are required to employ a minimum percentage of employees from these populations; the other is primarily concerned with providing training and a form of apprenticeship to those who have been socially excluded for various reasons as a means of assisting them back into full time employment in the community. Such social co-operatives may be found throughout Italy and are an important contributor to both the social and economic health of many localities. It has been the practice for a large number of therapeutic communities to separate out the residential treatment and re-integration phases of their activities. The former is registered with the Region and has a contract with the local health authority, etc. to provide treatment, the latter is registered as a social co-operative and obtains the different benefits available for this type of service.

As has already been noted, reintegration is a high priority at the national level and also at the Regional level. As examples of developments during the reporting year the following serve to illustrate a broad pattern of provision throughout the country.

The Umbria Region, using law 68 of 1999 which provides for research, training, strategies and support measures for those most vulnerable to long term unemployment <sup>[1]</sup>, and law 104 of 1992 which provides specific measures to support, amongst others, drug dependents and ex-drug dependents enter employment, has set up an occupational support service (SAL – Servizio di accompagnamento al lavoro). The SAL is part of the Regional Social Plan and has a central team of a co-ordinator and six staff with experience in this area. The SAL has been promoted to a wide range of bodies, including the Ser.T. and on the basis of referrals prepares individual programmes based on the competencies and potential of the person and including stage, employment counselling and the like. In its first period of operation the central team had 100 clients and an annual client rate of 200 – 250 was predicted.

In the Veneto Region, responding to a call from the Regional Assessor for the identification of new ways of responding to re-integration, the Associazione Temporanea di Imprese (made up of the Agenzia Formazione Lavoro AGFOL, the society of services for the development of the Politiche Comunitarie INNImpresa, the captain of a boat and the Villa Renata TC) proposed a pilot project 'Onda di Prua' to train eight ex-drug dependents in navigation and sailing. Undertaken in the Venice Lagoon the project aimed to strengthen social competences and the capacity to live with other people away from the more protected environment of the therapeutic community as well as providing basic knowledge in navigation, boat maintenance and sailing. It also included in its planning participation in a series of more professional modules aimed at gaining more specialist skills of specific value for employment in an area where water based activities were a significant source of employment.

These provide two recent examples of the approaches taken to re-integration within Italy. Similar examples could be found throughout the country. There have been no legislative changes in the reporting year. Rather, there has been a continuing use of the range of opportunities provided by existing legislation to develop re-integration projects largely concerned with social support for a return to the family and community and employment support to re-gain financial self-sufficiency in employment with improved skills or new skills and qualifications.

### **9.3 Prevention of drug-related crime**

There have been no new developments in terms of the prevention of drug-related crime other than the proposed legislative changes and the aims and priorities of the National Drugs Plan, both of which have been described fully elsewhere in this report. Alternatives to imprisonment and public nuisance, both of which are relevant to the prevention and reduction of drug-related crime, are key topics and therefore fuller exploration of this topic has been reserved for sections 12 and 13.

## **10 Drug markets**

### **10.1 Overview**

In terms of availability, cannabis is the most widely available drug. From population surveys, both general population and specific groups, amphetamine analogues would appear to be the next most available drugs. Heroin is available throughout the country and cocaine availability is increasing particularly in northern Regions. Hallucinogenic drugs appear to have had relatively low availability although data from the Italian early warning system suggests that there may be a gradual change from stimulant to hallucinogenic drugs occurring. The supply routes have not changed substantially from those reported last year.

Data on price and purity suggests that the street price has remained stable for some time for most drugs. Data on purity for 2003 is not directly comparable with data from earlier years. However, given that this data refers to purity in small (but not street level) quantities, it suggests that heroin purity may have fallen substantially but that purity levels of other drugs have not changed to any great degree.

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<sup>[1]</sup> Such approaches are required to be developed in close co-operation with other institutional bodies and the third sector

## 10.2 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 2003, hashish was predominantly brought into the country from Morocco, Albania and Spain. Also mentioned as routes of supply in 2003 were France, Iran and Pakistan.

The situation with marijuana is somewhat different. In 2003 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 2003 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.

### 10.3 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 or 2003 is available.

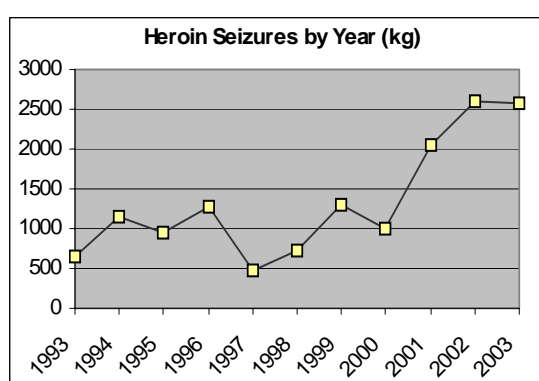


Figure 22 Source: Ministry of the Interior, DCSA

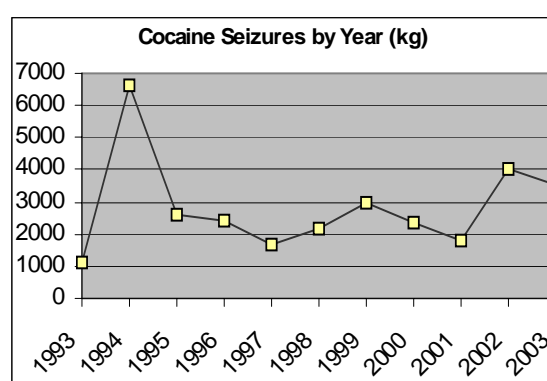


Figure 23 Source: Ministry of the Interior, DCSA

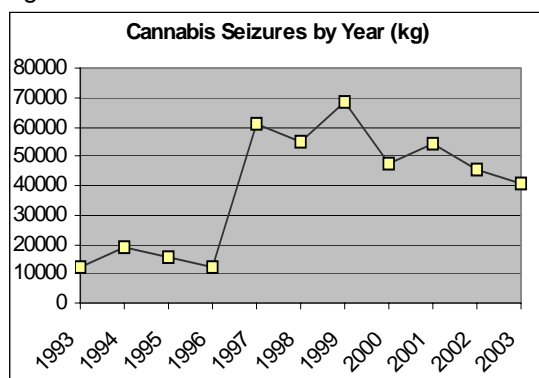


Figure 24 Source: Ministry of the Interior, DCSA

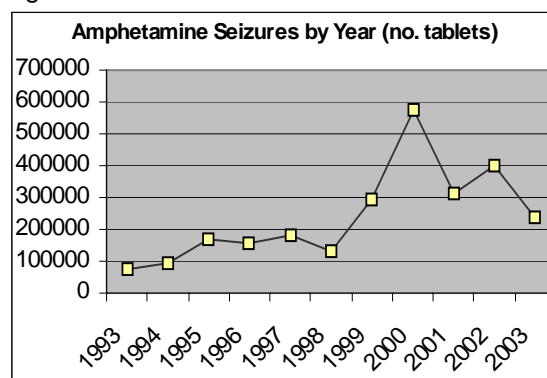


Figure 25 Source: Ministry of the Interior, DCSA

In terms of the quantity seized, there was a slight decrease in the amount of heroin sequestered (Fig.22), breaking the upward trend which can be seen from 1997. Although there have been some large seizures and a slight decrease in trafficking, there has been no obvious reduction in purity or increase in price. This would suggest that availability is still sufficient to meet demand and that seizures have not yet had an impact on overall supply. 78.2% of seizures were within Italy, 20.7% at the sea borders and 1.2% at the land and air borders. The Regions where the largest quantities were seized were Lombardia and Puglia, although in terms of the quantities seized there was a sharp fall in Lombardia and a large increase in Puglia. There were similar differences in quantities seized between 2002 and 2003 for other Regions. Whilst this may in part reflect changing trafficking routes aimed at reducing the likelihood of detection, the data also shows the potential for one or two large seizures to severely distort the overall picture and trends in drug supply and availability.



## Part B: Selected Issues

### 11 Buprenorphine, treatment, misuse and prescription practices

#### 11.1 Overview

The use of buprenorphine in the treatment of drug dependency has shown a steady increase in recent years in Italy. However, the primary drug of choice for medically assisted treatment remains methadone. The data reported by the Ser.T showed that 7.113 patients have been submitted to buprenorphine treatment during 2003. Most of these medically assisted programs with buprenorphine are long-term treatments.

#### 11.2 Treatment with buprenorphine

Data on treatment with buprenorphine has been collected through a specific reporting instrument for a number of years. This form is an additional request to the overall annual reporting requirements to the Ministry of Health placed on the Ser.T.

In many Regions there has been a very clear increase in the percentage of clients receiving this form of treatment. A very clear picture emerges of a marked increase over a four year period in the use of long term treatment (over 6 months). For 2003 the southern Regions seem to be the ones which most use this treatment approach with over 20% of clients in the reporting Ser.T. from Basilicata, Molise and Sicilia in buprenorphine treatment and over 17% in reporting Ser.T. from Abruzzo, Campania, Marche and Puglia.

A proportion of these patients switched from methadone maintenance treatment to buprenorphine at their own request because they wanted to try the "new" opioid drug with the aim of improving the quality of their life, relationships with their family and to avoid methadone stigma. On the other hand, a proportion of new heroin addicted individuals have been placed on buprenorphine treatment, directly from street heroin, at the suggestion of Ser.T. professionals following assessment.

When buprenorphine became available in Italy, patients were placed on buprenorphine treatment in relationship to their characteristics: medium level of addiction severity, higher social integration, more motivation to interrupt street heroin injection, less psychiatric comorbidity. The use of higher doses and a more rapid induction phase has also allowed the achievement of a successful outcome in a subgroup of patients characterized by severe heroin dependence.

The treatment schedule permitting buprenorphine sublingual administration every two days (32 mg), that seems to be possible for the kinetic of the drug (prolonged half life), was rarely applied in the public addiction centres in Italy. Buprenorphine at 8-16 mg completely counteracts heroin effects and discourages street heroin injection. Similarly to what has happened for methadone doses, low doses of buprenorphine are inappropriately prescribed in many centres. In addition, take-home buprenorphine does not guarantee the use of the full prescribed dose in many patients, favouring both heroin injection during treatment and diversion.

A variety of observational studies around the country, in agreement with scientific reports, showed no difference between high dose buprenorphine and methadone in terms of retention and a slight advantage for buprenorphine in terms of negative urines.

Given that the Italian findings in this area have almost all been obtained from observational clinical studies and not by double blind randomised controlled trials, buprenorphine positive outcome in terms of heroin discontinuation may be due to a pre-selection of the patients on the basis of their motivation to attend a drug-free oriented programme.

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 dependence 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.

Otherwise some studies has indicated the need of further research to determine if buprenorphine treatment is more effective in particular settings or in particular subgroups of patients (Barnett et al., 2001). The hypothesis that a specific subtype of addicted individual may benefit from buprenorphine was also formulated by Fischer and co-workers (Fischer et al., 1999), but the prognostic factors able to characterise patient subtypes and to predict buprenorphine outcome are still unclear and confused.

Patients who dropped out from buprenorphine treatment in Italy were reported to differ significantly from those who stayed, in terms of a higher level of psycho-pathological symptoms and a lower level of social integration, but the relationship between specific dual diagnoses and outcome measures was not evaluated in this study (Pani et al., 2000).

