



2012

NATIONAL REPORT



European Monitoring Centre
for Drugs and Drug Addiction



Reitox
Italian Focal Point

2012 National Report (2011 data) to the EMCDDA by the Reitox Italian Focal Point

ITALY

New Development, Trends and
in-depth information
on selected issues

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Index

| | |
|--|----|
| SUMMARY | 7 |
| <hr/> | |
| PART A: NEW DEVELOPMENTS AND TRENDS | 21 |
| 1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS | 23 |
| <hr/> | |
| 1.1. Legal framework | 23 |
| 1.2. National action plan, strategy, evaluation and coordination | 26 |
| 1.3. Economic analysis | 36 |
| 2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED GROUPS | 45 |
| <hr/> | |
| 2.1. Drug use in the general population (the GPS-DPA Study) | 46 |
| 2.2. Drug use in the school and youth population (SPS-DPA Survey) | 55 |
| 2.3. Drug use in the general population (wastewater analyses) | 65 |
| 2.4. Drug use among targeted groups (Drug tests of workers in high-risk professions) | 70 |
| 3. PREVENTION | 77 |
| <hr/> | |
| 3.1. Universal prevention | 77 |
| 3.2. Selective prevention in at-risk groups | 80 |
| 3.3. Prevention in specific target groups | 82 |
| 3.4. National and local media campaigns | 83 |
| 4. PROBLEM DRUG USE | 87 |
| <hr/> | |
| 4.1. Introduction | 87 |
| 4.2. Prevalence and incidence estimates of PDU | 88 |
| 4.3. Data on PDUs from non-treatment sources | 90 |
| 4.4. Intensive, frequent, long-term and other problematic forms of use | 92 |
| 5. DRUG-RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY | 95 |
| <hr/> | |
| 5.1 Strategy/policy | 95 |

| | |
|---|-----|
| 5.2 Treatment systems | 96 |
| 5.3 Characteristics of treated clients | 102 |
| 5.4 Trends of clients in treatment | 109 |
| 6. HEALTH CORRELATES AND CONSEQUENCES | 113 |
| 6.1. Drug related infectious diseases | 113 |
| 6.2 Other drug-related health correlates and consequences | 118 |
| 6.3 Drug related deaths and mortality of drug users | 120 |
| 7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES | 127 |
| 7.1. Prevention of drug-related emergencies and reduction of drug- related deaths | 127 |
| 7.2. Prevention and treatment of drug-related infectious diseases | 129 |
| 8. SOCIAL CORRELATES AND SOCIAL REINTEGRATION | 135 |
| 8.1 Social exclusion | 135 |
| 8.2 Social reintegration projects | 138 |
| 9. DRUG-RELATED CRIME, PREVENTION OF DRUG-RELATED CRIME, AND PRISON | 145 |
| 9.1. Drug-related crime | 145 |
| 9.2. Prevention of drug-related crime | 151 |
| 9.3. Interventions in the criminal justice system | 153 |
| 9.4 Drug use and problem drug use in prisons | 156 |
| 9.5 Responses to drug-related health issues in prisons | 161 |
| 10. DRUG MARKETS | 163 |
| 10.1. Drug production, supply and trafficking | 163 |
| 10.2. Drug Operations and Seizures | 165 |
| 10.3. Price/purity | 168 |

PART B: SELECTED ISSUES 173

11. RESIDENTIAL TREATMENT FOR DRUG USERS IN EUROPE 175

11.1. History and policy frameworks 175

11.2. Availability and characteristics of residential treatment 185

11.3. Quality management in residential treatment 192

PART C: BIBLIOGRAPHY AND ANNEXES 195

BIBLIOGRAPHY 197

LIST OF TABLES 203

LIST OF GRAPHS 207

Editing:

Giovanni Serpelloni, Bruno Genetti, Elisabetta Simeoni, Roberto Mollica, Luciana Saccone

Contributors:

Nadia Balestra, Iulia Alexandra Carpignano, Carlo De Luca, Angelina De Simone, Carmela Danila Facchini, Anna Maria Fanfarillo, Sonia Principe, Claudia Rimondo, Lorenzo Tomasini, Maria Alessandra Tullio.

Revision and support for data gathering and documentation:

Silvia Zanone.

Data sources and acknowledgements:

Ministero dell'Interno:

- Dipartimento della Pubblica Sicurezza - Direzione Centrale Anticrimine della Polizia di Stato
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- Dipartimento per le Politiche del Personale dell'Amministrazione Civile e per le Risorse Strumentali e Finanziarie – Scuola Superiore dell'Amministrazione dell'Interno - Ufficio Documentazione Generale e Statistica

Ministero della Giustizia:

- Dipartimento dell'Amministrazione Penitenziaria – Direzione Generale dell'Esecuzione Penale Esterna
- Dipartimento dell'Amministrazione Penitenziaria – Ufficio per lo sviluppo e la gestione del sistema informativo automatizzato, statistica ed automazione di supporto dipartimentale
- Dipartimento degli Affari di Giustizia – Direzione Generale della Giustizia Penale - Ufficio I - Affari Legislativi, Internazionali e Grazie
- Dipartimento degli Affari di Giustizia – Direzione Generale della Giustizia Penale - Ufficio III - Casellario
- Dipartimento per la Giustizia Minorile – Ufficio I del Capo Dipartimento

Ministero della Salute

- Dipartimento della sanità pubblica e dell'innovazione – Direzione Generale Prevenzione – Ufficio II e VII
- Dipartimento della Programmazione e dell'Ordinamento del Servizio Sanitario Nazionale – Direzione Generale Programmazione Sanitaria – Ufficio VI
- Dipartimento della Programmazione e dell'Ordinamento del Servizio Sanitario Nazionale – Direzione Generale Sistema Informativo Statistico Sanitario – Ufficio III
- Dipartimento della Programmazione e dell'Ordinamento del Servizio Sanitario Nazionale – Direzione Generale dei dispositivi medici, del servizio farmaceutico e della sicurezza delle cure

Ministero dell'Istruzione, dell'Università e della Ricerca:

- Dipartimento Istruzione – Direzione Generale per lo Studente, l'Integrazione, la Partecipazione e la Comunicazione

Ministero degli Affari Esteri

- Direzione Generale per gli Affari politici e di Sicurezza
- Direzione Generale per la Cooperazione allo Sviluppo
- Direzione Generale per l'Unione europea

Ministero della Difesa – Direzione Generale Sanità Militare

Istituto Superiore Sanità:

- Dipartimento del Farmaco – Sostanze Stupefacenti e Psicotrope
- Osservatorio nazionale Alcol CNEPS

Assessorati Sanità e Servizi Sociali delle Regioni e Province Autonome

Istituto di Ricerche Farmacologiche Mario Negri

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Graphic design:

Riccardo de Conciliis

SUMMARY

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

In 2011, a total of 8 national and EC Regulatory Acts were approved which fell in the sphere of competence of the Department for Anti-drug Policies. 7 of these were national Regulatory Acts and one was international. The latter dealt with regulations for the monitoring of trade in drug precursors between the Community and third-party countries.

National and EC
Regulatory Acts

Most national Acts approved during the course of 2011 involve the updating and completion of the tables containing descriptions of narcotic and psychotropic substances (in accordance with DPR 309/90). Among the various Regulatory Acts, two which can be counted among the most important, in particular regarding the approval or modification of Laws, are Legislative Decree No. 150 of 1 September 2011, "Modifying Art. 75, Paragraph 9 of D.P.R. 309/90" and the Unified Conference Agreement on the documents proposed by the standing consulting committee on penitentiary healthcare regarding filing systems for adult prisoners, minors and young adults who are drug addicts and/or alcoholics.

In 2011, in the interests of evaluating the National Action Plan, an assessment questionnaire was distributed whose goal was to collect the opinions of professionals in the field (Public Drug Addiction Services [SerT] and Public Addiction Services [SerD], addiction departments, volunteer associations, social cooperatives, therapeutic communities, etc.) regarding the Plan's overall structure and specific action areas.

Assessment of the
National Action
Plan

An analysis of the results which emerged from the National Action Plan on Drugs 2010-2013 assessment questionnaires reveals overall positive evaluations of the plan and its various components.

In order to provide concrete support for the NAPD, another 31 projects were added in 2011 to those already launched in 2010, for a total investment of €9,212,141. These projects have strong central coordination and encourage the creation of both national and international networks for collaboration and cooperation.

The 2011 Projects
Plan:
€9,212,141 of
budget invested

Another initiative of interest is the Scientific Community on Addiction project, entrusted to UNICRI and carried out in collaboration with the Ministry of Health and the Ministry of Education, Universities and Research (MIUR), with its realization of initiatives aimed to develop a multidisciplinary scientific community equipped with information tools, a national training school and international collaborations for sharing best practices in the field of addictions.

Scientific
Community on
Addiction

During the year 2011, the Department for Anti-drug Policies further reinforced its involvement in activities in the international arena through participation in numerous activities abroad.

The Department for
Anti-drug Policies'
institutional
relationships in the
international arena

Specifically, the Department maintained its institutional and technical relationship with the United Nations (the UN Commission on Narcotic Drugs, the General Assembly, UNODC - the United Nations Office on Drugs and Crime, INCB - the International Narcotics Control Board) and with the European Union (the Horizontal Drugs Group – HDG, National Coordinators, the European Action on Drugs – EAD, the Dublin Group, the S.O.N. project - the European Programme for the Prevention of and Fight Against Crime (ISEC), the ERANID - ERA-NET on illicit drugs project) and with the European Council (the Pompidou group – Ministerial Conference, Permanent Correspondents and Platforms), as well as collaborating in the

realization of international projects (Italy-USA bilateral agreements, the Pompidou Group MedNET network, the DAD.NET project).

According to the definition of “social costs” as the costs directly and indirectly borne by the citizens and the population as a whole which derive from the consequences of drug use and the drug market, the overall social cost of the drug use in Italy in 2010 has been estimated at €31,219,389,542.87, equivalent to 2.0% of Italian gross domestic product (GDP) during that same period. The direct costs of drug-fighting activities and of activities to reduce and suppress drug demand and supply, together with social and healthcare costs, amount to approximately 4 million Euros (€3,964,535,166), or 13% of the overall social cost, a 3.3% increase over the 2010 figure. The cost category which accounts for the greatest portion of the total is that of expenditures for the purchase of drugs which, according to an estimate criterion different from that used in 2009, amount to approximately 22.5 million Euros.

The social costs linked to the phenomenon of drug use

2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED GROUPS

In the 2012 general population survey (conducted on a sample group of 18,898 subjects between the ages of 18 and 64) the following percentages of drug users (who reported having used drugs in the 12 months prior to the survey) emerged: heroin 0.1% (0.2% in 2010); cocaine 0.6% (0.9% in 2010); cannabis 4.0% (5.3% in 2010); stimulants – amphetamines – ecstasy 0.1% (0.3% in 2010); hallucinogens 0.2% (0.2% in 2010).

Decrease in numbers of drug users in the 12 months between 2010 and 2012

The following percentages of drug users (who reported having used drugs in the 12 months prior to the survey) emerged from the 2012 student population survey (conducted on a sample group of 35,980 subjects between the ages of 15 and 19): heroin 0.3% (0.4% in 2011); cocaine 1.9% (2.0% in 2011); cannabis 19.1% (17.9% in 2011); stimulants – amphetamines – ecstasy 1.1% (0.9% in 2011); hallucinogens 1.7% (1.9% in 2011).

2012 survey of students aged 15-19: a decline in cocaine, heroin and hallucinogen use and a slight increase in the use of cannabis and stimulants

An analysis of the figures for subjects who had used drugs in the last 30 days confirmed the above-mentioned trend, showing a slight but not significant fluctuation in the prevalence of cannabis and stimulant use.

The surveys thus reveal an overall decline in use for this year as well, although not as great as the drop seen in 2010-2011.

The use of more than one type of licit or illicit psychoactive drug is becoming the most characteristic and widespread pattern of drug use, with a strong tendency toward the concomitant or consecutive use of alcohol (between 73.0% and 82,6% in the general population and between 90.9% and 92.4% of the student population) and cannabis (between 35.6% and 37.9% in the general population and between 70.2% and 83.4% in the student population), in the 30 days prior to the survey.

Strong trend towards polydrug use

Parallel to the classic epidemiological studies, the Department for Anti-drug Policies has entrusted the Mario Negri Pharmacological Research Institute of Milan with the collection and analysis of wastewater samples gathered during 2011 in 17 cities (8 in 2010) across the country in order to measure the concentration of residual substances in those samples.

The drug used in the most substantial amounts was cannabis, with an average of 35.6 doses per day per 1,000 inhabitants in 2011, a number which remained more or less the same in comparison with the average

number of doses found in 2010 (34.2). Among the drugs whose use had fallen were cocaine (5.91 doses per day per 1,000 inhabitants in 2011 vs. 7.57 in 2010), heroin (2.98 vs. 2.05), amphetamines (not present in 2011 vs. 1.1 in 2010) and methamphetamines (0.25 vs. 3.27). Drugs whose use had increased were ecstasy (0.07 vs. 0.05) and ketamine (4.11 vs. 1.92).

Cannabis was the drug used in the most substantial amounts; declines in the use of heroin, cocaine, amphetamines and methamphetamines

Data from the Drug Testing for Workers in High-Risk Professions projects shows that 88,058 workers were subjected to Level One testing in 2011 (1.2% more than in 2009). The prevalence of drug use among the subjects tested revealed a 50.8% decrease, falling from 0.63% in 2009 to 0.31% in 2011 (269 subjects). 73.3% of subjects who had tested positive during Level One testing were confirmed positive during Level Two testing (197 workers); of these, 16.2% were diagnosed as suffering from addictions. In both Level One and Level Two testing, the most commonly detected drug was cannabis (52-61%), followed by cocaine (approximately 26%).

Drug tests for workers in high-risk professions

3. PREVENTION

An examination of the reports submitted by the individual Regions reveals a slight decrease in numbers of both universal and selective prevention initiatives, while there was a significant increase in the amount of funds invested in this area.

Approximately 48 million Euros invested in prevention by the Regions

A total of approximately 28,125,000 Euros was invested in universal prevention in 2011, and a further 19,874,000 in selective prevention, for a total of nearly 48 million Euros.

In 2011, activities for the promotion and organization of information campaigns to raise awareness regarding drug-use prevention among the population were conducted not only by the Regional Administrations, but also, on an institutional level, by the Department for Anti-drug Policies, which organized and launched five information campaigns ("Don't get high, live your life", the "Beaches campaign", the "Say Youth, Say Future" festival, "Pins – Do you stand against drugs?" and "Elementary, but not too elementary...").

Information campaigns for universal and selective prevention

Most of the initiatives launched during 2011 by the Regions and Autonomous Provinces were universal prevention campaigns (40, equal to 70%) as opposed to selective prevention campaigns, and only three Regions launched at least one campaign for each of the two areas, in comparison with the 6 Regions which launched both types of campaigns in 2010.

4. PROBLEM DRUG USE AND TREATMENT

Subjects who suffer from drug addictions (drug addicts who require treatment) were found to number approximately 329,750, thus representing 8.2/1000 residents between the ages of 15 and 64 years of age. Of these, 193,000 were addicted to opiates (4.9/1000 residents) and approximately 136,750 to cocaine (3.4/1000 residents).

329,750 is the estimated number of subjects in need of treatment

5. DRUG-RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY

On 11 June 2010 the “Institution of the National Information System on Addictions”, was approved by decree of the Ministry of Health. This new information flow contains individual data on subjects receiving care from the addiction services of the Regions and Autonomous Provinces.

The National Information System on Addictions (SIND) decree

By the end of the first half of 2012, not all Regions had adopted the new information flow. The previous aggregated data flow thus remained partially active and was used by a number of Regions and Autonomous Provinces in addition to the already-adopted SIND flow in order to be able to compare the data from the two information flows and evaluate their consistency.

Data transmission by the Regions and Autonomous Provinces

On 31 December 2011, a census found a total of 1,630 social-healthcare facilities dedicated to the treatment and rehabilitation of drug-addicted individuals; 563 were public drug addiction services.

1,630 social-healthcare treatment facilities

There were 1,067 private non-profit social-rehabilitative facilities, of which 66.4% were residential facilities, 17.9% were semi-residential and 15.7% provided outpatient services.

563 SerTs (Public Drug Addiction Service Units)

In comparison with 2010, there was a 2.4% decrease (26 facilities) in the number of social-rehabilitation facilities.

1,067 Communities

Closure of 26 Communities

Based on the aggregate data provided by the Ministry of Health on the clientele of outpatient addiction services, comprising new clients entering care in 2011, those already known to services (both those which began a new treatment in 2011 and those already undergoing treatment when 2011 began), and also based on estimates calculated upon receiving the partial information from the new data flow, we can estimate that 172,211 individuals received assistance from public drug addiction services in 2011, a decline of 1.1% over the previous year's figures. Of this population, approximately 20% were beginning their first-ever treatment of any kind with drug addiction services, while 80% were already known to services.

A total of 172,211 people receiving care from public drug addiction services, according to the aggregate data provided by the Ministry of Health

Over the last year, according to the estimates calculated for 2011, a decrease of 2.7% was observed in the number of new clients in the care of services, which fell from 34,625 clients in 2010 to 33,679 in 2011. This downturn, which can be observed among clients already known to services as well, might be explained by the criteria used when calculating the estimate, by the different information flows employed or by the lower level of information-flow coverage in the previous two-year period.

Number of new clients decreased over the last year

Based once again on the aggregate data received from the Ministry of Health, between 1991 and 2009 the average age of new clients increased, rising from 26 for both genders to 31.0 for women and 31.6 for men. Among clients already known to services, the average age continues to rise, although differently for each gender, with a more pronounced age increase for men than for women: men rose from 35.2 years of age in 2010 to 35.9 in 2011, while the average age for women already known to services rose from 33.9 in 2010 to 34.7 in 2011.

Increase in average age at the time of first request for care from services: from 26 in 1991 to 31.6 for men and 31.0 for women in 2011

Of all the people undergoing treatment with Drug Addiction Services in 2011 who specified a primary drug of use, 69.3% reported that drug to be heroin, followed by cocaine (15.3% of the total number of clients undergoing treatment) and then by cannabis (9.2% of the total number of clients undergoing treatment).

Most commonly used primary drugs:
69.3% heroin,
15.3% cocaine,
9.2% cannabis

Among secondary drugs, in 2011, as in 2010, the most commonly used are cocaine and cannabis, with nearly equal percentages of about 30%. There was also a slight increase in injecting opiate use during the last year (58.9% in 2010 vs. 61.0% in 2011), although it still remains below the 1997 level (approximately 68%).

An initial analysis of estimated distribution of subjects in care divided by treatment type shows that most of these (66.6%) were receiving pharmacological treatment, of whom the majority (75.1%) received methadone, while 30.5% of subjects receiving treatment in 2011 were undergoing psycho-social and/or rehabilitation treatment. It is, however, important to remember that the total number of subjects receiving treatment during the course of the year could appear higher than it actually was, due to the fact that the same subject could be counted more than once if undergoing more than one type of treatment during the time period of reference.

186,073 treatments provided by Public Drug Treatment Units (SerTs)

6. HEALTH CORRELATES AND CONSEQUENCES

Information on testing for infectious diseases in 2011 remains partial due to the introduction of the new National Information System on Addictions (SIND) among drug-addiction services,

Information flows on infectious diseases remain partial

In fact, due to issues of only partial transmission of the information flow or to a failure to submit data, it was impossible to conduct an analysis of the situation concerning the infectious diseases HIV, HBV and HCV for four of the Regions.

In order to maintain continuity with data from previous years for those Regions for which information was available, data was processed based upon the aggregate data flow collected by the Ministry of Health through the annual survey conducted using the forms denominated ANN.04, ANN.05 and ANN.06. However, aggregate data does not allow for a detailed analysis of the prevalence of infectious diseases among those clients who inject psychoactive drugs.

In the 14 Regions which submitted data flows using the ANN forms (M.D. 20 September 1997), we find that in 2011, as in previous years, there is a tendency not to perform tests on subjects. The Regions with the highest percentage of subjects not being tested were found to be Tuscany (86.6% not tested), Abruzzo (83.4%), Sicily (81.1%) and Sardinia (81.0%).

'No Testing' in: Tuscany, Abruzzo, Sicily and Sardinia

There was a growing prevalence of HIV-positive test results among new clients during the period from 2006-2011 in Marche and Valle d'Aosta, while the number of HIV-positive results fell among the same client group in Molise, Apulia and Veneto.

Differences in trends of prevalence of HIV-positive test results during the period from 2006 to 2011 for new clients and clients already known to services

Among clients already known to services, we can see an increase in prevalence in Veneto (the trend among new clients is the opposite) and in Friuli Venezia Giulia, while there is a significant downturn in the Regions of Apulia, Sardinia and Marche (the trend among new clients is the opposite).

There has been an on-going tendency not to test patients for viral hepatitis B over recent years as well. Of the 14 Regions which submitted data in accordance with the M.D. 20 September 1997 (ANN forms) information flow, the national percentage distribution of 'No Testing' shows the highest

numbers of clients not being subjected to testing in Abruzzo (92.6%), Tuscany (92.1%) and Sicily (86.5%). On the other end of the spectrum, the Regions with the lowest percentage of clients not being subjected to testing are Campania (60.1%) and the Autonomous Province of Trento (69.0%).

Among new clients subjected to HBV testing, the prevalence of positive results was found to be falling in five Regions (Campania, Apulia, Sardinia, Tuscany and Veneto) but rising in the Regions of Calabria, Friuli Venezia Giulia and Molise, while the remaining six Regions displayed no significant variations in the trend of HBV-positive test results.

There was found to be greater variability among clients already known to services in comparison with new clients; indeed, it is only in four Regions that trends in HBV-positive test results showed no variation between 2006 and 2011. In the majority of the Regions (Abruzzo, Campania, Apulia, Sardinia, Veneto and the Autonomous Province of Trento) the percentage of HBV-positive clients already known to services decreased, in contrast with the rising trends in the Regions of Calabria, Molise, Sicily (Regions in which there was also found to be a rise in prevalence of HBV-positive results among new clients) and Valle d'Aosta.

We can see that the same alarming situation which exists for HIV and HBV also exists for HCV, with a wide spread of the virus and a low number of tests being performed. 'No Testing' percentages show that the Regions which perform the least testing are Tuscany (90.2%), Abruzzo (90.2%) and Valle d'Aosta (89.9%).

An analysis of trends in the prevalence of subjects testing positive for HCV in the period from 2006 to 2011 reveals a decrease in the Regions of Calabria, Campania, Marche, the Autonomous Province of Trento, Apulia, Sardinia and Sicily. The Regions where, on the other hand, the prevalence trend was shown to be rising between 2006 and 2011 were Tuscany and Veneto.

Among new clients in the six Regions of Campania, Apulia, Sardinia, Sicily, Tuscany and the Autonomous Province of Trento, the prevalence of HCV-positive test results was found to have fallen in the period from 2006 to 2011, while it was shown to have risen only in the Region of Molise. Among clients already known to services, the number of positive serological test results fell in most of the Regions as well (Calabria, Campania, Marche, Apulia, Sardinia, Sicily and the Autonomous Province of Trento), while the only rise in numbers was found in the Marche Region. Traffic accidents are a serious problem not only for drug and alcohol users but also third parties involved in these occurrences. Many accidents are alcohol- or drug-related. The total number of traffic accidents decreased by 1.9% between 2009 and 2010. Moreover, there was a 3.5% decrease in the number of deaths and a 1.5% decrease in the number of injuries.

The number of checks carried out on roads has increased, with a concomitant increase in the number of violations under Art. 186 of the Traffic Code (driving under the influence of alcohol +4.9%) and a decrease in violations under Art. 187 (-3.8% driving under the influence of drugs).

There has been a long-term, on-going decrease in drug-related deaths in Italy, and this trend is more pronounced than in Europe as a whole. In 1999, there were 1,002 deaths, while in 2011 there were 362. Deaths among female subjects have increased in proportion to deaths among male subjects (11.2% in 2010 and 13.3% in 2011). The average age at time of death has also risen.

Decrease in numbers of deaths and injuries related to traffic accidents

On-going fall in acute drug-related mortality (overdose, etc.)

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

The 2010 – 2013 National Action Plan on Drugs devotes a large section to the treatment and prevention of drug-related diseases, with a specific action area, which includes six targeted objectives. Between the end of 2011 and the beginning of 2012 a study was conducted to monitor regional best practices in the field of “addictions” under the various action areas and evaluate them in relation to the action areas set down in the NAPD.

With reference to the six NAPD goals dedicated to the prevention of drug-related diseases, the survey showed that, of these, the NAPD goals least implemented by the Regions and Autonomous Provinces were those having to do with the launch of gender-oriented programmes.

At the same time, the goals with the highest levels of conformity were found to be the reduction of acute drug-related mortality, the management of patients with drug-related diseases, reducing the transmission of infectious diseases (HIV, HCV, etc.) and reducing the risk of death by overdose. Other NAPD objectives which have been widely implemented at a regional level are the reduction of social risks and family problems linked to drug use and the guaranteeing of appropriate treatment to prison inmates.

The information collected from the Regional Administrations by means of Structured Questionnaire (SQ), 23 regarding the “Prevention and reduction of drug-related diseases and of acute drug intoxication mortality” shows a smaller number of priority programmes for the prevention of death by acute drug intoxication being in effect in 2011.

In comparison with 2010, the amount of funds set aside by the Regions for the prevention of acute mortality shrank by nearly two-million Euros (-21.8%). In 2011, there were 123 structured services in existence in the Regions and Autonomous Provinces (33.2% fewer than in 2010) serving over one-hundred thousand individual clients. The only type of service which increased its numbers in 2011 was that of street units dealing with problems associated with prostitution.

The decline, which has been on-going over recent years, in HIV and Hepatides B and C testing being offered by drug addiction services continues. To encourage the adoption and application of the guidelines published by the Department of Anti-drug Policies in 2010, in 2011 the Department launched a targeted project, Early Diagnosis and Treatment of Drug-related Diseases (a.k.a. DTPI), which has been entrusted to the AIDS Operative Centre of the Higher Institute of Health.