The association between affective disorders, depressive traits and buprenorphine treatment effectiveness was suggested many years ago (Emrich et al., 1983; Kosten et al., 1990). In agreement with this hypothesis recent findings of the "Centro Studi Farmacodipendenze" of Parma appear to indicate that buprenorphine may obtain more successful results in a subgroup of patients affected by depression, both in term of retention and opioid negative urines (Gerra et al., 2004). In the same report, high doses were found to influence street heroin discontinuation but not retention.

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 administered. The authors concluded that much higher doses of buprenorphine (8-10 mg) should be administered to clients with a long history of abuse at the initiation of treatment rather than the low doses (4-6 mg) more usually offered, to limit their withdrawal symptoms and improve treatment compliance.

De Rosa et 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). Cozzolino et al (2003) have

reported on the use of buprenorphine in a Milan Ser.T. Data was collected over a 22 month treatment period from March 2001 to December 2002 and was used to evaluate the safety and effectiveness of this treatment as well as the different characteristics of clients on methadone maintenance and buprenorphine treatment. 99 clients (69 male and 19 female) with a media age of 34 were given buprenorphine therapy. The study concluded that there had been good compliance with the treatment regime with high retention rates which were significantly better than for methadone. There were however, relatively small differences with the results for methadone maintenance for other measures, the latter having a higher completion rate (13.5% compared to 7.4%). The authors hypothesised that the socio-cultural differences between those who had buprenorphine therapy and those receiving methadone maintenance could have been an important impact. There were statistically significant differences between the educational levels, employment status and involvement in an integrated treatment programme between the two groups. On this basis it was proposed that a new client group could be identified who might benefit from a different therapeutic option than methadone treatment. Auriemma et al (2003) have reported further on their experience with buprenorphine. Based on an evaluation of 258 clients between May 2000 and September 2003, the study considered treatment compliance and efficacy, particular in terms of limiting drug related harm. Half of the clients had been in methadone treatment previously. The results of the evaluation showed that there was a 50% drop out rate, with 62% of these clients being re-enrolled in the methadone programme. Those clients who remained with the buprenorphine programme gained the best benefit for both their psychological and physical health and their overall quality of life. As in the Milan study, those in this form of treatment were more able to retain employment and seemed less likely to be involved in illicit drug use. The evaluation found that clients previously treated with methadone and more attuned to the treatment setting were more likely to remain in treatment whilst the largest percentage of drop outs came from those who had been absent from any form a treatment for a long time. Overall buprenorphine treatment was effective in terms of reducing drug-related harm and improving health and quality of life. However, it was not universally applicable.

These studies seem to be broadly compatible pointing towards specific benefits from buprenorphine treatment based on targetted use with specific client populations. Further studies and increased experience with this therapeutic approach is likely to provide a clearer basis for clinical judgement on the most appropriate treatment for an individual opiate dependent individual.

### 11.3 Misuse of buprenorphine

There have been sporadic unofficial reports in Italy of the misuse of buprenorphine but neither the DCSA nor the Italian early warning system has reported that buprenorphine has been diverted into illicit markets. Ser.T. professionals have had information about diversion. It is possible that, as there is still a relatively low level of use in treatment, the misuse potential has not yet been observed or identified. In the future it will be important to pay particular attention to the situation in Regions where use in treatment levels are high as these are likely to be the Regions which will experience diversion into illicit channels if misuse is to develop.

## 12 Alternatives to prison targeting drug using offenders

### 12.1 Policy, structure and organisation

#### National Policy

The National Drugs Plan <sup>[2]</sup>, includes amongst its objectives:

- To guarantee the right of drug dependent, on request, access to treatment as an alternative to detention

<sup>[2]</sup> Piano nazionale di interventi in materia di prevenzione dell'uso di sostanze stupefacenti e psicotrope, di contrasto al traffico illecito e di trattamenti sanitari e reinserimento socio-lavorativo delle persone tossicodipendenti (2004-2008). Presidenza del Consiglio dei Ministri, Comitato nazionale di coordinamento per l'azione antidroga, Ufficio del Commissario straordinario del Governo per il coordinamento delle politiche antidroga.

- The development of specific facilities for drug dependent prisoners who choose to undertake treatment and rehabilitation
- Reduction of the time lag between referral to the Prefect and the application of administrative sanctions and the first time users/referrals are dealt with away from chronic drug users

The overall policy, as developed through the draft legislation and the National Drugs Plan, both of which have yet to be formally adopted, is to challenge any idea that drug use is normal or acceptable behaviour whilst making appropriate guidance, treatment and rehabilitation available either as an alternative to imprisonment or within prison with continuity of treatment on return to the community. This is largely a continuation of earlier policy in terms of drug dependents who commit criminal offences. The primary difference is the priority given to this area of activity which is seen as providing a valuable opportunity to bring drug users into treatment and long term abstinence.

### **Legislation**

Italian legislation provides a very wide range of measures falling under the category of "Community sanctions and measures". These are broadly:

- Alternatives to custody at the sentencing phase (substitute sanctions). 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.
- Alternatives to custody in the enforcement phase (community measures). 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 main legislation relating to substitutive sanctions and community measures is Law 689 of 24 November 1981 "Modifications to the Penal System", the Penitentiary Act and Decree 309 of the President of the Republic of 1990. The first two are relevant to all persons charged with a criminal offence. The latter deals with measures specific to drug users.

Similar measures apply to both adult and juvenile offenders, although the latter are referred to the Juvenile Justice Service and custodial measures are relatively infrequently used.

### **Substitute Sanctions**

A judge may sentence an offender to one of the following substitute sanctions instead of imprisonment:

- 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

Semi-detention requires the offender to spend at least ten hours a day in prison. It also involves confiscation of the driving licence and passport.

Monitored liberty entails several restrictions and obligations for the offender, such as: disqualification from leaving the town of residence without a special authorisation; obligation to report to the local police station; handing in of driving licence and passport.

The duration of the substitutive sanction is calculated by considering each day of imprisonment as equivalent to one day of semi-detention or to two days of monitored liberty. The conditions attached to semi-detention and of monitored liberty are set by the Supervisory Magistrate, who can also change them where this is considered absolutely necessary. The police are responsible for checking that the conditions attached to an order are observed. If an offender sentenced to semi-detention and monitored liberty breaks any of the conditions imposed, the remaining part of the substitute measure is converted into a prison sentence. The conversion order is issued by the Supervisory Court.

### Community Measures

Italian legislation provides the following measures as alternatives to custody.

#### *Assignment of offenders to the Probation Service (Art. 47, Penitentiary Act) (Affidameno in prova al Servizio Sociale)*

Offenders may be assigned to the Probation Service when their prison sentence, or the remainder of the sentence to be served, is less than three years. Assignment to the Probation Service replaces the prison sentence and entails a rehabilitation programme carried out in the community under the supervision of social workers attached to the Penitentiary Department. This measure is usually granted on the basis of the results of one month or more observation in prison of the offender's personality, carried out by a special team. In cases where the measure is deemed likely to contribute to the rehabilitation of the offender, thanks in part to the conditions that may be attached, while ensuring the prevention of relapse, an assignment may be approved. Thus assignment to the Probation Service must be based on a conviction that the danger represented by the offender can be dealt with through the instruments provided by the measure rather than on a conviction of the lack of danger presented by the offender. It is now possible for assignment to be adopted before the offender is committed to prison, thus preventing it.

Assignment orders list all the conditions which offenders must observe as regards their relations with the Probation Service, their residence, employment, use of means of transport and any veto on the places they may frequent. The order may also forbid the probationer from residing in one or more named towns, or provide for him/her to reside in a named town; in particular, it sets out conditions preventing him/her from carrying out activities or maintaining relations which might lead to further offences. The order must also provide for any reparation that the probationer must make to the victim of his/her offence, as well as for compliance with his/her family duties. The conditions set out in an order may be modified during the execution of the order by the Supervisory Judge.

The Probation Service supervises the conduct of probationers and helps them overcome the difficulties of social insertion. This includes establishing contacts with their families and other people in their every-day life. The Service reports regularly to the Supervisory Magistrate on the behaviour of each probationer. Assignment may be revoked where the offender's behaviour does not comply with the law or with the conditions imposed and is, therefore, deemed incompatible with the continuation of the measure. For the measure to be revoked it is not sufficient for the probationer to have committed a single breach of the conditions, even if it be a serious one. The breach should rather be considered as the expression of a negative overall attitude, demonstrating lack of a positive response to treatment. Therefore, single episodes

must be evaluated in light of the offender's conduct as a whole. According to a decision by the Italian Constitutional Court (sentence N° 343/87), where an assignment is revoked, the Supervisory Court sets the length of imprisonment remaining to be served, taking into account the length of time the probationer has been assigned to the Probation Service and his/her conduct during assignment. Successful completion of the assignment period extinguishes the sentence and all other penal effects.

*Assignment of Special Categories of Offenders to the Probation Service (Art. 94 of Presidential Decree N° 309/1990)*

Drug-addicts or alcoholics sentenced to imprisonment, provided that the sentence or the remaining part of the sentence does not exceed four years, may at any time apply for assignment to the Probation Service in order to continue or begin therapy on the basis of a treatment programme agreed with the public health authorities. The latter must certify the drug-addiction or alcoholism of the offender and the suitability of the proposed rehabilitation programme for his/her rehabilitation.

To reach a decision on an assignment, the Supervisory Court may acquire a copy of the case records and order appropriate inquiries regarding the suitability of the proposed treatment programme. It must also be ascertained that the offender is not just using the addiction to drugs or alcohol and the execution of the rehabilitation programme to obtain assignment with no commitment to the treatment programme. At the end of these proceedings, the Supervisory Court issues an assignment order and immediately informs the Prosecutor responsible for its execution of the order. If the Court does not grant assignment, the Prosecutor issues an imprisonment order.

If the Supervisory Court grants assignment, the conditions imposed must also include those that determine the programme implementation modalities. The order must also specify the forms of monitoring that will be adopted to ascertain that the drug-addicted or alcoholic offender is following with the programme. This special type of assignment may be granted only twice to an offender. Unless otherwise established, the regulations governing the ordinary assignment of offenders to the Probation Service are applicable to this measure.

*Home Detention (Detenzione domiciliare) (Art. 47c, Penitentiary Act)*

Home Detention is another alternative to detention measure provided by the Italian Penitentiary Act.

Under this measure, if a prison sentence or the part of the sentence remaining to be served does not exceed four years or is a sentence of "arresto" (detention of up to 6 months for a petty offence), the offender may be allowed to serve the sentence in his/her own home, in another approved private abode or in some public structure providing care or medical treatment. Home Detention may be applied to offenders in special circumstances such as: pregnant women; mothers with children under the age of ten living with them; fathers exercising parental authority with children under the age of ten living with them; persons with very serious health problems requiring constant hospital care; elderly and disabled persons over sixty years of age; youths under the age of twenty-one having to study/work/fulfill family obligations.

The measure may also be applied generally, that is, to offenders other than those listed in the categories above, where the sentence or residual part of the sentence does not exceed two years. Where the conditions do not exist for assignment to the Probation Service, the measure must be considered suitable for preventing the commission of further offences. The measure cannot be granted for offences connected to organised crime. This measure is aimed at the "humanisation" of sentences, rather than at offender re-insertion. When ordering Home Detention, the Supervisory Court establishes the conditions attached to the measure. It also gives instructions to the Probation Service. These conditions or instructions may be amended by the Supervisory Magistrate with jurisdiction over the area where the measure is implemented.