Information regarding drug-related infectious disease prevention initiatives in prisons and in social-rehabilitation facilities, collected from Regional Administrations, shows that the most common prevention initiatives were, specifically, those concerning infectious disease risk assessment and individual counselling, with 75% of Regions reporting that such actions had been carried out both in therapeutic communities (80% of Regions) and in prisons (70% of Regions); in the other Regions these types of initiatives were more commonly conducted in communities than in prisons.

Monitoring
Regional best
practices in the
addictions field in
relation to the
NAPD

NAPD goals least
implemented by the
Regions

NAPD objectives
most implemented
by the Regions

2 million Euros less
than in 2010

Launch of the Early
Diagnosis and
Treatment of Drug-
related Diseases
(DTPI) Project

Drug-related
infectious disease
prevention
initiatives in
therapeutic
communities and in
prisons conducted
by the Regions

8. SOCIAL CORRELATES AND SOCIAL REINTEGRATION

33.7% of clients of Public Drug Treatment Units (SerTs) are unemployed. Women have the highest unemployment rate (41.1%). Moreover, the percentage unemployed is higher among heroin users than among cocaine and cannabis users. 4.3% of Public Drug Treatment Unit clients are homeless.

State of employment: 69% of service clients are employed

Among unemployed services clients, significant differences can be observed between new clients who use opiates and those already known to services for their use of these types of drugs (50.6% vs. 73.0%); on the contrary, cocaine and cannabis users already known to services have a much lower unemployment rate than their counterparts among new clients (-10.6 and -11.2 percentage points, respectively).

Another social aspect of particular interest when monitoring phenomena related to drug use is the living situation of clients in the care of Public Drug Treatment Units, with special regard to homelessness. In 2011, 4.3% of the total number of service clients were homeless. Of these, the largest percentage were opiate users.

With reference to the first nine NAPD objectives addressing rehabilitation and reintegration, the study monitoring Regional best practices in this area showed that the extent to which the Regions and Autonomous Provinces were found to have complied with these goals was much lower than the conformity found for goals that address treatment.

Monitoring regional best practices in the field of addictions in comparison with the NAPD

The majority of Regions claim only that the goals set forth in the NAPD exist in the form of regulations, with the exception of a small number of Regions who have already adopted the activities set forth in the NAPD as part of their routine practices.

The existence of a mediocre rate of conformity was found when evaluating the actual situation in the Regions with respect to the goals set. This is true in the case of some goals which fall largely under the competence of national authorities (the creation of a nationwide standard for principles and principal methods of rehabilitation and reintegration), as well as for a number which are of strictly local competence (reintegration into the employment structure of ordinary businesses, or the development of operative units for reintegration into departments).

In comparison with 2010, there has been an overall sharp drop in funding (-21.4%), largely attributable to the fact that funding in Campania was halved and in Piedmont was cut altogether. The Autonomous Province of Bolzano alone accounts for 15.7% of the national total.

21.4% less funding for social reintegration programmes than in 2010.

Concerning social reintegration, an average of 50% of Regions and Autonomous Provinces created housing programmes specifically created for individuals undergoing social and healthcare treatment for the use of psychotropic drugs in 2011. 55% of Regions and Autonomous Provinces report that they provide residential facilities for the social reintegration of drug addicts.

50% of Regions reported having launched housing programmes for drug addicts

Workplace reintegration was reported as being a high priority goal by the Regions and the Autonomous Provinces, although, in 2011, only 35% of these created employment and job training programmes exclusively for current and former drug users. If we include in this figure those programmes which are open to other socially disadvantaged groups as well, the percentage rises to 65%.

Few job training programmes have been put into effect

9. DRUG-RELATED CRIME, PREVENTION OF DRUG RELATED CRIME AND, PRISON

In 2011, if we look at actions combating violations of drug law, we find that there were 23,103 anti-drug operations, 36,796 charges brought (-5.8%) and 28,552 arrests made for crimes in violation of DPR 309/90. 65.6% of subjects reported to the Judicial Authorities in 2011 were Italian and 8.5% were women. The average age of subjects reported was approximately thirty-one.

In 2011, a total of 29,190 persons were reported under Article 75, of whom 27,275 were male (equal to 93.4%). In comparison with 2010, when 17,250 sanctions were issued under Art. 75, we can see a decrease in 2011 (16,254). Ever since 2006, there has been a steep decline in the number of subjects referred to treatment programmes and an increase in the number of sanctions applied. This phenomenon is sustained by the failure to suspend sanctions when subjects agree to enter treatment programmes (Law 49/2006).

In 2011, 24,608 adult subjects entered correctional institutions as a result of crimes under drug law, of whom some entered prison on more than one occasion during the year. With respect to 2010, we find there was a 5.9% decrease in the number of persons entering prisons for these types of crimes. 40.4% of subjects entering prisons in 2011 for crimes in violation of drug law returned to liberty during the course of the same year.

During the course of the same year, the number of persons with drug-related social and healthcare problems entering prisons stood at 22,413, while there were 24,008 in 2010, which means there were 1,595 less drug-addicted prison inmates, a 6.6% decrease. It is worth noting that the number of subjects who were granted parole or probation under Art. 94 of DPR 309/90 decreased by 8.7% over 2010, falling from 2,526 in 2010 to 2,306 in 2011.

The number of juveniles entering correctional facilities for crimes under DPR 309/90 increased by 45% with respect to 2010, with foreign juveniles accounting for a large part of this growth. Nearly all juveniles placed in custodial facilities for crimes in violation of drug law were male (95.4%), and the majority were Italians (55.7%), with an average age of little more than 17 for both Italians and foreigners.

10. DRUG MARKETS

In 2011 the number of Law Enforcement Activities targeting the three main fronts of drug production, trafficking and sales increased by 4.7% with respect to 2010. There were a total of 23,103 anti-drug operations in 2011, 84.3% of which led to the seizure of illicit drugs, 8.5% to additional crime detection and 6.6% to the discovery of quantities of drugs.

Amounts of marijuana and cocaine seized rose dramatically (98.1% and 65.2%, respectively) in comparison with 2010.

There was, however, a decrease in amounts of synthetic drugs (-77.8%) and heroin (-14.1%) seized.

There was a significant increase in the number of cannabis plants seized, which amounted to 1,008,215 (+1289.9%).

In 2011: 36,796 charges brought for crimes under DPR 309/90:
-5.8% charges
-1.8% arrests

29,190 subjects reported by Law Enforcement under Art. 75.
Decrease in sanctions under Art. 75 and in the number of persons sent to Public Drug Treatment Units

Decrease in numbers of subjects entering prisons for crimes under DPR 309/90

40.4% return to liberty within a year.

1,596 less drug-addicts in prisons (a 6.6% decrease)

2,306 subjects granted parole or probation

Decrease in the number of juveniles entering correctional facilities for crimes under DPR 309/90

Increase in the number of anti-drug operations

Increase in volumes for marijuana and cocaine
Significant increase in numbers of cannabis plants

In 2011, the average percentage of active principle discovered in samples analysed decreased both for cannabinoids (THC), falling from 7% to 6%, and for heroin, dropping from 26% to 22%. The percentage of pure drug in cocaine increased slightly.

Meanwhile, for MDMA, the number of mg of MDMA contained in each pill/unit rose from 30 mg in 2010 to 84 mg in 2011.

Sale prices for drugs were found to be stable (both minimum and maximum) for brown heroin (35 and 48 Euros, respectively) and amphetamines (16 to 17 Euros). The maximum costs fell for both hashish and LSD (11.5 and 27 Euros, respectively), as did the minimum price for cocaine (55 Euros). The maximum cost of ecstasy rose slightly (18.8 euro).

Heroin purity (ranging from 2% to 78%) remained variable in 2011, as in previous years, as did the purity of cocaine (13% to 86%) and MDMA (35 mg – 135 mg). Variability was more limited for cannabinoids (0.4 – 14.8%).

Decrease in % of active principle in cannabinoids and heroin
Slight increase in % of active principle in cocaine
Increase in mg of MDMA per pill/unit

Brown heroin and amphetamine prices remain stable

Slight increase in maximum price for ecstasy

11. RESIDENTIAL TREATMENT FOR DRUG USERS IN EUROPE

From a regulatory standpoint, social-rehabilitation facilities, like public drug addiction services, fall under the umbrella of the Consolidated Law of Presidential Decree (DPR) 309/90. This law identifies the competences of the responsible Regional, Provincial and Local Authorities' and Local Health Units regarding the social-rehabilitative care of drug addicts, types of facilities, including the requirements for facilities which are permitted to provide social-rehabilitative care, their functions, types and treatment contexts.

Following significant and diverse evolution of the responsibilities of the agencies and associations collaborating with public drug addiction services after the application of DPR 309/90, the State-Regions Accord Act of 5 August 1999 established the minimum standards required for private healthcare services to obtain authorization for operation and accreditation to assist drug-dependent individuals. The services offered by these facilities are divided into the areas of reception, therapeutic-rehabilitation services, specialized treatment services, pedagogical rehabilitation services and integrated multidisciplinary services.

In the sphere of anti-drug policies and strategies, the National Action Plan 2010-2013 contains five principal action areas, one of which is specifically devoted to the rehabilitation and social and work reintegration of drug addicts. Rehabilitation and reintegration are the central features of the plan, highlighting the belief that total recovery of drug-dependent individuals and their full reintegration into society is not only always possible but of fundamental importance.

Among those principal goals of the NAPD which focus on the rehabilitation and reintegration of drug addicts, we find the launch of the "RELI" project, funded with a budget of approximately 26 million Euros, equal to 34% of the total budget of the Projects Plan launched by the DPA in 2010-2011.

On 31.12.2011, according to sources of the Ministry of the Interior, there were a total of 1,067 social-rehabilitative facilities operating in Italy. The majority of these were residential facilities (66.4%), followed by semi-residential facilities (17.9%) and outpatient facilities (15.7%). In comparison with 2010, there has been a 2.4% decrease (26 facilities) in

The RELI Project

1,067 social-rehabilitative facilities, of which 66.4% residential communities

the number of social-rehabilitation facilities, a decrease which has affected a greater number of semi-residential facilities (5.4%) and outpatient facilities (4.5%).

In 2011, there were a total of 789 diagnostic - therapeutic - rehabilitative facilities listed according to the Framework of the State-Regional Accord Act of 5 August 1999, a 13.9% decrease in comparison with 2010. The number of residential facilities dropped sharply, confirming the trend already observed in the previous year (31.8% less than in 2010). The number of semi-residential facilities also fell (-30.4% in comparison with 2010).

As of 31.12.2011, according to sources from the Ministry of the Interior, there were a total of 16,923 clients receiving care from social-rehabilitative facilities. Most of these were men (83,8%). In comparison with 2010, we can see a 13.1% increase in the number of clients, in contrast with the trend observed between 2007 and 2010.

The State-Regions
Accord Act of 5
August 1999

Residential facilities
fell by 31.8%

16,923 persons in
the care of social-
rehabilitative
facilities

FINAL THOUGHTS AND CONCLUSIONS

The situation that emerges in the light of the large amount of information collected and processed regarding the drug phenomenon in Italy is one of an overall decrease in drug use in recent years, a decline which nonetheless has undergone a number of different variations, especially where some of the drugs used in lesser proportions, such as ketamine and ecstasy, are concerned. This situation can be viewed as a positive change in the decade-long trend of expansion seen in the past.

It is now clear that it is necessary to continue along the path laid by the strategies which have been implemented, which have led, in the last four years, to this positive reversal in trend. Nonetheless, we must keep our guard up since, even though the most commonly-used drugs are dropping in prevalence, as is their occasional use, this trend is not the same for all drugs nor in all parts of the country.

Moreover, the future could bring changes in the range of illegal drugs available, which might be the spark that could reignite consumption or launch new, albeit minor, markets, with the advent of new drugs or narcotic substances which are as yet unknown.

Regarding future issues, one worrisome problem is the low perception of risk associated with the use of cannabis and the tendency to underestimate this issue, which leads to greater prevalence of use, especially among the younger generations. It has been scientifically proven that this low risk perception on the part of adolescents derives, in part, from low social disapproval of cannabis use, as well as from a body of information which tends to make light of the negative effects cannabis has on health and on the safety of others and, last but not least, the fact that it compromises proper neuropsychological and cerebral development. It is not by chance that, when criminal organizations wish to open up new markets in geographic areas where drug use is not at all widespread, it is cannabis that they use as a "trail-blazer", and once the population has been sensitized to it, they introduce more serious and lucrative products such as heroin and cocaine. The truly serious issue of the next few years will therefore be to further reduce and check this general phenomenon, limiting and reducing the use of cannabis and its derivatives, especially among the younger generations and the most vulnerable individuals.

Similarly, the use and abuse of alcohol among the younger generations is also problematic, as alcohol can serve as a "gateway" substance, sensitizing young people for the development of drug addictions. This

problem is far too often underestimated and not taken into proper consideration.

In the opinion of the Head of the Department for Anti-drug Policies, and based upon accredited scientific studies, not to mention the current policy-direction taken by the United Nations, no quarter can be given to the idea of legalizing drugs, as this would only lead to an increase in their availability and accessibility, especially for the younger generations and would inevitably lead, over time, to a rise in the number of users, and therefore of vulnerable individuals who would become addicted to drugs such as heroin and cocaine. The expectation that this solution would be a way to deprive criminal organizations of the income from drug dealing has its appeal, but is practically unfeasible and, in any case, would require too high of a price in terms of public health, in addition to being an ineffective way to create true financial difficulties for criminal organizations.

Once again this year, a number of elements emerged which certainly still can be ameliorated, especially in the areas of prevention, education, care and, most of all, rehabilitation (a sector which is still poorly developed and in need of improvement); the fight against drug trafficking and dealing could also be further developed. The efficiency and effectiveness of many actions could be further increased and, most importantly, the time has arrived to orient the services system more towards rehabilitation and social and workplace rehabilitation, in order to improve the real effectiveness of treatment programmes.

The possibilities and the expertise exists, as the network of public and private non-profit services clearly demonstrate, but it is this very network that requires not only greater support and enhancement, but also reorientation towards new strategies for the recovery of drug-addicted individuals, offering them the chance to have a self-sufficient and socially integrated life.

Therefore, the launch or enhancement of Addiction Departments (self-managed and with clearly-defined character) could be the right, most advisable choice, from a technical and organizational standpoint, to strengthen us along this new and innovative path, which can be considered an investment. Indeed, its aim is the recovery of individuals, the majority of whom are young people and, therefore, a precious human and social resource which could, on the one hand, become a font of productive energy for our country or, on the other hand, end up actually being nothing more than a social and health cost, as well as a source of suffering and frustration for us all.

Another aspect which demands greater attention is that of drug-related infectious diseases, for which the early diagnosis situation is inadequate, leading to a consequent deficiency in early access to therapy for individuals who have contracted these illnesses. Indeed, the percentage of drug addicts in the care of Public Drug Treatment Units who have not been tested for HIV (69.5%) is alarming. This problem, which has been brought to the attention of the Regions and Autonomous Provinces on numerous occasions, including by means of a special alert from the Early Warning System on 09.12.2011, has not yet been solved and is tending to become ever more serious.

The capability to properly monitor the phenomenon from an epidemiological standpoint has, unfortunately, been lost, and this could certainly have an extremely negative effect on the ability to control the HIV, HBV and HVC epidemic in coming years. Apprehension only grows if we observe trends which, although the figures are only estimates and certainly require review, show an increase in HIV infection rates among new clients entering the care of Public Drug Treatment Units.

At the same time, the fight against drug trafficking and dealing must be continued and intensified, most importantly by supporting operations conducted within the country and by combating the illegal growing of cannabis, which has increased vertiginously in Italy, with a 1,290% increase in numbers of plants seized. The Internet phenomenon, with its online dealing not only of narcotic substances but also of counterfeit medications, often taken in concomitance with drugs, also requires careful monitoring.

The balanced approach which we have striven to create has certainly proved itself effective, but its principle lines of action must be further improved and strengthened, especially by seeking to establish greater coordination among all of the various organizations and institutions working in this field, whether they be Regional, Central or part of the non-profit sector.

The speed at which our existing systems are able to adapt is undeniably slow in comparison to the rapidity and “modernization” of the new system of drug dealing and trafficking, which leaves them unable to keep up with the appearances of new drugs or trends on the illegal market. Timeliness and coordination, which make it possible to effectively counter the problem, have become necessary, key elements of a critical nature.

Regarding matters more strictly related to prevention and treatment, in order to improve the current approach, we must more firmly base ourselves upon the belief, which has existed for years among the most important international scientific organizations and the United Nations, that drug addiction is not “criminal behaviour” or a moral problem, but rather a disease which can be prevented, treated and cured, a disease which constitutes a serious and important social and health problem which must be fought using plans and programmes based upon scientific evidence. Furthermore, any drug use, even occasional, must be considered a high-risk behaviour with the potential of causing harm not only to the user himself but also to others, and this behaviour must be fought, both by means of suitable early education and with legal solutions such as sanctions, as well as by actions in the administrative sphere, but with measures intended to deter and limit use, not discriminate.

Prevention must therefore go hand in hand with educational initiatives and programmes for deterrence founded upon rules and sanctions under the law. What remains indisputable is the need to legally prosecute those who produce, cultivate, traffic and deal in drugs in violation of the law in force.

Drug-dependent individuals should not be criminalized for their drug-using behaviour. However, it is also true that those who use drugs often commit crimes as a result of their disease. For this reason, we must help these individuals to end their drug use early, and with it any criminal behaviours. This can be done by always offering early and suitable forms of treatment and rehabilitation and by exploiting alternatives to imprisonment as often as possible.

It is therefore necessary to persist and continue in this commitment, which we hope may become as concerted as possible throughout all the different sectors involved in this field. This goal has been highlighted and well-defined in the strategic documents of the Department, as well as in the National Action Plan, which represents a point of reference for all the Regions, Autonomous Provinces and various organizations operating in Italy, all of which are united by their desire to collaborate effectively together in the fight against drugs in our country.

Part A

New Developments and Trends

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

1.1. Legal framework

The legal framework applicable in cases related to illegal psychotropic substances did not undergo any changes in 2011, remaining the same as in the previous year, both on a national level – where the legal framework consists of the Consolidated Law covering regulations in the field of narcotic drugs and psychotropic substances, prevention and treatment of drug addiction and rehabilitation of drug addicts, approved with Presidential Decree No. 309 on 9 October 1990, as well as on an international level. Internationally, the legal framework is comprised of the Single Convention on Narcotic Drugs of 30 March 1961, the 26 March 1972 Protocol Amending the Single Convention of 1961, the 21 February 1971 Convention, based on the principle of banning the use of psychotropic substances if not for medical and scientific needs and which likewise regulates and monitors the legal drug market, controlling and monitoring, albeit less strictly, approximately one-hundred additional substances not covered under the 1961 Convention, as well as the 20 December 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

Legal framework

1.1.1 National and international regulatory measures approved in 2011

We refer back to that which was already reported in the 2011 National Report regarding Legislative Decree No. 50 of 24 March 2011 which established “The Implementation of *Regulations (EC) No. 273/2004, No. 111/2005 and No. 1277/2005*, as amended by *Regulation (EC) 297/2009* on drug precursors, enacted by *Article 45 of Law No. 96 of 4 June 2010*.” What follows is a brief note on further relevant regulations which were enacted during the course of 2011.

Article 34, Paragraph 7 of Legislative Decree No. 150 of 1 September 2011, establishing “Code of Civil Procedure complementary measures for the reduction and simplification of civil cognizance proceedings, in accordance with Article 54 of Law No. 69 of 18 June 2009, which substituted Paragraph 7 of Art. 5 of Presidential Decree (D.P.R.) No. 309/1990, regulating legal actions which can be brought before the judicial authorities appealing against decisions by Prefects regarding sanctions issued under the aforementioned Art. 75, Paragraph 1.

Objective No. 3, Action 3.1 of the “Legislation, combating drugs and youth justice” Action Area of the National Drug Plan 2010-2013 calls for the facilitation of the procedure for updating the tables attached to the Consolidated Law on Drugs, in order to guarantee timely inclusion of new drugs appearing on the illegal market in these lists. In line with this objective, and thanks to collaboration between the Ministry of Health, the Department for Anti-drug Policies and the Higher Board of Health, four ministerial decrees were issued during the time period under consideration:

Ministerial Decree of 31 March 2011, establishing an “Update to the tables containing descriptions of narcotic and psychotropic substances and

related medicinal compounds, in accordance with the requirements of Presidential Decree No. 309 of 9 October 1990 and subsequent amendments and additions, with the addition of Tapentadol to Annex III.2 and Tapentadol-based medicinal compounds, limited to non-injectable pharmaceutical formats, to Table II of Section D”.

Ministerial Decree of 11 May 2011 establishing an “Update to the tables containing descriptions of narcotic and psychotropic substances, in accordance with the requirements of *Presidential Decree No. 309 of 9 October 1990* and subsequent amendments and additions. Addition of 3,4-methylenedioxypropylvalerone (MDPV), JWH-250, JWH-122 and analogues structurally derived from 3-phenylacetylindole and 3-(1-naphthoyl)indole to Table I.”

Ministerial Decree of 2 August 2011 establishing an “Update to the tables containing descriptions of narcotic and psychotropic substances, in accordance with the requirements of *Presidential Decree No. 309 of 9 October 1990* and subsequent amendments and additions, moving the drugs Amfepramone (diethylpropion), Phendimetrazine, Phentermine and Mazindol into Table I.”

Ministerial Decree of 29 December 2011 establishing an “Update to the tables containing descriptions of narcotic and psychotropic substances, in accordance with the requirements of *Presidential Decree No. 309 of 9 October 1990* and subsequent amendments and additions. The addition of the substances Butylone and bk-MBDB, some analogues structurally derived from 2-amino-1-phenyl-1-propanone, the substance AM-694 and analogues structurally derived from 3-(benzoyl)indole to Table I.”

At the UNIFIED CONFERENCE of 18 MAY 2011, under Article 9 of Legislative Decree No. 281 of 28 August 1997, an Agreement was reached on the document put proposed by the standing consulting committee on penitentiary healthcare regarding filing systems for adult prisoners, minors and young adults who are drug and/or alcohol addicts, supplementing the Agreement signed at the Unified Conference at the session of 8 July 2010 (Act No. 59/CU) (Act. No. 48/CU of 18 May 2011). (11A07486) (OG General Series No. 132 of 9 June 2011).

The Unified
Conference of 18
May 2011

In line with that which was set forth in Objective No. 11, Action No. 11.1 of the “Legislation, combating drugs and youth justice” Action Area of the National Drug Plan 2010-2013, the Department for Antidrug Policies drafted and issued the publication “Prison and Drugs”, containing guidelines, in November 2011. These guidelines regard drug addicts and alcoholics subjected to judicial action by the Judicial Authorities or deprived of their personal freedom.

Guidelines for
increasing
alternative
measures to
imprisonment

The objective is to create a constant and improved exit flow from prison in order to avoid overcrowding and, at the same time, to provide a valid therapeutic alternative. This publication is intended for professionals working in this field and for the Regions and Autonomous Provinces (while respecting their full autonomy with regard to organization and planning) and is meant as an aid when facing especially significant problems, such as: the lack of uniformity which currently exists in the formulation of the diagnosis of “drug addiction”; the tortuousness of the procedures which must be followed in order to more quickly; access to and benefit from alternative measures; coordinating with the Surveillance Magistracy.

Objective No. 10, Action 10.1 and all other actions of the Action Area “Legislation, combating drugs and youth justice” of the aforementioned National Drug Plan, in adherence to the provisions of Art. 41, Paragraph 4.2 of Legislative Decree 81/08, provides that, in accordance with agreements stipulated during the State-Regions Conference, the conditions and methods for checking for the presence of drug addiction or alcoholism in the workplace be reviewed. To this end, the Department of Anti-drug Policies has a long-established technical task-force which works together with administrations competent in the field to keep Unified Conference Agreement No. 99 of 20 October 2007 up to date.

Checking for the absence of drug addiction; the State/Regions Agreement of 30 October 2007

The body of European Community and international regulations concerning drug precursors

EC regulations currently in force concerning precursors aim to call attention to the implementation of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, adopted in Vienna on 20 December 1988 and ratified in Italy on 5 November 1990 with Law No. 328. Article 12 of said Law sets forth the legislation applicable internationally for the control of 23 chemical precursors.

International regulatory framework. The Vienna Convention against illicit drug trafficking

In short, the Convention establishes a surveillance system for monitoring international trade in substances susceptible to use in drug production.

It should be pointed out that an important innovation in the field was made during the course of 2011 as a result of the amendment introduced by Commission Regulation (EU) No 225/2011 of 7 March 2011.

The adaptation of internal regulations to EC regulations has caused the European Union College of Commissioners to permanently pigeonhole infraction procedure 2007/2443 for “violation of Community law” with regard to non-conformity with Regulation (EC) No. 273/2004 on drug precursors.