An offender on Home Detention is not subject to the penitentiary regime as provided by the Penitentiary Act and its enforcement rules. No costs relevant to maintenance or health care of offenders undergoing Home Detention is borne by the Penitentiary Department. Home Detention is revoked when the behaviour of the offender does not comply with the law or with the conditions imposed and therefore appears incompatible with the continuation of the measure. It can also be revoked if the offender leaves his/her place of residence without permission. This is considered as a prison escape which in itself is a crime. Under the last paragraph of Art. 47c of the Penitentiary Act, the simple fact of being reported for this crime used to cause suspension of the measure, but this provision was declared illegal by the Constitutional Court (sentence N° 173/97).

#### *Semi-liberty (Semilibertà) (Art. 48, Penitentiary Act)*

Under this measure the offender, whilst still considered a prisoner, may spend part of the day outside the prison for purposes of work, education or participation in other activities which contribute to his reintegration into society. As a general rule, the prisoner may be granted semi-liberty only after having served at least half of his/her sentence.

For prisoners convicted of serious crimes, for instance, Mafia-type association, kidnapping, homicide, extortion and aggravated robbery, association in the trafficking of illegal or psychotropic drugs and the like, semi-liberty may be granted only after the serving of two thirds of the whole sentence. For those sentenced to life imprisonment, it is only available after 20 years in prison. The measure may be granted before imprisonment where the sentence does not exceed six months. Immediate granting of semi-liberty is also possible where the sentence does not exceed three years and the prisoner, having applied for Probationary Assignment, has been found unsuitable by the Supervisory Court. Internees, i.e. persons subject to detentive security measures, may be granted semi-liberty at any time. The granting of semi-liberty is decided in relation to the progress made by the prisoner in the course of treatment and where the conditions for a gradual social re-insertion exist.

A special treatment programme is laid down for each prisoner/internee granted semi-liberty. The programme contains the conditions which the prisoner/internee must observe during the time spent outside prison. Semi-liberty may be revoked, at any time, where the recipient proves unsuitable for such form of treatment. Moreover, a report of escape (i.e. when the recipient is unjustifiably absent from the prison establishment for more than twelve hours) causes suspension of the measure, and conviction for escape causes revocation. Revocation of semi-liberty results in continuation of the original imprisonment sentence.

#### Other Concessions

Although these concessions are neither substitute sanctions nor community measures, they do provide further mechanisms for diversion into treatment or for an alternative to continued detention aimed at assisting the offender to be reintegrated into society. They belong to the post-trial phase.

#### *Suspended Sentences for drug and alcohol addicts (Sospensione dell'esecuzione della pena detentiva) (Art. 90 - 93 of Presidential Decree N° 309/1990.)*

The Supervisory Court may suspend for five years the execution of a prison sentence or the residual part of a longer sentence not exceeding four years in the case of offenders who have committed crimes related to their drug or alcohol addiction, provided that they are already undergoing therapy or a social rehabilitation programme. If the convicted person follows the programme and does not commit any crime punishable only with imprisonment, within five years following the suspended sentence, the penalty and all penal effects are removed from the records. Suspension is revoked if the offender abandons the programme without a justified reason, or commits a non-culpable crime punishable only with imprisonment.

### ***Conditional Release [Parole] (Liberazione condizionale) (Art. 176, Penal Code)***

Offenders serving custodial sentences whose conduct, while serving the sentence, shows definite amendment, may be granted conditional release after having served at least one half of the sentence, or at least three quarters in the case of recidivism, and at least twenty-six years in the case of a life sentence.

Offenders on conditional release are subject, up until the expiry of the sentence, to supervised liberty. This measure involves a series of obligations intended to prevent opportunities for further offences. Monitoring of offenders on conditional release is carried out by the Police. The Probation Service provides support and aimed at reintegrating offenders into society. Conditional release is revoked if the offender commits a crime or petty offence, or breaches the conditions attached to supervised liberty, from the time of release until the expiry of the sentence.

According to a Constitutional Court decision (Sentence N°. 282/1989), in cases of revocation of conditional release, it is for the Supervisory Court to determine the length of imprisonment remaining to be served, taking into account the time the offender has served on conditional release, the limitations of liberty imposed while on release, and his/her conduct during that time. Prior to this decision by the Constitutional Court, the time spent on conditional release was not taken into account on revocation. The offender used to serve the whole sentence with only the part of it already served in prison being deducted.

At the end of the penalty or, in the case of a life sentence, five years after conditional release has been granted, if no cause for revocation has occurred, the penalty is extinguished.

### ***Work Release***

The management of a penal institution may allow offenders in custody, or internees, to work outside the institution. In such cases, the Probation Service may be asked by the Director of the institution to check that the offender is observing the conditions attached to the work release and to ensure that the rights and dignity of the offender are fully respected by the employer.

### ***"Reward" leave permits***

This concession allows offenders who meet certain criteria to cultivate their affections and their cultural and professional interests. It is granted for a maximum of 45 days a year and for not longer than 15 days at any one time. Given that this concession has a clear rehabilitative function, the provision that this experience should be followed by educators from the penal institution and by social workers from the Probation Service is appropriate. However, the work load of both these categories of staff is such that it is seldom possible to carry out this provision.

### ***Leave for offenders in semi-liberty and for internees***

During periods of leave spent outside prison. Offenders in semi-liberty and internees are subject to liberty under supervision. This is a non-custodial security measure. During these periods, offenders are monitored by the police whilst the Probation Service provides them with support and assistance.

### ***Early Release***

This concession is granted to offenders who have demonstrated active participation in the rehabilitation process. It involves sentences being shortened by 45 days for each 6 month period in which the offender has been assessed favourably by the Supervisory Court. The consequence is that the custodial sentence is abridged but fully served. There is, therefore, no action required by the Probation Service.

### ***Release of Debt***

Offenders who are serving a custodial sentence, a community measure or have been released at the end of their sentence may apply for release of debt related to legal costs and costs of maintenance in prison. The Supervisory Magistrate may ask the Probation Service to enquire into the social and family background of offenders to

provide him/her with information which will assist a decision on whether or not to accept the application.

*Amendment to the contents of and procedures for implementing Alternatives to detention*

Law N° 165 of 27 May 1998, containing "Amendments to Article 656 of the Code of Penal Procedure and of Law N°354 of 26 July 1975, and following modifications", modified and broadened the use of alternative to imprisonment measures. It came into force on 14 June 1998. This law establishes a mechanism to suspend a detention order, where the penalty is no longer than three years (or four years for drug-addicts), to allow the offender to be granted a Community Measure without entering prison. In particular, the law provides for the imprisonment order to be suspended and for this to be communicated to the person concerned. Within thirty days, s/he may then submit a request for one of the Community Measures. The Supervisory Court decides, within forty-five days of receipt of such a request, whether it should be granted. If the request is not made in good time, or the Supervisory Court determines that it is inadmissible or rejects it, the Public Prosecutor revokes the decree of suspension of detention.

Where the request for Probationary Assignment to the Social Service, or for the granting of Home Detention or Semi-liberty (in the case of prison sentences not exceeding six months) is proposed after the beginning of the execution of the sentence, the Supervisory Judge may order, in the first case, the suspension of the execution of the sentence and the consequent release of the offender. In the other two cases, the provisional enforcement of the alternative measures may be ordered. The suspension of the execution of the sentence, or the provisional enforcement of the alternative measures remains in force until the Supervisory Court delivers a judgement within forty-five days.

The law also modifies the regulation governing Home Detention. The maximum penalty where Home Detention may be granted has been increased from three to four years.

### Public Debate

There has been relatively little public debate about the draft laws that are currently in discussion at Italian Parliament.

## 12.2 Interventions

There are a wide range of interventions aimed at supporting the use of alternative measures and community sanctions for drug misusers and dependents. These only apply to criminal offences and are not relevant to the administrative offence of unlawful possession of a controlled drug. Unlawful possession may result in a referral into treatment and/or the imposition of sanctions including suspension of driving licence, gun licence and a ban on travelling, but none of the actions are an alternative to imprisonment.

Data from the Central Directorate for Documentation and Statistics of the Ministry of the Interior shows that at the end of March 2003 there were 265 residential, 47 semi-residential and 30 ambulatory services with an agreement to provide services for drug dependents to the Ministry of Justice. This represented around one in four of all socio-rehabilitative services and almost one third of all residential services.

Based on the legal provisions described above, a drug misuser or dependent may be referred to the probation service and enter a treatment programme as an alternative to imprisonment or to continued imprisonment. The client is entrusted for treatment but supervision in terms of compliance with the requirements of the court order remains with the probation service. The treatment provider is required to provide regular reports on progress in treatment and to report any breach of the conditions of the treatment order.

Table 17 shows the use of alternative to prison for drug dependents for the

### Alternative measures for drug users

	2001	2002	2003
New alternatives to prison	2484	2635	2579
All alternatives to prison	5243	5301	5278
New alternatives from prison	837	840	801
All alternatives from prison	1620	1657	1605

80

Table 17

Source: Ministry of Justice

last three years. As can be seen from this data there was a slight reduction in the number of new alternatives to prison compared to 2002, but this was expected because the number of drug users prosecuted and received into prison prior to a court finding had also fallen. There was also a fall in new alternatives from prison which was almost certainly for the same reason. In total during 2003 there were 6,883 drug dependents under the supervision of the probation service, representing a significant proportion of its clients (22.6%).

It is also possible to review revocations for breaches of the conditions attached to the alternative. In 2003 10.3% of all those in receipt of an alternative had this revoked. This was slightly higher than in 2002 (10.1%) but lower than in 2001 (11.2%). Revocation rates were higher for those released as an alternative to continued imprisonment compared to those given an alternative to a prison sentence. In 2003 8.5% of those receiving an alternative to prison had their order revoked whilst 15.9% of those receiving an alternative to continued imprisonment had their order revoked. These percentages were similar in 2002 and 2001.