Infraction procedure pigeonholed

Table 1.1: National and international regulations issued in 2011.

| National Regulatory Acts | Field of Application |
|--|---|
| Legislative Decree No. 150 of 1 September 2011 | Provided, in Article 36, Paragraphs 1 and 2, for the amendment of Article 75, Paragraph 9, of DPR 309/90. |
| Commission Regulation (EU) No 225/2011 | Amending Commission Regulation (EC) No 1277/2005 laying down implementing rules for Regulation (EC) No 273/2004 of the European Parliament and of the Council on drug precursors and for Council Regulation (EC) No 111/2005 laying down rules for the monitoring of trade between the Community and third countries in drug precursors. |
| Legislative Decree No. 50 of 24 March 2011 | Implementing Regulations (EC) Numbers 273/2004, 111/2005 and 1277/2005, as amended by Regulation (EC) No. 297/2009 on drug precursors, in accordance with Article 45 of Law No. 96 of 4 June 2010. |
| Ministerial Decree of 29 December 2011 | Updating the tables containing descriptions of narcotic and psychotropic substances, in accordance with the requirements of Presidential Decree No. 309 of 9 October 1990 and subsequent amendments and additions. The addition of the substances Butylone and bk-MBDB, some analogues structurally derived from 2-amino-1-phenyl-1-propanone, the substance AM-694 and analogues structurally derived from 3-(benzoyl)indole to Table I. |

| National Regulatory Acts | Field of Application |
|---|--|
| Ministerial Decree of 2 August 2011 | Updating and completion of the tables containing descriptions of narcotic and psychotropic substances, in accordance with the requirements of Presidential Decree No. 309 of 9 October 1990 and subsequent amendments and additions, moving the drugs Amfepramone (diethylpropion), Phendimetrazine, Phentermine and Mazindol into Table I." |
| Ministerial Decree of 11 May 2011 | Updating and completion of the tables containing descriptions of narcotic and psychotropic substances, in accordance with the requirements of Presidential Decree No. 309 of 9 October 1990 and subsequent amendments and additions. Addition of 3,4-methylenedioxypropylvalerone (MDPV), JWH-250, JWH-122 and analogues structurally derived from 3-phenylacetylindole and 3-(1-naphthoyl)indole to Table I. |
| Ministerial Decree of 2011 | Updating the tables containing descriptions of narcotic and psychotropic substances and related medicinal compounds, in accordance with the requirements of Presidential Decree No. 309 of 9 October 1990 and subsequent amendments and additions, with the addition of Tapentadol to Annex III.2 and Tapentadol-based medicinal compounds, limited to non-injectable pharmaceutical formats, to Table II of Section D. |
| The UNIFIED CONFERENCE Agreement of 18 May 2011 | Agreement, under Article 9 of Legislative Decree No 281 of 28 August 1997, on the document proposed by the standing consulting committee on penitentiary healthcare regarding filing systems for adult prisoners, minors and young adults who are drug and/or alcohol addicts, supplementing the Agreement signed at the Unified Conference at the session of 8 July 2010 (Act No 59/CU), (Act No. 48/CU of 18 May 2011), (11A07486) (OG General Series No. 132 of 9 June 2011). |

Source: Presidency of the Council of Ministers – Department for Anti-drug Policies

1.2. National action plan, strategy, evaluation and coordination

Action plan

In the session held on 29 October 2010, the Council of Ministers approved the National Drug Action Plan for 2010-2013. This document represents the point of reference for policies relating to this the field of drugs for the three-year period in which it will be in effect. It lays out the action strategies in a practical and straightforward fashion, beginning with the analyses shared during the 5th National Conference in Trieste and by the post-conference working groups, and maintains its consistency with the instructions laid out in the European Action Plan throughout. It is therefore a particularly important instrument for determining the direction to be taken when developing concrete actions, organised and coordinated through combined efforts of the National Department and the Regions/Autonomous Provinces.

All of the actions and recommendations contained within the National Drug Action Plan (NDAP) are consistently supported by project activities created by the Department through the delineation of appropriate project plans (Section 1.2.2).

In addition, during 2011, an assessment of the NDAP was launched by means of the distribution of an assessment questionnaire. The aim of this National Drug Action Plan 2010 – 2013 assessment questionnaire was to collect the opinions of professionals in the field (Public Drug Addiction Services [SerT] and Public Addiction Services [SerD], addiction

departments, volunteer associations, social cooperatives, therapeutic communities, etc.) regarding the Plan's overall structure and specific action areas (Section 1.2.1).

1.2.1 Assessment of the National Action Plan

In the interests of assessing the NDAP 2010-2013 with regard to its overall structure and specific action areas, the assessment questionnaire was designed so as to allow respondents to express their opinions both in a structured and standardized fashion (using assessments on a scale from 1 to 10) as well as in a free manner, leaving room for them to express their thoughts, suggestions and criticisms.

The questionnaire is composed of 7 sections, each devoted to a separate topic, each of which contains questions of both quantitative and qualitative natures:

1. Overall assessment of the logical structure employed when drafting the NDAP
2. Assessment of the "Prevention" area
3. Assessment of the "Care, Diagnosis and Drug-related Diseases" area
4. Assessment of the "Rehabilitation and Reintegration" area
5. Assessment of the "Monitoring and Assessment" area
6. Assessment of the "Legislation, combating drugs and youth justice" area
7. Overall assessment of the NDAP

The Department for Anti-drug Policies collected a total of 123 National Drug Action Plan 2010-2013 assessment questionnaires. In 41.5% of this total, the *qualitative* parts of the questions, those regarding the *notes and suggestions for improvement* (section 1), *notes and suggestions for the improvement of strategies* (sections 1,2,3,4,5,6) and *the three most innovative and significant goals / most critical and of little significance* (sections 1,2,3,4,5,6) were not filled out. This means that, while the quantitative analysis of the data was completed on all the questionnaires received (123), the qualitative analysis was completed on only 72 questionnaires.

The assessments which respondents gave regarding the logical structure employed in the drafting of the NDAP (section 1 of the questionnaire) tend to be quite high and displayed limited variability: indeed, the average score given for the *Logical structure employed and action areas* criterion was found to be 8.56, while the average score for *Guidelines and general principles* was 8.50.

These two averages are well above the minimum pass score, and even the lowest scores given are never lower than a score of "5", indicating an overall homogeneity in the opinions provided.

General opinions expressed concerning the document as a whole (section 7 of the questionnaire) were also quite high (the average score was in fact 8.30 on a scale of 1 to 10) with quite limited variability. The interest areas "*Degree to which the NDAP corresponds to the conclusions drawn at the V Conference on Drugs, Trieste 2009*" and the "*Degree of agreement with the specific area 'Legislation, combating drugs and youth justice'*", low opinion marks of 2 were collected, because a number of respondents nonetheless gave these elements a critical assessment.

As mentioned above, the assessment questionnaire, like the plan, was divided into action areas (the same that appear in the National Drug Action Plan). Each of these areas was divided into two parts: a) the first, quantitative, containing a battery of items on the conceptual structure of the area in question; b) the second, qualitative, whose aim was to discover the opinions of the respondents with regard to the each area's objectives.

After having analysed the results revealed by the National Drug Action Plan 2010 – 2013 assessment questionnaires, we can say that, overall, the various parts of the National Drug Action Plan were given positive assessments.

Conclusions

The logical structure employed in drafting the NDAP received positive opinions, and opinions on its general content were also favourable. There was also, however, sharp criticism and suggestions were made for improvement which bear consideration, such as the use of unequivocal concepts when dealing with such a complex topic as that of addictions.

As far as the specific areas are concerned, opinions were found to be decidedly positive and more than sufficiently high, although assessments of "Degree of Feasibility" were the lowest of all the action areas put forward in the Plan. The area which received overall a slightly more critical assessment was that of monitoring and assessment activities.

The action of monitoring regional best practices in the field of addictions within the Regions and Autonomous Provinces and comparing them to the National Drug Action Plan 2010 – 2013 was thus begun. The results of this monitoring action are, however, still being verified and validated with the respective Regions and Autonomous Provinces.

Monitoring regional best practices in the addictions field and comparing them to the NDAP.

During the period between the end of 2011 and the beginning of 2012, best regional practices in the field of "addictions" were recorded by observing prevention, care and prevention of drug-related diseases, reintegration, systems of epidemiological assessment and research. Mapping was divided into the following phases. In the first phase, general information on the Regions' organizational structures, regulations in the field of addictions and policy activities (plans and projects) were collected by consulting regional sites. In the second phase, the general information dossiers obtained during phase one were sent to Regional Management through the Regional Coordination Health Commission. In the third phase, Regional Management were interviewed in order to validate the information dossier and identify best practices. In the fourth phase, contacts for best practices were interviewed in order to gain more knowledge of Regional recommendations. In the month of June 2012, recording was carried out in the following Regions: Piedmont and Lombardy, where interviews were performed to test the information-collection tools, Veneto, Molise, Lazio, the Autonomous Province of Bolzano, Calabria, Abruzzo, Friuli Venezia Giulia, Campania and Basilicata.

The comparison was carried out by putting together a matrix where the columns contained the actions set forth in the NDAP and the rows contained the actions carried out by the Regions. In order to make the comparison, the "conformity" (present/absent) criterion was adopted, using a scale of 1 to 4, where 1 stood for an action which was absent and 4 meant that the action set forth in the NDAP was present and had been adopted as routine practice by the Regional administration in question).

1.2.2 Coordination arrangements

The 2011 Projects Plan

In order to provide concrete support for the National Action Plan, a large number of projects have been launched. These projects have strong central coordination and encourage the creation of both national and international networks for collaboration and cooperation.

During the course of 2011, the numerous activities launched over previous years continued and, in some cases, were concluded. Furthermore, a series of further initiatives were developed which represent the on-going realization of the long-term strategies devised in 2009.

The National Monitoring Centre operates from within the Department, as set forth in Paragraph 7 of Art. 1 of DPR 309/90. Over the course of 2011, in addition to the institutional tasks assigned to the Service (the Annual Report to the Parliament, the National Report and Standard Tables for the Monitoring Centre in Lisbon, the statistical flows for UNODC), the National Monitoring Centre participated in the realization and assessment of all on-going projects, collaborating in the planning of those in the development and launch phases.

The Monitoring Centre also worked closely with the National Focal Point to bring about the reorganization of national data flows and those of the regional monitoring centres for addiction-information flows, aligning them with European standards, (the "National Information System on Addictions" – SIND project and the "Italian Network of Addiction Monitoring Centres" – NIOD), projects which it currently manages in collaboration with the Ministry of Health.

Specifically, it developed and published:

- The "National Information System on Addictions" Operations Manual (May 2011)
- The "Guidelines for the Organization and Operation of Regional Monitoring Centres" Operations Manual (September 2011)
- "Guidelines for completing the NIOD standard report". It also contributed to the drafting of the "Guidelines and organizational suggestions for integrating services offered and provided in Drug Addiction Departments" (November 2011).

Two new data-gathering projects have been launched. The first is in relation to the State-Regional Agreement of 18 May 2011 and involves an investigation to be conducted on drug-addicted prison inmates. The second is to involve subjects undergoing treatment with Drug Addiction Services for pathological gambling.

The National Early Warning System continued its operations in 2011. The System's organization makes it possible to identify phenomena which are potentially harmful to public health in a timely fashion. These phenomena involve the appearance of new drugs and new methods of drug use in Italy. Moreover, the System makes it possible to launch warnings which rapidly ensure the involvement both of organisations responsible for safeguarding and promoting public health as well as those responsible for launching suitable response measures to counter the emergencies which triggered the warnings.

The Department's internal operations were divided among working groups dedicated to specific matters for the purpose of providing support for the realization and completion of specific lines of action. This type of organization became necessary in order to make it easier to carry out the

Activities carried out during the course of 2011

National Monitoring Centre

The Early Warning System

Working groups

work and reach the expected objectives when confronted with complex situations which call for the involvement of other parties (institutional and non) external to the Department itself.

One working group is responsible for checking for an absence of drug addiction among workers in high-risk professions. Ministries concerned with and involved in this field participate in the institutional task-force, whose task is to review and systematize existing regulations in this sphere (these Ministries include the Ministry of Health, the Ministry of Infrastructure and Transport, the Ministry of Labour and Social Policies, the Defence Ministry and the Ministry of the Interior), as do representatives of the Privacy Authority, occupational doctors' organizations, the National Agency for Flight Assistance [ENAV] and the Italian State Railway System. In 2010, the last of these was entrusted with a specific project (DTLR) whose purpose was to monitor progress of checks being carried out on workers in high-risk professions throughout the country.

Workers in high-risk professions

The State-Regions Conference saw the Department for Anti-drug Polices (DPA) participate in the technical task force handling the application of the Decree of the President of the Council of Ministers (DPCM) of 1 April 2008. This DPCM lays down the details for the transfer of healthcare competencies for prison inmates from the Justice Ministry to the Regions, and also impacts drug-addicted subjects and those with problems related to drug use. On 18 May 2011, with a view to encouraging the movement of drug addicts out of prison and into probation programs, an agreement was ratified establishing a new data flow method which makes it possible to quantify the drug-addiction phenomenon within prisons and monitor the application of probation as a manner of executing external sentencing.

The State-Regions Conference

In support of the above-described activity, the Department drew up specific guidelines, published and distributed in 2011, which suggest methods which can improve the chances of drug-addicted prison inmates of entering probation programs. The applicability of the guidelines is verified through a special project (Prison and Drugs) entrusted to Formez.pa.

Guidelines: "Drug Addiction and Prison"

Additionally, in 2011, guidelines to provide support for the prevention of drug-related infectious diseases were also published and distributed. This document, based on hard data and proof, is crucial for the promotion of HIV and hepatitis screening in at-risk subjects, considering the alarming, on-going decline in the number of tests being performed, especially on subjects undergoing treatment with Drug Addiction Services. A special project, Early Diagnosis and Treatment of Drug-Related Infectious Diseases (DTPI), entrusted to the AIDS Operations Centre of the Higher Institute for Health, has been launched in order to promote the adoption and implementation of the guidelines.