Examined in greater detail the reasons for the revocation are interesting (Figs.26 – 28). The vast majority of revocations occurred for negative behaviour. There is no specific explanation of the meaning of this term and it may vary slightly in interpretation but the intention is reasonably clear as an unwillingness to show commitment to and comply with treatment. The next most likely reason was a new legal situation. This did not necessarily mean a new offence, it could mean a further conviction for an offence

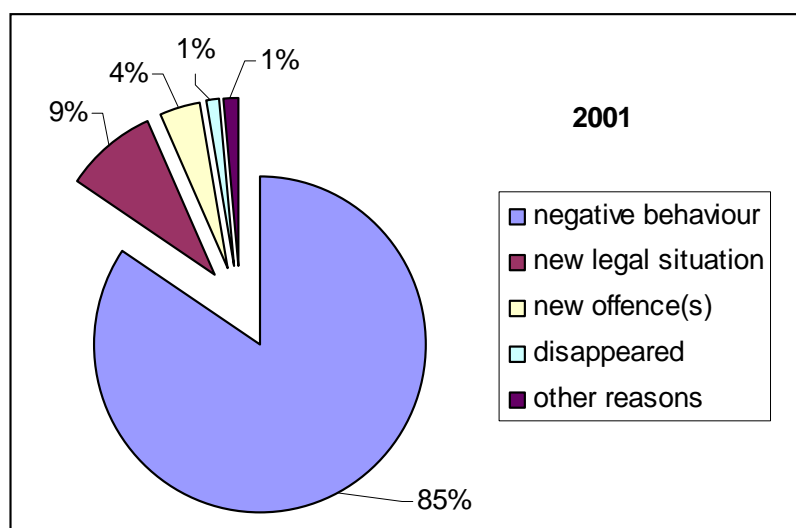


Figure 26

Source: Ministry of Justice

committed before the alternative was granted or circumstances coming to light which made the individual ineligible for an alternative to prison. The other reasons for revocation were negligible. There is a difference between the reasons for revocation for those given an alternative to prison and those released as an alternative to continued imprisonment. The latter group were more likely to be recalled for negative behaviour than the former group – 91% of revocations as against 86.7% but were less likely to disappear or to be faced with a new legal situation. These differences were slightly greater in 2002 and may reflect inappropriate treatment placements. In particular, it may be that drug dependents who have spent a considerable time in the prison system with the necessary restrictions such a situation implies, may be less ready to submit to a further period of restrictions on entering a therapeutic community. At the same time, it is important to note that many organisations provide specific services designed for work with drug dependent prisoners and ex-prisoners, both as an alternative to continued prison and to provide support for

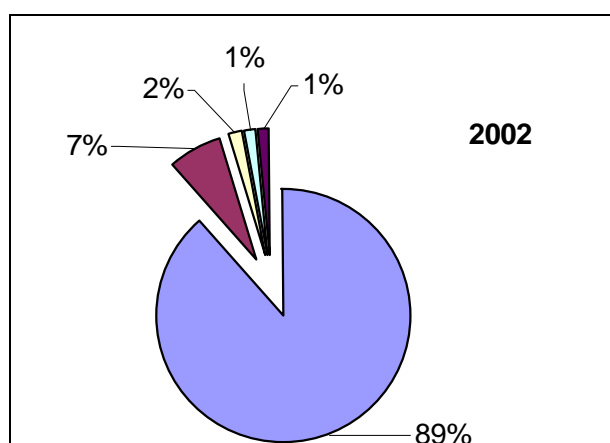


Figure 27

Source: Ministry of Justice

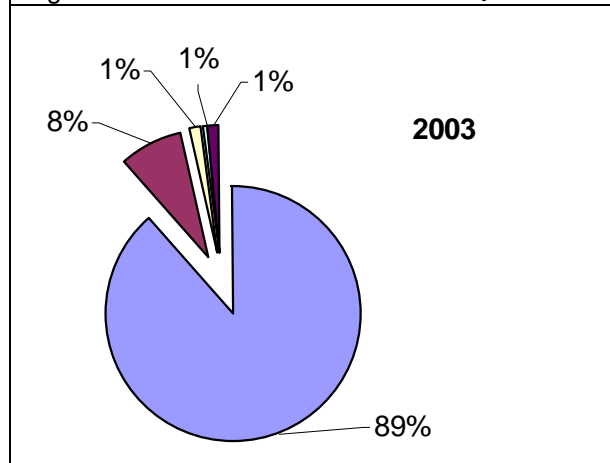


Figure 28

Source: Ministry of Justice

re-integration on completion of their sentence. These types of service may well have served to reduce early drop out and to limit the number of revocations.

Because of the responsibility devolved to the Regions for health and social care, including health care of prisoners, most Regions have now established protocols or agreements for the provision of services to the prisons. Treatment of drug dependent prisoners was one of the first areas of health care to be taken over and has resulted in even closer ties and improved capacity to provide appropriate alternatives to custody or to continued imprisonment. The existence of continued care is clearly shown by the increase in the use of longer term methadone for the treatment of drug dependent prisoners. It is likely that some of these prisoners were already in treatment with the Ser.T. and that others are eligible for an alternative to prison and were brought into treatment on this basis. The impact of this devolution is also shown by the increased allocation of resources at the Regional level for work with this specific population and the increased emphasis on building improved capacity to meet the needs of drug dependents both within the prison system and as an alternative to custody. As one example, the Marche Region during 2003 had 203 drug dependent prisoners. An assessment of their needs identified serious health and social problems, with some problems arising specifically from abrupt cessation of drug use. There were 8 deaths in the Pesaro prison in 2003 despite the high quality of services in the Region. The deaths were among young men aged 25 – 30 in prison for less than 6 months and awaiting trial. In most cases there were no psychological symptoms manifested but in virtually every instance the death was preceded by a request for help. As a result of this assessment and the situation identified, the development of a network of alternative projects, including structured non-residential centres, day centres, therapeutic communities and semi-residential facilities is planned, bringing together existing services and identifying and filling specific gaps. This approach will also include a prison after care service designed to support rehabilitation and reintegration into the social and work environments.

### **12.3 Quality assurance**

Quality assurance is achieved at two different levels but which interlink and provide an overall quality control system.

At the level of the justice system and the probation service, quality is focused on compliance with the conditions attached to the alternative measure and avoidance of re-offending or abandonment of the programme. At the level of the service provider, quality is focused on treatment compliance and achievement of successful programme completion. Together, these offer a quality system in terms of both the needs of the justice system and the individual drug dependent.

Although there are no specific quality assurance tools for this area of work universally used within Italy, it is clear from the high level of retention in treatment programmes that the services offered have the confidence of both the courts and the clients. It is also likely that the programmes have a good long term outcome given all the research findings which have indicated that retention within a therapeutic programme for a minimum of 6 months significantly improves all quality of life indicators and the likelihood of long term abstinence being maintained, with longer treatment times increasing the benefits further.

Overall, therefore, there is good reason to believe that the long-established and well-developed system for providing alternatives to custody or to continued imprisonment has high quality with close monitoring at different levels and good long term outcomes.

## **13 Public nuisance: definitions, trends in policy, legal issues and intervention strategies**

### **13.1 Definition**

There is no specific definition of 'public nuisance' within Italy. Rather, there is a broad concept of public safety and security which covers a range of community issues. Most Regions and many Communes have programmes concerned with safety and security which commonly focus on the following broad areas:



- Crime prevention
- Quality of urban life and security
- Urban planning and environmental protection
- Conflict mediation
- Safety for children and young people
- Support and safety for specific, vulnerable populations

The priorities adopted in different Regions and Communes will depend on local circumstances and there are substantial variations between and within Regions. However, the areas referred to above appear in most public/urban safety programmes.

### **13.2 Genesis**

As stated above, public nuisance is not a specific concept within Italy.

The concept of public safety began in relation to criminal behaviour and both actual crime and fear of crime. As such, the starting point was the rule of law and ensuring that the rule of law was more effectively enforced. This initial approach was adapted by a number of Regions and Communes based on the developing ideas about urban security within Europe and led to the establishment of the Italian Forum for Urban Security as a national partner with the European Forum for Urban Safety.. Within this framework the concept was extended to include a much wider range of activities than traditional law enforcement tasks and included programmes and projects aimed at reducing and where possible preventing criminality and behaviours which caused social alarm. The genesis of the present approach to public safety and security has thus been with ensuring the proper upkeep of public facilities and improvement of the physical and social environment and the feelings of safety of the general public as well as with crime prevention and detection.

There is no single legislative act which defines the concept, rather there are national laws which codify acceptable and unacceptable behaviours and local laws at Regional or Commune level which establish the basis for programmes and projects at that level based on locally identified needs and priorities.

### **13.3 Measures taken**

The measures taken within Italy are extensive, although relatively few are specifically focused on drug-related issues. They are focused more on ways of improving local situations as a means of preventing future harm rather than on a specific issue which might represent one part of a larger problem.

In every Region and in the vast majority of communes there are specific projects concerned with public security and safety. In many instances these are focused on environmental improvements, cleansing and securing of public buildings and facilities, improving the presence of the Local Police and the sense of security of citizens and tackling micro-criminality and anti-social behaviour.

There is only one project which is known to have undertaken some work on identifying public concerns about drug misuse. In Verona Il Corallo has developed a project "*Itinerari di Sicurezza Sociale*" funded through the National Drugs Fund allocation to the Veneto Region. The project has been specifically concerned with identifying security and public nuisance problems associated with drug dependency and in seeking resolution of identified problems. As one phase of the project a survey has been undertaken involving interviews with traders and the general population, travelling with outreach workers and interviews with privileged observers. In total some 1,000 interviews were conducted, around 75% with traders and 25% with the general population. The box shows the reported results of this research which is more in relation to perceptions of problems rather than research on direct experience of these problems. In terms of the problems seen as associated with drug misuse, discarded syringes and drug dealing are direct consequences. The other issues may be associated with drug misuse but other factors might also be involved. It is clear, however, that street crime and fear of crime are major concerns. There is a significant difference between perceptions of the effectiveness of health and social services and of law enforcement agencies. There appears to be general ignorance about the work of the health and social services and dissatisfaction with them is consequently low. By contrast, expectations on law enforcement agencies to intervene appears to be high and failure to make an impact on the situation appears to have resulted in a relatively high level of dissatisfaction.

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Health and Public Safety Survey, Verona	
<i>Are there health and public safety problems in your area associated with drug use? What are the risks?</i>	
Theft and bag-snatching	47.3
Threats and personal safety	29.5
Discarded syringes	18.4
Illegal immigrants	11.5
Dirt and environmental degradation	11.2
Drug dealing	9.6
Fear of infection	6.9
Other	6.0
<i>Who is most at risk as a result of drug use in your area?</i>	
Old people	66.9
Minors	50.4
Women	30.3
<i>Are the social and health services effective in prevention and treatment of drug misuse?</i>	
Don't know	41.2
Ineffective	34.2
Effective	24.6
Little prevention or health education	10.0
They do their best but the problem is complex	8.5
Insufficient services	3.7
They don't care about the problem	2.2
<i>In your view, how effective are the law enforcement services for your area?</i>	
Ineffective	53.7
Effective	33.8
Hardly seen	31.4
They have their hands tied	14.5
Don't know	12.5
They don't care	10.5
Too few people and too few powers	10.3
Inadequate organisation	4.4

Table 18

Source: Il Corallo, Verona

There appears to be general ignorance about the work of the health and social services and dissatisfaction with them is consequently low. By contrast, expectations on law enforcement agencies to intervene appears to be high and failure to make an impact on the situation appears to have resulted in a relatively high level of dissatisfaction.

The only other data which can be found on this area concerns reports from outreach projects. Unfortunately the data which is reported often provides no time scale and is, therefore, difficult to interpret. However, from a number of reports from Milan, Bologna and Rome, amongst others, the return rate of syringes is around 30% - 40% of the number dispensed. This suggests that the remainder may be disposed of through normal refuse collection systems or by casual disposal, possibly in public areas. This would correlate with the concern about discarded syringes reported in the Verona survey.

In terms of specific interventions relevant to drug misuse and public nuisance, there are those which are concerned with altering the physical and social environment in which drug misuse related nuisance amongst others might occur and those which are specifically concerned with drug misuse. Given that these projects are so widespread, if not drug specific, in Italy, one or two examples are given to show the broad pattern.

By the end of 2003 there were signed agreements between Prefects and Mayors with regard to public security. These have three main foci:

- ◆ Dealing with problems of civil life with particular regard to different types of urban problem including places where young people gather
- ◆ Combatting problems which cause social alarm, such as drug misuse, vandalism and prostitution
- ◆ Supporting and giving incentive to means of raising the quality of the urban environment, such as dealing with abandoned areas, rehabilitating public buildings and areas, improving transport and mobility and road safety.