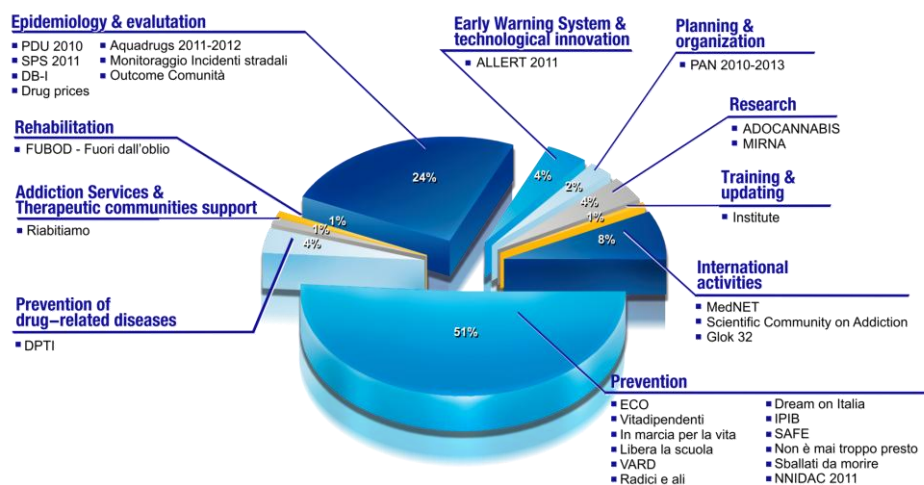
Guidelines: "Screening and early diagnosis of the principal drug-related infectious diseases"

These guidelines are a follow-up to the document entitled "Measures and Concrete Actions for the Prevention of Drug-related Diseases", published and distributed in 2009..

During the course of 2011, another 31 projects were added to the 49 project activities already set down in the 2009-2010 plan, for a total investment of €9,212,141, allocated as shown in the figure.

Projects Plan 2011

Figure 1.1: Allocation of funds within the 2011 Projects Plan *



Source: Presidency of the Council of Ministers – Department for Anti-drug Policies

2011 also saw the continuation of two important projects: the realization of the Italian Network of Addiction Monitoring Centres (NIOD); supporting the development of information systems capable of producing standardized information on subjects undergoing treatment (SIND Support).

Support for the
NIOD and SIND
projects

The main goal of the Edu.Care project is to reinforce and improve parents' knowledge and attitudes (and those of adult role models in general) through specific educational training so that they will be able to properly manage relationship, educational and familial settings and their relationships with their very young children, as well as issues which might come up regarding potential use of drugs or alcohol abuse by minors.

Edu.Care Project:
50 localities
involved

To this end, 48 localities were each set up with their own operative unit comprising school staff and the staff of private non-profit organizations who, after having been appropriately trained, launched training programmes consisting of 10 training sessions for parents alone and for parents and children together. Training sessions were held during the course of the 2010-2011 school year.

The preliminary results were as follows:

- 48 operative units set up across the all of the regions of Italy
- 14,380 adults involved
- 1,038 children involved
- 522 teachers
- 134 schools
- 266 organizations/institutions involved
- 58,017 training hours provided

The Scientific Community on Addiction project, entrusted to UNICRI and carried out in collaboration with the Ministry of Health and the Ministry of Education, Universities and Research (MIUR), has been the realization of initiatives aimed to develop a multidisciplinary scientific community equipped with information tools, a national training school and international collaborations for sharing best practices in the field of addictions.

Scientific
Community on
Addiction

Institutional activities in the international arena.

During the year 2011, the Department for Anti-drug Policies further reinforced its involvement in activities in the international arena, with both European institutional bodies and international organizations as well as through bilateral agreements.

Areas of
involvement

Italy's activities at the United Nations consist principally of its participation in the Commission on Narcotic Drugs (CND), established by the Economic and Social Council of the United Nations (ECOSOC) by Resolution 9 (I) of 16 February 1946 as a subsidiary body in the field of drugs. The 54th Session of the UN Commission on Narcotic Drugs, held in Vienna from the 21st to the 25th of March 2011, constituted, as it does every year, the principal UN event for discussing the global drug problem and agreeing upon common international strategies to deal with it. This session was of great importance for Italy, as it saw the approval of its draft resolution, first at the Council of the European Union, and then by the 193 member states of the United Nations: *"Promoting rehabilitation- and reintegration-oriented strategies, aimed to promote health and social well-being among individuals, families and communities, in response to drug use disorders and their consequences"*.

UN - CND

The resolution aims to promote action strategies which prioritize the concept of complete recovery on the part of addicts.

In addition, the Department had an important role in the negotiation phase of the High-level Meeting of the General Assembly on HIV/AIDS, held at the United Nations in New York from the 8th to the 10th of June 2011. This role was borne out by the Italian proposal of a balanced approach which took into due account, at an international level, that which had been agreed upon at the European Union.

UN – High-level
Meeting on
HIV/AIDS

2011 saw an intensification of bilateral relations between Italy and the United States, thanks to the signing of two important collaboration agreements, with the *Office of National Drug Control Policy* (ONDCP) the White House body responsible for drug control policies, and with the *National Institute on Drug Abuse* (NIDA), the principal American research centre for drugs and drug addiction. The Memorandum of Intent with the ONDCP, signed in Washington on 11 July 2011, aims to create shared bases to reinforce and implement bilateral collaboration for prevention, for research in the fields of the neurosciences and of the rehabilitation of persons addicted to drugs, as well as for general action policies/strategies. The agreement, which involves the stipulation of specific accords concerning the sharing of research and best clinical practices, is the fruit of a journey which the governments of our two countries, with their shared values, have made together.

Bilateral agreements
Italy - USA

Subsequently, and in a more technical setting, the Department signed a second agreement with the United States. To be specific, the Memorandum of Intent was signed with NIDA in Rome on 25 July 2011. The agreement aims to promote the development of joint research in areas including: research, early diagnosis, screening, treatment and short-term therapy for addiction disorders, especially in adolescents and young adults.

Furthermore, during the course of 2011, cooperative collaboration actively continued with the principal United Nations organizations working in the drug field: in particular, with the United Nations Office on Drugs and Crime (UNODC), the organ of the United Nations in charge of the fight against drugs and international crime. With the UNODC, the Department renewed its participation in the joint program launched in 2009 in collaboration with

UN
UNODC – INCB

the World Health Organization (WHO) concerning the treatment and care of drug addiction in the Balkan region. The program's objective consists of reducing demand for illicit drugs, reducing the suffering and harm related to drug use for individuals, family, the community and society. Cooperation between the two organizations in this field is fundamental and aims to promote effective treatments and care for drug addicts and reinforce specific obligations taken on by the national and international players involved, with respect to their responsibilities in the fight against the international drug problem.

Moreover, work with the International Narcotics Control Board (INCB), the independent monitoring body for the implementation of the United Nations international drug control conventions, continued throughout the course of 2011. This work involved handling and filling out the questionnaires sent by the INCB in order to monitor current and emerging trends in drug abuse.

Italian activity in the European Union arena is characterized by Italy's active and on-going participation in the work of the Horizontal Drugs Group (HDG), the interdisciplinary Working group of the Council of the European Union whose responsibility it is to launch, monitor and coordinate all activities that fall within the drugs field, developing the Council's anti-drug policy.

EU Activities –
Horizontal Drugs
Group (HDG)

The Department took part in the activities of the National Anti-drug Coordinators. Coordinator meetings are called twice a year by the Presidency of the Council of the European Union, as set forth in the EU Action Plan for the fight against drugs 2009-2012. This is done in order to promote effective coordination of Community policies in the field of drugs. The purpose of these meetings is to guarantee effective coordination and ensure that a real impact is made on a strategic level regarding specific and/or urgent matters. The topics addressed in these meetings are decided by the nation which holds the Presidency of the Council of the EU.

EU Activities –
National
Coordinators

The Department's European activity also involves participation and collaboration in the filling out of questionnaires sent by the institutions of European nations. For the purpose of carrying out this activity, the Department has enlisted and coordinated the other competent Italian central administrations. In 2011 specifically, the Department participated in the following initiatives:

EU Activities –
Miscellaneous

- Questionnaire for assessing the European drug strategy for 2005-2012; public consultation on future funding activities in the fields of justice, basic rights and equality.
- Public consultation on EU funding for internal affairs policies after 2013
- Public consultation on the EU research programme; questionnaire on minimum quality standards in the reduction of drug demand
- Questionnaire: "Towards a more effective European response to drugs"
- Questionnaire on the implementation of the Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence
- Questionnaire for the assessment of the impact of a new instrument with the purpose of substituting Council Decision 2005/387/JHA on new psychoactive substances.

In addition to these activities, the Department considers fundraising activities to be of the utmost importance. To this end, the Department

plays an active role in promoting and/or providing support for new projects on both European and international levels, in the interests of moving towards an ever-more effective anti-drug policy.

Specifically, in the context of the European Programme for the Prevention of and Fight Against Crime (ISEC), the Department obtained funding from the European Commission to implement an innovative new project: “*Save Our Net (S.O.N.): Drug Sale and Trade under Attack. Let the Civil Society give Minors a Safer Internet*”. The goal of this project is to develop a new and efficient method for monitoring and discouraging the sale and trafficking of harmful substances online by minors and, at the same time, to create information campaigns targeting parents on the dangers of the internet.

In the context of the Seventh framework programme for research and technological development (2007-2013), the Department actively participated in the creation of ERANID (ERA-NET on illicit drugs), an association of European nations including Italy, the Netherlands, Belgium, France, Portugal and the United Kingdom which aims to pool the resources of its various members for research in the field of drugs. The main goal of the network, through which each nation will receive Community funding in order to carry out its activities, is to identify common priorities in the sphere of scientific research in the field of drugs in order to be able to draw up a Strategic Research Plan and to present two joint calls to the European scientific community by the end of 2013.

The Department also participates in the work carried out by the Dublin Group, a body which informally coordinates regional cooperation policies and which consists of 27 EU Member States, the European Commission, the United States, Australia, Norway and Japan. The Group’s operations continued during the course of 2011.

The Dublin Group is divided into numerous regional bodies, the so-called “Dublin mini-groups”. For the third year, Italy presided over the mini-group which monitors a number of Central Asian countries, meaning Tajikistan, Uzbekistan, Kazakhstan, Kirghizstan and Turkmenistan.

Italian activity in the context of the European Council is characterized by its participation in the Pompidou Group, an inter-governmental body for cooperation in combating drug abuse and illicit drug trafficking, which allows its 37 Member nations to share national policies and practices, with the objective of standardizing their respective actions and strategies and making them consistent and effective.

The Group’s policy follows the Work Programme approved for the period 2011-2014. This programme sets forth a more balanced approach between demand and supply reduction activities, strengthening the latter; it aims to develop a multidisciplinary strategy and ever closer cooperation between different Member nations.

During the course of 2011, the Department continued to contribute to the activities of the Pompidou Group, periodically submitting comments through its contributions and proposals, maintaining its on-going participation in the meetings of the single ad-hoc Groups and of the Permanent Correspondents (representatives of each Member nation belonging to the Group representing their countries in respect of all questions concerning drugs and drug addiction whose is to monitor and manage the progress of the Pompidou Group’s activities and prepare the work programme).

The MedNET network – the Mediterranean network for cooperation on drugs and addictions – aims to foster cooperation, exchanges and transfers of knowledge and experience between the countries of the

Fundraising:
European Union –
Funding
programmes – the
S.O.N. Programme

The European
Union – the
ERANID project

The Dublin Group

European Council
Activities

Pompidou Group –
Permanent
Correspondents

The Pompidou
Group MedNET
network

southern Mediterranean, beneficiaries of the activities being conducted, and the northern Mediterranean, who serve as providers.

In the context of MedNET, the Department has continued to support the activities set forth in the Network programme. Specifically, during the course of 2011, the Department engaged in cooperative activities with Egypt, Lebanon and Morocco.

The Department, in collaboration with the United Nations Interregional Crime and Justice Research Institute (UNICRI), promoted the DAD.NET Project. The project's main objective is the drafting of guidelines and the organization of online training courses to meet the needs of care for women with more appropriate services and, at the same time, to provide suitable instruments for proposing gender-specific prevention and rehabilitation activities.

The Project was launched and presented in March of 2011 with the organization of an international conference which was held at the FAO headquarters in Rome.

The Project's main targets are three specific categories of the female gender: young women who do not use drugs but who are considered to be at risk, girls and women who use drugs occasionally and girls and women who have already developed addiction problems and/or are affected by addiction-related diseases which require care that is respectful of their gender and covers both treatment and reintegration.

In the context of institutional competencies as these are set forth in regulations, the Department for Anti-drug Policies has the task of collaborating with the European Monitoring Centre on Drugs and Drug Addictions (EMCDDA), an agency of the European Commission with headquarters in Lisbon, to nominate the representatives of the Management Board and handle the management and coordination of information flows through the Italian Focal Point REITOX network.

During the course of 2011, the Department guaranteed its presence in biannual meetings of the Management Board, actively participating in discussions on the agenda regarding the management of the EMCDDA budget, the definition of the Board's annual work programme and the revision of the definitions and protocols of a number of key epidemiological indicators.

In 2011, as in the past, the Italian Focal Point stipulated its annual contract with the Reitox Coordination of the EMCDDA and brought all prescribed activities to their conclusions. In particular, these were:

- Preparation and submission to the EMCDDA of the National Report
- Preparation and submission to the EMCDDA of the Standard Statistical Tables and Structured Questionnaires
- Activities to implement the 5 key epidemiological indicators: a) surveys conducted among the general and student populations on drug use b) treatment demand c) estimates of problematic drug use d) drug-related deaths and mortality e) drug-related infectious diseases
- Fulfilling obligations established under the "Council Decision on information exchange, risk-assessment and the control of new psychoactive substances" and participation in activities of the European "Early Warning System".
- Revision and updating with respect to institutional, legislative and political developments on a national level
- Revision of national data and information submitted to the

The "Women,
Alcohol and Drugs"
(DAD.NET) Project

DPA/EMCDDA
Collaboration

The EMCDDA
Management Board

Contractual
activities carried out
in 2011

EMCDDA and contained within the European Annual Report and online statistical bulletin

- Linguistic revision of EMCDDA publications during their translation into Italian
- Participation of Italian Focal Point representatives and experts in all the meetings scheduled on the calendar

The Italian Focal Point, in close collaboration with the European Monitoring Centre on Drugs and Drug Addiction in Lisbon, organized the Second Reitox Academy of the NIOD (Italian Network of Addiction Monitoring Centers) project.

The second NIOD
Reitox Academy

The Academy was held in Rome from the 7th to the 9th of September 2011, and it witnessed the participation of the representatives of the Regions and Autonomous Provinces which are a part of the NIOD project. Representatives of the Polish Focal Point and heads of the Israeli Monitoring Centre on Drugs also took part in the work of the Academy.

Following and First Academy, which was held at Lisbon in December 2010, and in order to develop its content, the Second Reitox NIOD Academy's work programme included the goal of analysing and evaluating the state of progress of the constitution of regional and provincial monitoring centres and the acquisition of instruments for monitoring their work and activities they carry out.

In full agreement with the European Monitoring Centre in Lisbon, it was decided to hold a Third Reitox Academy in 2012, upon conclusion of the NIOD project.

1.3. Economic analysis

An analysis of the phenomenon of illegal narcotic drug use cannot be separated from an assessment of its economic impact on the country, especially at such a momentous time of great socioeconomic difficulty for all the countries of the world.

Following is a hypothetical calculation of the monetary value of the most significant elements of the economic impact that this phenomenon has on society, according to the now-consolidated definition of the concept of "social costs", presented in the 2011 edition of the National Report.

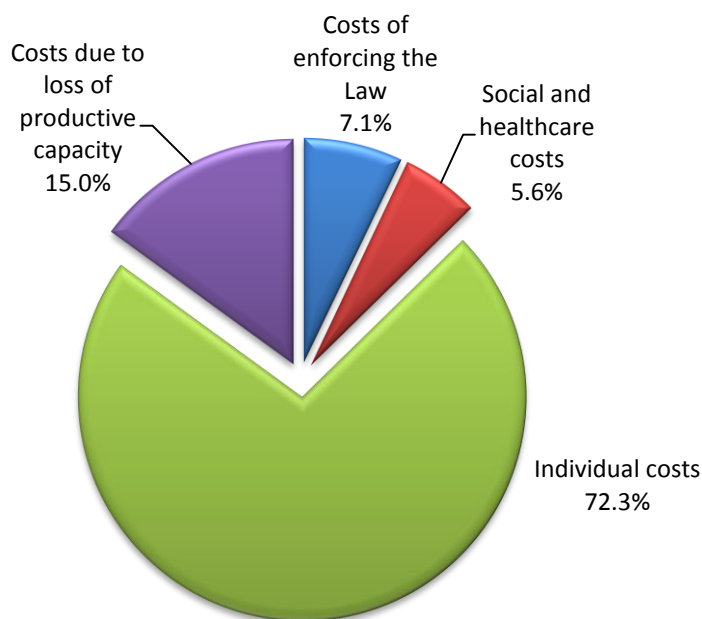
The social costs
linked to the
phenomenon of
drug use

1.3.1. Estimate of social costs

Using the methodological criteria described in section 1.3.2, and according to the suggestions put forward by the European Monitoring Centre, the overall social cost of the use of illicit psychoactive drugs in Italy during the course of 2010 has been estimated at €31,219,389,542.87, equivalent to 2.0% of Italian gross domestic product (GDP) during that same period which, when calculated in terms of cost per capita, is equivalent to 748 Euros per year for every member of the public between 15 and 64 years of age.

Approximately 31.2
billion Euros is the
overall estimated
social cost of the
drug phenomenon
for 2010 (2% of
GDP)

Figure 1.2: Distribution of the social costs by macro-category. The year 2010



Source: Department for Anti-drug Policies

Table 1.2: Social costs of the drug-use phenomenon. The year 2010

| Cost category | Cost | Percentage |
|--|---------------------------|----------------|
| Individual costs | €22,574,221,857.14 | 72.31% |
| Costs due to loss of productive capacity | €4,680,632,520.60 | 14.99% |
| Costs of enforcing the Law | €2,209,981,956.57 | 7.08% |
| Social and healthcare costs | €1,754,553,208.56 | 5.62% |
| Total | €31,219,389,542.87 | 100.00% |

Source: Department for Anti-drug Policies

Regarding the four principal cost components identified in the introductory portion of this section, calculated according to the criteria described in the methodological section, the greatest social cost is due to expenditures for the purchase of drugs (€22,574,221,857.14), which account for 72.3% of the overall cost (Figure 1.2).

The greatest cost is that of expenditures for the purchase of drugs by consumers: 22.6 billion Euros

Table 1.3: Estimate of costs due to loss of work capacity. The year 2010

| Cost category | Cost | Percentage |
|-------------------------------|--------------------------|----------------|
| Loss of productivity | €3,180,976,933.39 | 67.96% |
| Loss due to premature death | €542,645,107.66 | 11.59% |
| Cost due to traffic accidents | €957,010,479.55 | 20.45% |
| Total | €4,680,632,520.60 | 100.00% |

Source: Department for Anti-drug Policies

4.7 billion in costs due to loss of productive capacity

The second-largest cost category overall, accounting for 15% of the total social costs, is the cost due to the loss of productive capacity (€4,680,632,521) which includes loss of productivity due to loss of professional employment (€3,181 million), cost due to loss of productivity as a result of premature death (€543 million) and the social cost

attributable to drug users involved in traffic accidents (€957 million).

Table 1.4: Estimate of the costs attributable to enforcing the Law. The year 2010

| Cost category | Cost | Percentage |
|------------------------------------|-------------------|------------|
| Law Enforcement Activities | €413,592,760.62 | 18.71% |
| Prison and alternative measures | €1,065,924,951.57 | 48.23% |
| Trials and legal expenses | €720,336,244.38 | 32.59% |
| Other Central Administration costs | €10,128,000.00 | 0.46% |
| Total | €2,209,981,956.57 | 100.00% |

Source: Department for Anti-drug Policies

2.2 billion is the cost of activities related to the fight against drugs, reduction and suppression of drug supply and demand

Activities related to the fight against drugs and the reduction and suppression of drug supply and demand account for approximately 7% (2,209,981,957 Euros) of the overall social costs, of which nearly half is borne by the Ministry of Justice for the detention of persons reported for crimes in connection with DPR 309/90 or of drug-addicted subjects held for other crimes. 19% of the costs of enforcing the law are spent by Law Enforcement Agencies in activities related to prevention (Articles 121 and 75 of DPR 309/90) and to the fight against the production, trafficking and sale of drugs, in addition to traffic checks targeting drivers operating their vehicles while under the influence of alcohol or drugs (Articles 186 and 187 of the Traffic Code).

Social and healthcare assistance accounts for a total of €1,754,553,209, which is equivalent to 5.6% the overall social cost of the phenomenon of drug use. The highest costs are those for the cost of treatment for subjects suffering from infectious diseases (in particular HIV and HCV) (705,840,000 Euros), closely followed by the cost of outpatient care provided by drug addiction services (approximately 695 million Euros). Inserting clients who are receiving care from local services into socio-rehabilitative programmes accounts for a further expenditure of approximately 250 million Euros, while hospitalisations of users of psychotropic drugs account for at least 2.9% of these costs (53 million Euros).

1.8 billion Euros spent on social and healthcare assistance for persons undergoing treatment

Table 1.5: Estimate of social and healthcare costs. The year 2010

| Cost category | Cost in Euros | Percentage |
|--|-------------------|------------|
| Addiction services | €694,769,648.69 | 39.60% |
| Semi-residential and residential care | €249,560,404.75 | 14.22% |
| Inpatient treatment programmes in hospital | €51,473,742.64 | 2.93% |
| Care for drug-related diseases | €705,840,000.00 | 40.23% |
| Prevention projects | €52,909,412.48 | 3.02% |
| Total | €1,754,553,208.56 | 100.00% |

Source: Department for Anti-drug Policies

Per capita, taking into consideration the costs sustained by the Addiction Services, the costs for residential and semi-residential assistance and the cost of providing therapies and treatment for drug-related infectious diseases, the national average cost borne by the individual member of the public between the ages of 15 and 64 on a national level is equal to over 40 Euros per year, varying greatly from one Region or Autonomous Province to the next, ranging from a minimum of 22 Euros per capita per year in the Region of Calabria to a maximum of 70 Euros in the Region of Liguria.

The average cost per capita of social and healthcare assistance ranges from 22 Euros per year in Calabria to 70 Euros per year in Liguria

1.3.2. Methodological aspects

For each macro cost category previously identified as well as related cost subcategories, appropriate quantification criteria for the cost components attributable to the drug-use phenomenon were applied based on information flows made available by the Central and Regional Administrations.

Regarding the estimate of the cost of the purchase of drugs by users, the methodological criteria applied in previous editions, based upon the estimate of drug use calculated based upon the amount of drugs seized by Law Enforcement Agencies, have been revised in the light of new methods of estimation. These methods are still based upon an estimate of drug demand, but are based upon hypotheses of drug use within the population, starting with estimates of users broken down into categories based upon frequency of use, according to different hypotheses¹². Costs attributable to the purchase of drugs were therefore calculated by attributing an average daily, weekly or monthly level of use to each category of user and applying these levels to the estimated group of users for each category.

Methods for estimating the cost of the purchase of drugs

Table 1.6: Estimate of drug users, by type. The years 2010-2011

| Users | Minimum | Maximum |
|--|-----------|-----------|
| Total users (of whom): | 2,127,000 | 2,548,000 |
| • Active drug addicts (of whom): | 213,600 | 434,000 |
| - Drug addicts in treatment (of whom): | 171,508 | 171,508 |
| ➤ Drug addicts not responding to pharmacological treatment | 51,452 | 51,452 |
| - Drug addicts not in treatment | 42,092 | 262,492 |
| • Occasional users | 1,913,400 | 2,114,000 |

Source: Department for Anti-drug Policies

Table 1.7: Average daily/weekly/annual cost according to two minimum and maximum hypotheses, by type of user

| Individual Costs | Min € / day | Max € / day | Min annual € | Max annual € |
|------------------|--------------|--------------|--------------|--------------|
| Drug addicts | € 50.00 | € 200.00 | € 18,250.00 | € 73,000.00 |
| Individual Costs | Min € / week | Max € / week | Min annual € | Max annual € |
| Occasional users | € 50.00 | € 200.00 | € 2,600.00 | € 10,400.00 |

Source: Department for Anti-drug Policies

¹ Il mercato delle droghe – dimensione, protagonisti, politiche, a cura di Rey G.M, Rossi C, Zuliani A.

² Analisi economica dei dipartimenti delle dipendenze: prima ricognizione dei costi e valorizzazione dei risultati. G.Serpelloni, M. Gomma (2006)

Table 1.8: Estimate of costs for the purchase of drugs, by type of user. The years 2010-2011

| User type | Minimum | | Maximum | |
|-------------------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| Occasional users | 1,913,400 | | 2,114,000 | |
| Active drug addicts (who use daily) | 93,544 | | 313,944 | |
| Individual costs | Min (millions € / year) | Max (millions € / year) | Min (millions € / year) | Max (millions € / year) |
| Occasional users | €4,974.84 | €19,899.36 | €5,496.40 | €21,985.60 |
| Active drug addicts (who use daily) | €1,707.19 | €6,828.74 | €5,729.49 | €22,917.94 |
| Total costs of drug use | €6,682.03 | €26,728.10 | €11,226.00 | €44,903.54 |

Source: Department for Anti-drug Policies

A comparison of the estimates produced by these two independent sources of information (Central and Regional Administrations; Law Enforcement Agencies) reveal that they agree on an average number of more or less the same amount, which is the reason why the choice to adopt the average of the different hypotheses' results as the average calculated value was made.

Table 1.9: Estimate of costs (in millions of Euros) for the purchase of drugs, by type of user. The year 2010

| Individual costs | Low hypotheses | Mid-range hypotheses | High hypotheses |
|--------------------|----------------|----------------------|-----------------|
| Problem users | €10,706.58 | €12,847.89 | €12,847.89 |
| Recreational users | €8,408.13 | €10,096.58 | €10,627.45 |
| Occasional users | €736.69 | €959.78 | €1,250.54 |
| Total | €19,851.39 | €23,904.25 | €24,725.88 |

Source: "The drug market – its dimensions, protagonists and policies"

The costs relating to the enforcement of the Law are represented by a variety of components, which range from actions by Law Enforcement Agency related to the enforcement of DPR 309/90 and of Articles 186/187 of the Highway Code, to actions carried out by the Drug Addiction Operating Units of the Prefectures, penal measures implemented by the various Directorates of the Ministry of Justice (from legal costs to costs of imprisonment and the application of alternatives to imprisonment) and, finally, to costs for activities carried out by the Presidency of the Council of Ministers while implementing the body of laws and regulations currently in force in the sphere of drug addictions.