As can be seen from this, all three areas have relevance for drug misuse and public nuisance although only one specifically refers to drug misuse. As an example of activity relevant to the first area, in all the provinces of Toscana projects have been developed to improve the presence of the Local Police and to build improved collaboration between them and the national policing service (State Police, Carabinieri, Guardia di Finanza). Improved presence has particularly focused in many projects on public areas where large numbers of people congregate.

In terms of the second area, in Portoferraio (Toscana) as part of an overall urban security project, prevention of drug misuse is one of the specific themes and activities, as it is in Siena. In Genova a harm reduction programme has been promoted with the provision of a drop in centre as an area where homeless drug dependents can attend and access a range of services both in terms of personal hygiene and in terms of their physical and mental health and social service needs.

In terms of the third area, projects around the country have focused on activities such as improving street lighting and installing video-surveillance cameras as a means of improving feelings of security. They have also sought to rehabilitate areas which have become run down and used for illegal or anti-social activity. This has also included the demolition of abandoned structures or those erected illegally, especially where the structures have become the focus for illegal or anti-social behaviour.

These brief examples of the types of response are illustrative of the Italian situation. Whilst they are not classified in terms of public nuisance within Italy, in practice at all levels the original concept of public security has expanded to first a concept of public safety, where law enforcement was still the primary motivation to the present concept of a wide concept of urban security in which law enforcement, social and environmental considerations all combine in favour of improving the living environment for local citizens.

#### **13.4 Results/evaluation**

The broad range of urban security and public safety projects carried out in every part of Italy are ones which are not commonly evaluated or subject to research or public reports. Rather, the results are based on the satisfaction expressed by citizens to the changes which they observe in their local situation.

The main results which have been published have appeared in the Annual Report of the Ministry of the Interior on Public Security (Interno 2003). The operation "Alto Impatto" (High Impact) which was based on a new model for taking action to deal with local problems. It began in August 2002 and was focused on responding to the offending behaviour which most undermined feelings of safety. These offences were identified as prostitution, illegal immigration, drug trafficking, unlicensed street trading and property crimes. Arising specifically from this approach Ministry reported that there were 12,555 arrests, 15,142 reports to the police, 2,820 Kg.s of drugs seized, 671,244 contraband or counterfeit products seized and 15,560 illegal immigrants removed from the country.

Although it has not been possible to identify other explicit results or evaluation reports published with particular reference to drug misuse, much of the activity which has been undertaken has concerned evident physical improvements and would not be expected to have any formal evaluation. There would be value in future to undertake some small scale studies of the impact of such projects on the feeling of security and safety, perhaps with an initial focus on issues related to drug misuse.

## Part C: Bibliography and annexes

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## 14.2 Relevant data bases

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 Regional Department or through Regional or Provincial Drugs Observatories. Amongst the most developed are those in Piemonte, Emilia-Romagna, Veneto, Lombardia, Liguria and Abruzzo.

#### 14.3 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 quantitative or qualitative data. Where quantitative data is available there may be no indication of the reference period. Nevertheless, the listed web addresses were consulted to identify material which might be relevant to the National Report. It has not always been possible to provide full references for material.

##### Ministries and national institutions

<a href="#">La Presidenza del Consiglio</a> <a href="#">Dipartimento Nazionale per le Politiche Antidroga</a>	<a href="http://www.governo.it/Presidenza/index.html">http://www.governo.it/Presidenza/index.html</a> <a href="http://www.governo.it/Presidenza/DPAD/index.html">http://www.governo.it/Presidenza/DPAD/index.html</a>
<a href="#">Ministero della Difesa</a> <a href="#">Direzione General Sanità Militare</a>	<a href="http://www.difesa.it/">http://www.difesa.it/</a> <a href="http://www.difesa.it/sgd/index.html">http://www.difesa.it/sgd/index.html</a>
<a href="#">Ministero di Giustizia</a> <a href="#">Dipartimento dell'Amministrazione penitenziaria</a>  <a href="#">Dipartimento per la Giustizia Minorile</a>  <a href="#">Le Statistiche della amministrazione penitenziaria</a> <a href="#">Le Statistiche della giustizia minorile</a>	<a href="http://www.giustizia.it/">http://www.giustizia.it/</a> <a href="http://www.giustizia.it/ministero/struttura/dipartimenti/dip_amm_penitenz.htm">http://www.giustizia.it/ministero/struttura/dipartimenti/dip_amm_penitenz.htm</a> <a href="http://www.giustizia.it/ministero/struttura/dipartimenti/dip_giust_minorile.htm">http://www.giustizia.it/ministero/struttura/dipartimenti/dip_giust_minorile.htm</a> <a href="http://www.giustizia.it/misc/STATISTICHE.HTM">http://www.giustizia.it/misc/STATISTICHE.HTM</a> <a href="http://www.giustizia.it/misc/STATISTICHE.DAP.HTM">http://www.giustizia.it/misc/STATISTICHE.DAP.HTM</a>
<a href="#">Ministero dell'Interno</a> <a href="#">Direzione Centrale per i Servizi Antidroga (DCSA)</a> <a href="#">Direzione Centrale per la documentazione e la statistica</a> <a href="#">Dipartimento per le libertà civili e l'immigrazione</a>  <a href="#">Dati statistici</a>	<a href="http://www.mininterno.it/">http://www.mininterno.it/</a> <a href="http://www.interno.it/sezioni/attivita/sicurezza/dip_ps/dcsa/s_000000223.htm">http://www.interno.it/sezioni/attivita/sicurezza/dip_ps/dcsa/s_000000223.htm</a> <a href="http://pers.mininterno.it/">http://pers.mininterno.it/</a>  <a href="http://www.interno.it/sezioni/organizzazione/dipartimenti/s_000000218.htm">http://www.interno.it/sezioni/organizzazione/dipartimenti/s_000000218.htm</a> <a href="http://www.poliziadistato.it/pds/online/antidroga/antidroga.htm">http://www.poliziadistato.it/pds/online/antidroga/antidroga.htm</a>
<a href="#">Ministero dell'Istruzione, dell'Università e della Ricerca</a> <a href="#">Direzione Generale per lo status dello studente, per le politiche giovanili e per le attività motorie</a>	<a href="http://www.istruzione.it/">http://www.istruzione.it/</a>  <a href="http://www.istruzione.it/mpi/amministrazione/dg_studente.shtml">http://www.istruzione.it/mpi/amministrazione/dg_studente.shtml</a>
<a href="#">Ministero della Salute</a> <a href="#">Direzione Generale della Prevenzione</a> <a href="#">Dati di attività dei Ser.T.</a> <a href="#">Bollettino per le Farmacodipendenze e l'Alcolismo</a>	<a href="http://www.ministerosalute.it/">http://www.ministerosalute.it/</a> <a href="http://www.ministerosalute.it/ministero/sezMinistero.jsp?label=dip2&amp;id=43">http://www.ministerosalute.it/ministero/sezMinistero.jsp?label=dip2&amp;id=43</a> <a href="http://www.unicri.it/min.san.bollettino/default.htm">http://www.unicri.it/min.san.bollettino/default.htm</a>
<a href="#">Istituto Superiore di Sanità</a> <a href="#">Osservatorio Fumo, Alcol e Droga</a> <a href="#">Area laboratorio sostanze stupefacenti e psicotrope</a>	<a href="http://www.iss.it/">http://www.iss.it/</a> <a href="http://www.ossfad.iss.it/">http://www.ossfad.iss.it/</a> <a href="http://progetti.iss.it/ssps/">http://progetti.iss.it/ssps/</a>
<a href="#">Ministero del Welfare</a>	<a href="http://www.welfare.gov.it/default.htm">http://www.welfare.gov.it/default.htm</a>



<a href="http://www.istat.it/">ISTAT</a>	<a href="http://www.istat.it/">http://www.istat.it/</a>
<b>Other national organisations</b>	
<a href="http://www.cnca.it/">Coordinamento Nazionale Comunità d'Accoglienza</a>	<a href="http://www.cnca.it/">http://www.cnca.it/</a>
<a href="http://www.intercear.it/">Coordinamenti Regionali Enti Ausiliari per le Tossicodipendenze</a>	<a href="http://www.intercear.it/">http://www.intercear.it/</a>
<a href="http://www.dronet.org/">DRONET</a>	<a href="http://www.dronet.org/">http://www.dronet.org/</a>
<a href="http://www.fict.it/">Federazione Italiana Comunità Terapeutiche</a>	<a href="http://www.fict.it/">http://www.fict.it/</a>
<a href="http://www.federserd.it/">Federazione Italiana degli Operatori dei Dipartimenti e dei Servizi delle Dipendenze - FeDerSerD (Ser.T.)</a>	<a href="http://www.federserd.it/">http://www.federserd.it/</a>
<a href="http://www.sims.it/">Gruppo S.I.M.S. (Studio e Intervento sulle Malattie Sociali)</a>	<a href="http://www.sims.it/">http://www.sims.it/</a>
<a href="http://www.iefcos.it/">I.E.F.Co.S</a>	<a href="http://www.iefcos.it/">http://www.iefcos.it/</a>
<a href="http://www.indipendenzadonna.org/index.php">In - dipendenza donna</a>	<a href="http://www.indipendenzadonna.org/index.php">http://www.indipendenzadonna.org/index.php</a>
<a href="http://www.irefrea.org/italia/inicio.htm">IREFREA Italia</a>	<a href="http://www.irefrea.org/italia/inicio.htm">http://www.irefrea.org/italia/inicio.htm</a>
<a href="http://www.itacaitalia.it/">ITACA Italia</a>	<a href="http://www.itacaitalia.it/">http://www.itacaitalia.it/</a>
<a href="http://www.medol.com/mdt/">Medicina delle Tossicodipendenze</a>	<a href="http://www.medol.com/mdt/">http://www.medol.com/mdt/</a>
<a href="http://www.na-italia.it/">Narcotici Anonimi</a>	<a href="http://www.na-italia.it/">http://www.na-italia.it/</a>
<a href="http://www.alcol.net/">Osservatorio permanente sui giovani e l'alcol</a>	<a href="http://www.alcol.net/">http://www.alcol.net/</a>
<a href="http://www.psychomedia.it/">Psychomedia</a>	<a href="http://www.psychomedia.it/">http://www.psychomedia.it/</a>
<a href="http://www.droga.net/">La pagina Web di Riccardo C. Gatti</a>	<a href="http://www.droga.net/">http://www.droga.net/</a>
<a href="http://www.sitd.org/">SITD (Società Italiana Tossicodipendenze)</a>	<a href="http://www.sitd.org/">http://www.sitd.org/</a>
<a href="http://www.aipdb.it/">S.I.A. (Società Italiana di Alcolologia)</a>	<a href="http://www.aipdb.it/">http://www.aipdb.it,</a>
<b>Italian Regions</b>	
<a href="http://www.regione.abruzzo.it/">Abruzzo</a>	<a href="http://www.regione.abruzzo.it/">(http://www.regione.abruzzo.it/)</a>
<a href="http://www.seiunico.it/">Progetto obiettivo "Sei unico" - Regione Abruzzo</a>	<a href="http://www.seiunico.it/">http://www.seiunico.it/</a>
<a href="http://www.regione.basilicata.it/">Basilicata</a>	<a href="http://www.regione.basilicata.it/">(http://www.regione.basilicata.it/)</a>
<a href="http://www.regione.calabria.it/">Calabria</a>	<a href="http://www.regione.calabria.it/">(http://www.regione.calabria.it/)</a>
<a href="http://www.regione.campania.it/">Campania</a>	<a href="http://www.regione.campania.it/">(http://www.regione.campania.it/)</a>
<a href="http://digilander.iol.it/sertd49aslna1">Ser.T Distretto 49, A.S.L. Napoli 1</a>	<a href="http://digilander.iol.it/sertd49aslna1">http://digilander.iol.it/sertd49aslna1</a>
<a href="http://digilander.libero.it/ser51/">Ser.T. Distretto 51, A.S.L. Napoli 1</a>	<a href="http://digilander.libero.it/ser51/">http://digilander.libero.it/ser51/</a>
<a href="http://www.regione.emilia-romagna.it/">Emilia-Romagna</a>	<a href="http://www.regione.emilia-romagna.it/">(http://www.regione.emilia-romagna.it/)</a>
<a href="http://www.regione.emilia-romagna.it/agenziasan">Agenzia Sanitaria Regionale - Emilia-Romagna</a>	<a href="http://www.regione.emilia-romagna.it/agenziasan">http://www.regione.emilia-romagna.it/agenziasan</a>
<a href="http://www.regione.emilia-romagna.it/tossicodipendenze/">Regione Emilia-Romagna "Progetto regionale tossicodipendenze"</a>	<a href="http://www.regione.emilia-romagna.it/tossicodipendenze/">http://www.regione.emilia-romagna.it/tossicodipendenze/</a>
<a href="http://www.ceisparma.org/index.html">Centro di Solidarietà di Parma</a>	<a href="http://www.ceisparma.org/index.html">http://www.ceisparma.org/index.html</a>
<a href="http://www.solidarieta.re.it/">Centro di Solidarietà di Reggio Emilia</a>	<a href="http://www.solidarieta.re.it/">http://www.solidarieta.re.it/</a>
<a href="http://www.sanmaurizio.org/">Comunità San Maurizio</a>	<a href="http://www.sanmaurizio.org/">http://www.sanmaurizio.org/</a>
<a href="http://up.comune.re.it/">Comune di Reggio Emilia - Unità di prevenzione</a>	<a href="http://up.comune.re.it/">http://up.comune.re.it/</a>
<a href="http://www.stradanove.net/dipdoc">Dip&amp;Doc</a>	<a href="http://www.stradanove.net/dipdoc">http://www.stradanove.net/dipdoc</a>
<a href="http://www.ausl.fo.it/giovani/Servizi/ser.htm">Dipendenze patologiche Forlì</a>	<a href="http://www.ausl.fo.it/giovani/Servizi/ser.htm">http://www.ausl.fo.it/giovani/Servizi/ser.htm</a>
<a href="http://www.giannimorandi.it/Prof/dipatol.htm">Dipartimento dipendenze Modena</a>	<a href="http://www.giannimorandi.it/Prof/dipatol.htm">http://www.giannimorandi.it/Prof/dipatol.htm</a>
<a href="http://www.drogaonline.it/">Drogaonline - Centro di Solidarietà Reggio Emilia</a>	<a href="http://www.drogaonline.it/">http://www.drogaonline.it/</a>
<a href="http://www.ontheroadonlus.it">On the Road</a>	<a href="http://www.ontheroadonlus.it">http://www.ontheroadonlus.it</a>
<a href="http://www.ossdipbo.org/">Osservatorio epidemiologico AUSL Bologna</a>	<a href="http://www.ossdipbo.org/">http://www.ossdipbo.org/</a>
<a href="http://www.sanpatrignano.org/">San Patrignano</a>	<a href="http://www.sanpatrignano.org/">http://www.sanpatrignano.org/</a>
<a href="http://www.ausl-cesena.emr.it/ser/Default.htm">Ser.T di Cesena</a>	<a href="http://www.ausl-cesena.emr.it/ser/Default.htm">http://www.ausl-cesena.emr.it/ser/Default.htm</a>
<a href="http://www.monicaepaolo.it/">Ser.T. della Provincia di Modena</a>	<a href="http://www.monicaepaolo.it/">http://www.monicaepaolo.it/</a>
<a href="http://www.ausl.ra.it/h3/h3.exe/auragest/funicoweb?NRECORD=0000000094">Ser.T. Faenza</a>	<a href="http://www.ausl.ra.it/h3/h3.exe/auragest/funicoweb?NRECORD=0000000094">http://www.ausl.ra.it/h3/h3.exe/auragest/funicoweb?NRECORD=0000000094</a>
<a href="http://www.comune.fe.it/legge-simeone/aiuti/ser.htm">Ser.T. Ferrara</a>	<a href="http://www.comune.fe.it/legge-simeone/aiuti/ser.htm">http://www.comune.fe.it/legge-simeone/aiuti/ser.htm</a>

<a href="#">Ser.T di Imola</a>	<a href="http://www.regione.emilia-romagna.it/web_gest/enti/usl/uslimola/dist-3.htm">http://www.regione.emilia-romagna.it/web_gest/enti/usl/uslimola/dist-3.htm</a>
<a href="#">Ser.T. Lugo</a>	<a href="http://www.ausl.ra.it/h3/h3.exe/auragest/funicoweb?NRECORD=0000000071">http://www.ausl.ra.it/h3/h3.exe/auragest/funicoweb?NRECORD=0000000071</a>
<a href="#">Ser.T. Ravenna</a>	<a href="http://www.ausl.ra.it/h3/h3.exe/auragest/funicoweb?NRECORD=0000000093">http://www.ausl.ra.it/h3/h3.exe/auragest/funicoweb?NRECORD=0000000093</a>
<a href="#">Ser.T. Rimini, Progetto SIDA</a>	<a href="http://www.geocities.com/HotSprings/9949/italiano.html">http://www.geocities.com/HotSprings/9949/italiano.html</a>
<a href="#">Unità Mobile SerT</a>	<a href="http://www.ossdipbo.org/UMobile/">http://www.ossdipbo.org/UMobile/</a>
<b><a href="#">Friuli-Venezia Giulia</a></b> ( <a href="http://www.regione.fvg.it/">http://www.regione.fvg.it/</a> )	
<a href="#">Dipartimento delle Dipendenze, Trieste</a>	<a href="http://www.ass1.sanita.fvg.it/ser/welcome.htm">http://www.ass1.sanita.fvg.it/ser/welcome.htm</a>
<a href="#">Sert Udine</a>	<a href="http://www.friuli.to/ser_ud/">http://www.friuli.to/ser_ud/</a>
<b><a href="#">Lazio</a></b> ( <a href="http://www.regione.lazio.it/">http://www.regione.lazio.it/</a> )	
<a href="#">Servizi Tossicodipendenze - Regione Lazio</a>	<a href="http://213.175.14.99/redazione/sanita/asl.nsf/ser?openview">http://213.175.14.99/redazione/sanita/asl.nsf/ser?openview</a>
<a href="#">Agenzia Comunale per le Tossicodipendenze</a>	<a href="http://www.comune.roma.it/act">http://www.comune.roma.it/act</a>
<a href="#">Centro Italiano di Solidarietà (CeIS)</a>	<a href="http://www.ceis.it/">http://www.ceis.it/</a>
<a href="#">Dipartimento Disagio, Devianza, Dipendenze, ASL di Frosinone</a>	<a href="http://www.asl.fr.it/dipar/dipar_d3d.html">http://www.asl.fr.it/dipar/dipar_d3d.html</a>
<a href="#">Dipartimento delle Dipendenze, ASL Roma A</a>	<a href="http://www.asl-rma.rm.it/DiD.htm">http://www.asl-rma.rm.it/DiD.htm</a>
<a href="#">Fondazione Villa Maraini</a>	<a href="http://www.villamaraini.it/">http://www.villamaraini.it/</a>
<a href="#">Movimento delle Associazioni di Volontariato Italiano</a>	<a href="http://www.modavi.it/">http://www.modavi.it/</a>
<a href="#">Gruppo Magliana '80</a>	<a href="http://www.magliana80.it/home.htm">http://www.magliana80.it/home.htm</a>
<a href="#">SERT, ASL Roma H (Ciampino, Nettuno, Velletri, Genzano, Frascati)</a>	<a href="http://web.genie.it/utenti/s/sernet/">http://web.genie.it/utenti/s/sernet/</a>
<a href="#">Ser.T. ASL di Viterbo</a>	<a href="http://www.asl.vt.it/cittadino/servizi/tossicodipendenze.html">http://www.asl.vt.it/cittadino/servizi/tossicodipendenze.html</a>
<b><a href="#">Liguria</a></b> ( <a href="http://www.regione.liguria.it/">http://www.regione.liguria.it/</a> )	
<a href="#">il Centro di Solidarietà "L'Ancora"</a>	<a href="http://www.centroancora.it/">http://www.centroancora.it/</a> and <a href="http://members.tripod.com/centroancora/">http://members.tripod.com/centroancora/</a>
<a href="#">Centro di Solidarietà di Genova</a>	<a href="http://www.csngenova.org/">http://www.csngenova.org/</a>
<a href="#">SerT ASL 3 Genovese</a>	<a href="http://www.asl3.liguria.it/servizi/05_dipendenze/0201.htm">http://www.asl3.liguria.it/servizi/05_dipendenze/0201.htm</a>
<a href="#">SerT ASL 4 Chiavarese</a>	<a href="http://digilander.iol.it/gianninouliivi">http://digilander.iol.it/gianninouliivi</a> and <a href="http://www.asl4.liguria.it/Servizi_sul_territorio/Sert/ser.html">http://www.asl4.liguria.it/Servizi_sul_territorio/Sert/ser.html</a>
<a href="#">Ser.T. di Imperia</a>	<a href="http://www.asl1.liguria.it/indice/guida.htm">http://www.asl1.liguria.it/indice/guida.htm</a>
<a href="#">SerT La Spezia</a>	<a href="http://www.ausl5.la-spezia.it/droga/index.htm">http://www.ausl5.la-spezia.it/droga/index.htm</a>
<b><a href="#">Lombardia</a></b> ( <a href="http://www.famiglia.regione.lombardia.it/dip/dip.asp">http://www.famiglia.regione.lombardia.it/dip/dip.asp</a> )	
<a href="#">ASL Bergamo, Dipartimento delle Dipendenze</a>	<a href="http://www.asl.bergamo.it/web/intsert.nsf">http://www.asl.bergamo.it/web/intsert.nsf</a>
<a href="#">ASL Milano</a>	<a href="http://www.asl.milano.it/droga">http://www.asl.milano.it/droga</a>
<a href="#">Asl di Varese Dipartimento Dipendenze</a>	<a href="http://www.asl.varese.it/dipartimenti/dipendenze.html">http://www.asl.varese.it/dipartimenti/dipendenze.html</a>
<a href="#">Associazione Mondo X</a>	<a href="http://www.mondox.it/">http://www.mondox.it/</a>
<a href="#">Associazione Saman</a>	<a href="http://web.tin.it/saman/">http://web.tin.it/saman/</a>
<a href="#">Centro "Gulliver"</a>	<a href="http://www.gulliver-va.it/">http://www.gulliver-va.it/</a>
<a href="#">Centro per lo Studio e la Terapie delle Psicopatologie /Ce.S.Te.P)</a>	<a href="http://www.cestep.it/">http://www.cestep.it/</a>
<a href="#">Comune di Milano</a>	<a href="http://www.comune.milano.it/webcity/documenti.nsf/">http://www.comune.milano.it/webcity/documenti.nsf/</a>
<a href="#">La comunità Casa del Giovane</a>	<a href="http://www.cdg.it/">http://www.cdg.it/</a>
<a href="#">Comunità Mondo Nuovo</a>	<a href="http://www.mondonuovo.org/start.htm">http://www.mondonuovo.org/start.htm</a>
<a href="#">Comunità Nuova</a>	<a href="http://www.comunitanuova.it/">http://www.comunitanuova.it/</a>

<a href="#">CONT@TTO - SPAZIO ADOLESCENTI</a>	<a href="http://www.con-tatto.it/">http://www.con-tatto.it/</a>
<a href="#">Droga Milano</a>	<a href="http://fc.retecivica.milano.it/Rete%20Civica%20di%20Milano/Societa'%20e%20Politica/Salute%20e%20Sanita'/DROGA%20MILANO%20SOS/">http://fc.retecivica.milano.it/Rete%20Civica%20di%20Milano/Societa'%20e%20Politica/Salute%20e%20Sanita'/DROGA%20MILANO%20SOS/</a>
<a href="#">ECCAS</a>	<a href="http://www.asl.bergamo.it/web/intsert.nsf/pages/Homepage">http://www.asl.bergamo.it/web/intsert.nsf/pages/Homepage</a>
<a href="#">EXODUS</a>	<a href="http://www.exodus.it/">http://www.exodus.it/</a>
<a href="#">Fondazione Promozione e Solidarietà Umana</a>	<a href="http://www.promozioneumana.it/home.asp">http://www.promozioneumana.it/home.asp</a>
<a href="#">Reinserimento Socio Lavorativo per Tossicodipendenti</a>	<a href="http://www.inserisciti.it/">http://www.inserisciti.it/</a>
<a href="#">Servizio Dipendenze, A.S.L. dell Provincia di Cremona</a>	<a href="http://www.aslcremona.it/html/carta_servizi/sanitarie/dipendenze.htm">http://www.aslcremona.it/html/carta_servizi/sanitarie/dipendenze.htm</a>
<a href="#">Ser.T. Montichiari</a>	<a href="http://www.sdrogabrescia.it/SerT.htm">http://www.sdrogabrescia.it/SerT.htm</a>
<a href="#">Ser.T., A.S.L. dell Provincia di Milano 2</a>	<a href="http://www.aslmi2.it/assi/SDipendenze/tossicod.htm">http://www.aslmi2.it/assi/SDipendenze/tossicod.htm</a>
<a href="#">Ser.T., A.S.L. dell Provincia di Milano 3</a>	<a href="http://www.mi3.asl.it/carta/frame/frame_int4c.htm">http://www.mi3.asl.it/carta/frame/frame_int4c.htm</a>
<a href="#">Usi e Abusi (Provincia di Brescia)</a>	<a href="http://www.sdrogabrescia.it/">http://www.sdrogabrescia.it/</a>
<b><a href="#">Marche</a></b> ( <a href="http://www.regione.marche.it/">http://www.regione.marche.it/</a> )	
<a href="#">Centro di Solidarietà "Vita Nuova"</a>	<a href="http://www.csv.marche.it/spazioadv/vitanuova">http://www.csv.marche.it/spazioadv/vitanuova</a>
<a href="#">Ser.T. di Macerata</a>	<a href="http://www.asl9.marche.it/SERT/home.htm">http://www.asl9.marche.it/SERT/home.htm</a>
<a href="#">Ser.T. di Pesaro</a>	<a href="http://www.ausl1ps.marche.it/CarteServizi/CartaServiziPS/DipPatologiche.htm">http://www.ausl1ps.marche.it/CarteServizi/CartaServiziPS/DipPatologiche.htm</a>
<a href="#">Ser.T. di S. Benedetto del Tronto</a>	<a href="http://www.asl12.marche.it/sert.html">http://www.asl12.marche.it/sert.html</a>
<a href="#">Ser.T. di Senigallia</a>	<a href="http://www.asl4.marche.it/territoriale/sert.htm">http://www.asl4.marche.it/territoriale/sert.htm</a>
<b><a href="#">Molise</a></b> ( <a href="http://www.regione.molise.it/">http://www.regione.molise.it/</a> )	
<b><a href="#">Piemonte</a></b> ( <a href="http://www.regione.piemonte.it/">http://www.regione.piemonte.it/</a> )	
<a href="#">Osservatorio Epidemiologico delle Dipendenze, Regione Piemonte - ASL 5 - Servizio di Epidemiologia</a>	<a href="http://www.oed.piemonte.it/italiano.htm">http://www.oed.piemonte.it/italiano.htm</a>
<a href="#">Associazione Fides</a>	<a href="http://web.tiscalinet.it/Fides">http://web.tiscalinet.it/Fides</a>
<a href="#">l'Associazione Le Patriarche</a>	<a href="http://www.lepatriarche.org/">http://www.lepatriarche.org/</a>
<a href="#">Dialoghi di Tossicodipendenza</a>	<a href="http://www.dialoghiditossicodipendenza.it/">http://www.dialoghiditossicodipendenza.it/</a>
<a href="#">Fermata d'Autobus</a>	<a href="http://www.fermatadautobus.org/">http://www.fermatadautobus.org/</a>
<a href="#">Gruppo Abele</a>	<a href="http://www.gruppoabele.org/">http://www.gruppoabele.org/</a>
<a href="#">Ser.T. ASL 1 (Torino)</a>	<a href="http://www.asl1.to.it/cartaservizi2001/sert.htm">http://www.asl1.to.it/cartaservizi2001/sert.htm</a>
<a href="#">Ser.T. ASL 7 (Settimo T.se - Chivasso - S. Mauro/Gassino)</a>	<a href="http://www.asl7.to.it/medspec_asstossic.htm">http://www.asl7.to.it/medspec_asstossic.htm</a>
<a href="#">Ser.T. ASL 9 (Ivrea)</a>	<a href="http://www.asl.ivrea.to.it/sert/index.html">http://www.asl.ivrea.to.it/sert/index.html</a>
<a href="#">Ser.T. ASL 10 (Pinerolo)</a>	<a href="http://www.asl10.piemonte.it/sert/index.htm">http://www.asl10.piemonte.it/sert/index.htm</a>
<a href="#">Ser.T. ASL 11 (Provincia di Vercelli)</a>	<a href="http://www.asl11.piemonte.it/servizi/tossico.htm">http://www.asl11.piemonte.it/servizi/tossico.htm</a>
<a href="#">Ser.T. ASL 13 (Provincia di Novara)</a>	<a href="http://www.asl13.novara.it/intranet/I-Servizi-/Ser-T-/index.htm">http://www.asl13.novara.it/intranet/I-Servizi-/Ser-T-/index.htm</a>
<a href="#">Sert ASL 14 Verbano Cusio Ossola</a>	<a href="http://www.asl14piemonte.it/ita/sert.htm">http://www.asl14piemonte.it/ita/sert.htm</a>
<a href="#">Ser.T. ASL 15 (Cuneo)</a>	<a href="http://www.asl15.sanitacn.it/Sert.html">http://www.asl15.sanitacn.it/Sert.html</a>
<b><a href="#">Puglia</a></b> ( <a href="http://www.regione.puglia.it/">http://www.regione.puglia.it/</a> )	
<a href="#">Servizi Tossicodipendenze - Regione Puglia</a>	<a href="http://www.servizisocialipuglia.it/">http://www.servizisocialipuglia.it/</a>
<a href="#">Cattedra di Tossicologia Forense</a>	<a href="http://www.tossicologia.uniba.it/index.html#0">http://www.tossicologia.uniba.it/index.html#0</a>
<a href="#">Comunità Emmanuel</a>	<a href="http://www.emmanuel.it/alcooltossicodip/dipendenza.asp">http://www.emmanuel.it/alcooltossicodip/dipendenza.asp</a>

<a href="http://www.promosud.it/">Consortio Promosud</a>	<a href="http://www.promosud.it/">http://www.promosud.it/</a>
<a href="http://digilander.libero.it/teseoct/Home%20page.html">Cooperativa Sociale Teseo</a>	<a href="http://digilander.libero.it/teseoct/Home%20page.html">http://digilander.libero.it/teseoct/Home%20page.html</a>
<a href="http://www.geocities.com/simssava">Gruppo SIMS SAVA (TA)</a>	<a href="http://www.geocities.com/simssava">http://www.geocities.com/simssava</a>
<a href="http://www.auslba3.it/ServiziTerritoriali/s45tossi.htm">Ser.T., ASL Bari 3</a>	<a href="http://www.auslba3.it/ServiziTerritoriali/s45tossi.htm">http://www.auslba3.it/ServiziTerritoriali/s45tossi.htm</a>
<a href="http://www.auslba5.it/DistrettiSocioSanitari/Sert.htm">Ser.T., ASL Bari 5</a>	<a href="http://www.auslba5.it/DistrettiSocioSanitari/Sert.htm">http://www.auslba5.it/DistrettiSocioSanitari/Sert.htm</a>
<a href="http://www.auslbr1.brindisi.it/seconda/CDSFrame2.htm#tossicodipendenza">Ser.T., ASL Brindisi 1</a>	<a href="http://www.auslbr1.brindisi.it/seconda/CDSFrame2.htm#tossicodipendenza">http://www.auslbr1.brindisi.it/seconda/CDSFrame2.htm#tossicodipendenza</a>
<a href="http://www.asl2maglie.le.it/dipartimenti/TOSSICODIPENDENZE.HTM">Ser.T., ASL Lecce 2</a>	<a href="http://www.asl2maglie.le.it/dipartimenti/TOSSICODIPENDENZE.HTM">http://www.asl2maglie.le.it/dipartimenti/TOSSICODIPENDENZE.HTM</a>
<b>Sardegna</b>	( <a href="http://www.regione.sardegna.it/">http://www.regione.sardegna.it/</a> )
<a href="http://web.tiscalinet.it/mondoxsardegna/">Associazione Mondo X - Sardegna</a>	<a href="http://web.tiscalinet.it/mondoxsardegna/">http://web.tiscalinet.it/mondoxsardegna/</a>
<i>Comunità Promozione Umana</i>	<a href="http://www.insiemesenza.org/">http://www.insiemesenza.org/</a>
<a href="http://vaxca1.unica.it/~saramu/new">Univerità di Cagliari, Dipartimento di Neuroscienze</a>	<a href="http://vaxca1.unica.it/~saramu/new">http://vaxca1.unica.it/~saramu/new</a>
<b>Sicilia</b>	( <a href="http://www.regione.sicilia.it/">http://www.regione.sicilia.it/</a> )
<a href="http://www.casarosetta.it/">L'Associazione "Casa Famiglia Rosetta"</a>	<a href="http://www.casarosetta.it/">http://www.casarosetta.it/</a>
<a href="http://www.ausl6palermo.org/energia.htm">Azienda USL 6 - Palermo</a>	<a href="http://www.ausl6palermo.org/energia.htm">http://www.ausl6palermo.org/energia.htm</a>
<a href="http://www.farosol.it/">Il Centro di Solidarietà F.A.R.O.</a>	<a href="http://www.farosol.it/">http://www.farosol.it/</a>
<a href="http://www.fenicecoop.org/">Cooperativa Fenice</a>	<a href="http://www.fenicecoop.org/">http://www.fenicecoop.org/</a>
<a href="http://www.regione.sicilia.it/sanita/x(foglioA).htm">Ser.T. in Sicilia</a>	<a href="http://www.regione.sicilia.it/sanita/x(foglioA).htm">http://www.regione.sicilia.it/sanita/x(foglioA).htm</a>
<a href="http://www.ausl7.rg.it/Strutture/servTossic.htm">Ser.T. ASL 17 (Ragusa)</a>	<a href="http://www.ausl7.rg.it/Strutture/servTossic.htm">http://www.ausl7.rg.it/Strutture/servTossic.htm</a>
<b>Toscana</b>	( <a href="http://www.regione.toscana.it/index.htm">http://www.regione.toscana.it/index.htm</a> )
<a href="http://www.agcionline.org/">Associazione Genitori Comunità Incontro</a>	<a href="http://www.agcionline.org/">http://www.agcionline.org/</a>
<a href="http://www.odissea.it/coorATanas/insieme.htm">Associazione Insieme</a>	<a href="http://www.odissea.it/coorATanas/insieme.htm">http://www.odissea.it/coorATanas/insieme.htm</a>
<a href="http://www.progettoaliente.it/">Associazione Progetto Aliante (onlus)</a>	<a href="http://www.progettoaliente.it/">http://www.progettoaliente.it/</a>
<a href="http://www.cedostar.it/">Centro Documentazione e Ricerca sul Fenomeno delle Dipendenze Patologiche (Ce.Do.S.T.Ar.)</a>	<a href="http://www.cedostar.it/">http://www.cedostar.it/</a>
<a href="http://www.csfirenze.com/Index2.html">Centro di Solidarietà di Firenze - onlus</a>	<a href="http://www.csfirenze.com/Index2.html">http://www.csfirenze.com/Index2.html</a>
<a href="http://www.ceislucce.it/">Centro di Solidarietà di Lucca</a>	<a href="http://www.ceislucce.it/">http://www.ceislucce.it/</a>
<a href="http://www.comune.prato.it/associa/centsol/">Centro di Solidarietà di Prato</a>	<a href="http://www.comune.prato.it/associa/centsol/">http://www.comune.prato.it/associa/centsol/</a>
<a href="http://www.cesda.net/">Centro Studi, Ricerca e Documentazione su Dipendenze e AIDS</a>	<a href="http://www.cesda.net/">http://www.cesda.net/</a>
<a href="http://www.cesdop.it/">Centro Studi e Documentazione Provinciale sulle tossicodipendenze e l'emarginazione</a>	<a href="http://www.cesdop.it/">http://www.cesdop.it/</a>
<a href="http://www.asf.toscana.it/modules.php?op=modload&amp;name=Sections&amp;file=index&amp;req=viewarticle&amp;artid=41&amp;page=1">Dipartimento Dipendenze, Firenze</a>	<a href="http://www.asf.toscana.it/modules.php?op=modload&amp;name=Sections&amp;file=index&amp;req=viewarticle&amp;artid=41&amp;page=1">http://www.asf.toscana.it/modules.php?op=modload&amp;name=Sections&amp;file=index&amp;req=viewarticle&amp;artid=41&amp;page=1</a>
<a href="http://www.usl9.grosseto.it/pagine/info/dipen.htm">Dipartimento delle Dipendenze, Grosseto</a>	<a href="http://www.usl9.grosseto.it/pagine/info/dipen.htm">http://www.usl9.grosseto.it/pagine/info/dipen.htm</a>
<a href="http://www.sims.it/associazioni/SIMS/">Gruppo SIMS</a>	<a href="http://www.sims.it/associazioni/SIMS/">http://www.sims.it/associazioni/SIMS/</a>
<a href="http://www.cedostar.it/cedro.htm">PROGETTO CEDRO.net</a>	<a href="http://www.cedostar.it/cedro.htm">http://www.cedostar.it/cedro.htm</a>
<a href="http://www.sert.it/">Ser.T.</a>	<a href="http://www.sert.it/">http://www.sert.it/</a>
<a href="http://www.usl2.toscana.it/sert/">Sert USL 2, Lucca</a>	<a href="http://www.usl2.toscana.it/sert/">http://www.usl2.toscana.it/sert/</a>
<a href="http://www.usl3.toscana.it/UOAziendali/sertvdm/sito/default1.htm">Ser.T. USL 3, Pistoia - Zona Valdinievole</a>	<a href="http://www.usl3.toscana.it/UOAziendali/sertvdm/sito/default1.htm">http://www.usl3.toscana.it/UOAziendali/sertvdm/sito/default1.htm</a>
<a href="http://www.usl6.toscana.it/sert/home.htm">Sert USL 6, Livorno</a>	<a href="http://www.usl6.toscana.it/sert/home.htm">http://www.usl6.toscana.it/sert/home.htm</a>
<a href="http://www.usl7.toscana.it/distretti/sert.html">Sert USL 7, Siena</a>	<a href="http://www.usl7.toscana.it/distretti/sert.html">http://www.usl7.toscana.it/distretti/sert.html</a>
<b>Trentino-Alto Adige</b>	( <a href="http://www.regione.taa.it/">http://www.regione.taa.it/</a> )
<a href="http://www.aziendasanitaria.trentino.it/direzioni/cura/sert.htm">Azienda Provinciale per i Servizi Sanitari, Provincia Autonoma di Trento</a>	<a href="http://www.aziendasanitaria.trentino.it/direzioni/cura/sert.htm">http://www.aziendasanitaria.trentino.it/direzioni/cura/sert.htm</a>
<a href="http://www.aziendasociale.bz.it/se04_01_20.html">Azienda Servizi Sociali di Bolzano</a>	<a href="http://www.aziendasociale.bz.it/se04_01_20.html">http://www.aziendasociale.bz.it/se04_01_20.html</a>
<a href="http://digilander.libero.it/marcoligorio/cts/Home.html">Centro Trentino di Solidarietà - ONLUS</a>	<a href="http://digilander.libero.it/marcoligorio/cts/Home.html">http://digilander.libero.it/marcoligorio/cts/Home.html</a>

<b>Umbria</b> ( <a href="http://www.regione.umbria.it/">http://www.regione.umbria.it/</a> )	
<a href="http://www.sedes.it/">Agenzia SEDES - Regione Umbria</a>	<a href="http://www.sedes.it/">http://www.sedes.it/</a>
<a href="http://www.comunitaincontro.org/">Comunità Incontro</a>	<a href="http://www.comunitaincontro.org/">http://www.comunitaincontro.org/</a>
<a href="http://www.asl3.umbria.it/carta/assterri/6.htm">Dipartimento per le dipendenze patologiche, ASL 3 di Foligno</a>	<a href="http://www.asl3.umbria.it/carta/assterri/6.htm">http://www.asl3.umbria.it/carta/assterri/6.htm</a>
<a href="http://www.asl4.terni.it/azienda/ser/ser.htm">Ser.T. ASL 4, Provincia di Terni</a>	<a href="http://www.asl4.terni.it/azienda/ser/ser.htm">http://www.asl4.terni.it/azienda/ser/ser.htm</a>
<b>Valle D'Aosta</b> ( <a href="http://www.regione.vda.it/">http://www.regione.vda.it/</a> )	
<a href="http://www.regione.vda.it/sanita/servterritoriali/dipendenze/default_i.asp">Servizio Tossicodipendenze e Salute Mentale</a>	<a href="http://www.regione.vda.it/sanita/servterritoriali/dipendenze/default_i.asp">http://www.regione.vda.it/sanita/servterritoriali/dipendenze/default_i.asp</a>
<b>Veneto</b> ( <a href="http://www.regione.veneto.it/">http://www.regione.veneto.it/</a> )	
<a href="http://www.pianodizonavi.org/">ASL Vicenza, Piani di Zona</a>	<a href="http://www.pianodizonavi.org/">http://www.pianodizonavi.org/</a>
<a href="http://www.autoaiutocorallo.org/">Auto Aiuto Corallo</a>	<a href="http://www.autoaiutocorallo.org/">http://www.autoaiutocorallo.org/</a>
<a href="http://www.ceisdonmilani.com/">Centro "Don Lorenzo Milani"</a>	<a href="http://www.ceisdonmilani.com/">http://www.ceisdonmilani.com/</a>
<a href="http://www.sunrise.it/ceis">Centro di Solidarietà di Belluno</a>	<a href="http://www.sunrise.it/ceis">http://www.sunrise.it/ceis</a>
<a href="http://www.ceistreviso.it/">CeIS Treviso</a>	<a href="http://www.ceistreviso.it/">http://www.ceistreviso.it/</a>
<a href="http://www.villarenata.eurovenezia.org/">Comunità terapeutica "Villa Renata"</a>	<a href="http://www.villarenata.eurovenezia.org/">http://www.villarenata.eurovenezia.org/</a>
<a href="http://veneto.dronet.org/">Dronet Veneto</a>	<a href="http://veneto.dronet.org/">http://veneto.dronet.org/</a>
<a href="http://www.itinerarisicurezza.org/">Itinerari di Sicurezza Sociale - Associazione Famiglie Veronesi Contro La Droga</a>	<a href="http://www.itinerarisicurezza.org/">http://www.itinerarisicurezza.org/</a>
<a href="http://www.pianodizonavi.org/auto_strutture/sertvicenz949574680.htm">Ser.T. Vicenza</a>	<a href="http://www.pianodizonavi.org/auto_strutture/sertvicenz949574680.htm">http://www.pianodizonavi.org/auto_strutture/sertvicenz949574680.htm</a>

## 15 Annexes

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- Map 10 Male clients of the Ser.T. testing positive for HIV infection as a percentage of male clients tested for HIV infection - 2002
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- Map 17 Female clients of the Ser.T. testing positive for HBV infection as a percentage of female clients tested for HBV infection - 2001
- Map 18 Male clients of the Ser.T. testing positive for HBV infection as a percentage of male clients tested for HBV infection - 2002
- Map 19 Female clients of the Ser.T. testing positive for HBV infection as a percentage of female clients tested for HBV infection - 2002
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- Map 25 Female clients of the Ser.T. testing positive for HCV infection as a percentage of female clients tested for HCV infection - 2001
- Map 26 Male clients of the Ser.T. testing positive for HCV infection as a percentage of male clients tested for HCV infection - 2002
- Map 27 Female clients of the Ser.T. testing positive for HCV infection as a percentage of female clients tested for HCV infection - 2002
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#### **15.4 Abbreviations used in the text**

DCSA	Direzione Centrale per i Servizi Antidroga (Central Directorate for Drug Services)
IPSAD	Italian Population Survey on Alcohol and Drugs
IFC – CNR	Istituto di Fisiologia Clinica (Sezione di Epidemiologia), Consiglio Nazionale delle Ricerche (Epidemiology Section of the Institute of Clinical Physiology, National Research Council)
ISTAT	Istituto Nazionale di Statistica (National Statistics Institute)
ISS	Istituto Superiore di Sanità (National Health Institute)
OIDT	Osservatorio Italiano sulle droghe e sulle tossicodipendenze (Italian Observatory on Drugs and Drug Addiction)