Each of these components was estimated by calculating the value of the cost of personnel and the cost of goods and services employed in the course of drug-fighting activities and activities related to reduction and suppression of drug supply and demand. Broadly speaking, the estimate of personnel cost was obtained by multiplying the average cost per member of personnel by the total number of personnel employed in drug-fighting activities during the period of time in question. The cost of goods and services was calculated by applying the percentage amount of personnel costs for personnel employed in drug-fighting activities over total personnel costs, to the total cost of goods and services.

By way of an example, the cost of Law Enforcement personnel for

Criteria for
calculating the costs
of enforcing the
Law

activities related to prevention under Art. 75 of DPR 309/90 was calculated according to the following points:

- 1) Estimate of personnel hours per single report filed under Art. 75 of DPR 309/90 based on interviews with key informants
- 2) Calculation of total personnel (in personnel years) employed in activities linked to reports filed under Art. 75 (data provided by the Central Directorate for Documentation and Statistics of the Ministry of the Interior), as the product of personnel time per single report multiplied by the total number of reports filed per reporting entity (State Police, Carabinieri Corps, Guardia di Finanza [Revenue and Excise Police])
- 3) Estimate of the total personnel cost per report filed under Art. 75, as the product of the average cost per member of personnel multiplied by the total number of personnel employed in prevention activities under Art. 75 during the period in question. The average cost per member of personnel was calculated based on information provided by the State General Accounting Office, as the relationship between total personnel cost, individual reporting entity and total volume of personnel (in personnel years).

Table 1.10: Estimate of costs (millions of Euros) of Law Enforcement activities for prevention and the fight against drugs. The year 2010

| Cost category | Number of Law Enforcement Actions | Average cost per action | Total cost (millions of Euros) |
|--|-----------------------------------|-------------------------|--------------------------------|
| Reports filed under Article 75 | 50,253 | 361 | 18.14 € |
| Charges filed under Articles 73/74 | 138,497 | 1,989 | 275.47 € |
| Checks under Articles 186/187 (of which): | 1,688,100 | | |
| Negative | 1,643,135 | 26 | 42.72 € |
| Positive Art. 186 | 40,721 | 281 | 11.44 € |
| Positive Art. 187 | 4,244 | 421 | 1.79 € |
| Drug Addiction Operating Unit (NOT) Activities | | | 13.36 € |
| General costs (Law Enforcement Agencies) | | | 50.67 € |
| Total | | | 413.59 € |

Source: Compiled by the Department for Anti-drug Policies based on data from the Ministry of the Interior and R.G.S.

The same procedure was also used to calculate the cost of criminal proceedings and legal proceedings subsequent to subjects being reported for crimes involving the production, trafficking and sale of drugs (Articles 73 and 74 of DPR 309/90) or other crimes committed by drug addicts. Having established the average number of hearings per report, and having calculated the total number of hearings held under DPR 309/90, based on the unit cost per type of personnel member employed and the number of personnel members (in personnel years) employed in said proceedings, the total cost of personnel was calculated, applying the unit cost per type of personnel member to the contingent of lawyers and judges (in personnel years) employed in the application of drug law.

Table 1.11: Estimate of the costs (in millions of Euros) of trial-related activities. The year 2010

| Cost category | Number of trials | Average cost per activity | Total cost (millions of Euros) |
|----------------------------|------------------|---------------------------|--------------------------------|
| Legal expenses | 93,332 | 3,702.12 | € 341.82 |
| Trial costs Articles 73/74 | 93,332 | 2,880.90 | € 267.00 |
| General costs | | | € 112.52 |
| Total | | | € 720.34 |

Source: Compiled by the Department for Anti-drug Policies based on data from the Ministry of the Interior and R.G.S.

With reference to the costs sustained by the Justice Ministry as a consequence of the imprisonment of subjects in penitentiaries for crimes in connection with DPR 309/90 and/or the imprisonment of drug addicts, the estimate was obtained by parameterising the total cost of personnel based on the ratio of these types of convicts in prisons on 31/12/2009 of the period in question (data provided by the Ministry of the Interior – Department of Prison Administration –) to the total number of convicts. The same criterion was used to calculate the cost of personnel working in the Offices for the Execution of External Sentencing of the Department of Prison Administration, for tasks managed during the course of the year linked to alternative measures to imprisonment for subjects who exploited Art. 94 of DPR 309/90.

Table 1.12: Estimate of costs (in millions of Euros) for incarceration of drug addicts in penitentiaries. The year 2010

| Cost category | Number of drug-addicted convicts | Average yearly cost per convict (thousands of Euros) | Total cost (millions di Euros) |
|---------------|----------------------------------|--|--------------------------------|
| Adults | 24,008 | €42.59 | €1,022.37 |
| Minors | 474 | €42.59 | €20.19 |
| Total | 24,482 | €42.59 | €1,042.56 |

Source: Compiled by the Department for Anti-drug Policies based on data from the Ministry of the Interior and R.G.S.

Table 1.13: Estimate of costs (in millions of Euros) per drug addict placed on probation as an alternative sentence. The year 2010

| Cost category | Total cost of personnel (thousands of Euros) | Coefficient of probation placements of drug addicts | Total cost (millions of Euros) |
|---------------|--|---|--------------------------------|
| Personnel | €130,201.71 | 16% | €20,792.08 |
| General costs | | | €2,573.66 |
| Total | | | €23,365.74 |

Source: Compiled by the Department for Anti-drug Policies based on data from the Ministry of the Interior and R.G.S.

Table 1.14: Estimate of the costs (in millions of Euros) of hospital care for drug users. The year 2010

| Type of hospitalization | Number of hospitalizations | Total cost (millions of Euros) |
|--|----------------------------|--------------------------------|
| Ordinary admissions | 19,035 | €50.23 |
| Outpatient admissions or ambulatory care | 4,859 | €1.25 |
| Total | 23,894 | €51.48 |

Source: Compiled by the Department for Anti-drug Policies based on data from the Ministry of Health

Table 1.15: Estimate of the costs (in millions of Euros) for care for drug-related diseases. The year 2010

| Cost category | Clients in treatment | Unit cost per year (Euros) | Total cost (millions of Euros) |
|---------------|----------------------|----------------------------|--------------------------------|
| HIV Treatment | 15,570 | €12,000 | €186.84 |
| HCV Treatment | 25,950 | €20,000 | €519.00 |
| Total | 41,520 | | €705.84 |

Source: Compiled by the Department for Anti-drug Policies based on data from the Ministry of Health

Identifying costs relating to the third macro- cost category, that of social and healthcare services of the individual Regions and Autonomous Provinces, was more straightforward. As a matter of fact, it is possible to gather data on funding for specific projects in the drug-addiction sector and for social-rehabilitation facilities from Regional balance sheets. Furthermore, using management accounting for the Local Health Authorities' cost/responsibility centres, the Regional Administrations have arrived at the costs attributable to activities carried out by Drug Addiction Services. Another cost category attributable to the healthcare sector concerns the economic value of hospitalisations of patients who, in principal or secondary diagnosis, were shown to have used or abused psychotropic drugs. The cost for hospitalisations of narcotic drug users was estimated by applying corresponding national DRG (Diagnosis Related Group, a classification system for hospitalisations according to homogeneous iso-resource groups) class C 436/07 fees to hospitalisations classified according to DRG.

Table 1.16: Estimate of the costs (in millions of Euros) for loss of productive capacity. The year 2010.

| Cost category | Subjects | Unit cost per year (Euros) | Total cost (millions of Euros) |
|---|----------|----------------------------|--------------------------------|
| Clients in treatment who can be reintegrated (exclusive of unemployment rate) | 98,263 | €32,372.17 | €3,180.98 |
| Deaths by overdose | 374 | €1,450.92 | €542.65 |
| Traffic accidents | | | €957.01 |
| Total | | | €4,680.64 |

Source: Compiled by the Department for Anti-drug Policies based on data from the Ministry of Health

Calculation of the value of the last macro- category, loss of productivity due to reduction of drug users' work capacity, was estimated based upon

subjects in care of drug addiction services. Based on data provided by the services themselves (subjects in their care, subjects holding jobs, subjects discharged upon completion of treatment), an estimate was made of the number of subjects in care who were of a productive age who could potentially be integrated into the work force according to the current employment rate and, therefore, the economic estimate of the loss of productivity based upon an average wage for individuals with an analogous level of education, gathered from the industrial and agricultural sectors.

To this estimate were added the social costs imputable to persons who died prematurely due to acute drug-related mortality, calculated according to parameters published by the ACI / ISTAT for calculating the social costs of persons who died prematurely as a consequence of traffic accidents. Concerning this last topic, the social cost of traffic accidents linked to drug use was estimated and included within this macro-category.

2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED GROUPS

The well-known structural limits of epidemiological studies conducted using these methodologies, with their low response levels in the surveys and the consequent problems in terms of the weight of the information collected, call for careful reflection on methodology and create incentive to put thought into new, alternative and comprehensive information-collecting strategies in addition to the population surveys, in view of obtaining a profile that reflects the actual situation as faithfully as possible.

Since 2010, this way of thinking has led the Department of Anti-drug Policies to launch complementary, supplementary studies which apply alternative methods for collecting data on drug use, the first through a microbiological analysis of wastewater in water catchment areas, and the second through the analysis of the atmospheric concentration of certain substances. Although these methods do not allow for a direct estimate of drug use prevalence (in terms of percentage of the population), they are able to provide information on the quantity of drugs used in specific places at specific times.

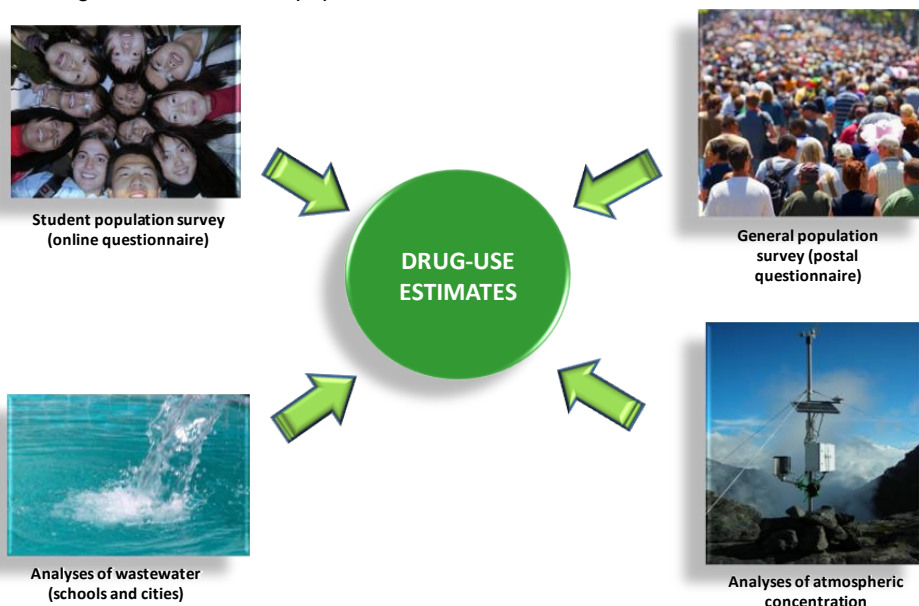
A periodic use of these analyses, moreover, makes it possible to assess the development of drug-use trends over time, providing data which can be used to make a direct comparison with the information gleaned from other types of studies on drug use.

Methodological limitations of general population surveys and low response rate

New multi-observational complementary methodologies launched

Analyses of wastewater and of airborne microparticles

Figure 2.1: Projects launched by the Department for Anti-drug Policies for monitoring drug use in the general and student populations



Estimates based on multidimensional observations

Source: Department for Anti-drug Policies

This chapter contains the results of the general and student population surveys conducted during the first half of 2012, as well as a final section devoted to the results of the wastewater analyses and to drug use in specific targeted groups.

2.1. Drug use in the general population (the GPS-DPA study)

Data regarding the extent of psychoactive substance use in Italy was obtained from the national GPS-DPA 2012 (General Population Survey) launched and managed by the Department for Anti-drug Policies and conducted on the general population aged 18-64 during the first half of 2012 in collaboration with the Ministry of Health and the University Consortium of Industrial and Managerial Economics (CUEIM). The results regarding LTP, LYP and LMP use prevalence can be found in ST01.

Survey of the
population
18-64 years of age

(Standard Table 01)

Methodological aspects

The general population survey was conducted via a paper questionnaire sent by post which had been created according to the instructions provided by the EMCDDA in the document entitled, "Handbook for survey on drug use among general population".

Representative
samples

From a methodological standpoint, the sampling plan for the statistical units was designed taking as stratification variables the age groups of 18-24, 25-34 and 36-64 years of age within the geographical areas of the northwest, the northeast, central Italy, southern Italy and the Italian islands. The sample size was determined so as to produce significant estimates for each of the strata identified above. In order to compensate for the effect of a low response rate (typical for these types of surveys) on prevalence of use estimates, the sample design was appropriately planned based upon the response rates observed in previous surveys.

The design of the statistical sampling units selected for the survey consisted of two stages: during the first stage, the selection of the statistical sampling units (city selection) and during the second stage, the selection of residents from the census data supplied by the selected cities. The selection of the cities in the first stage was carried out using a stratified sampling plan in two strata in self-representative cities (cities of a larger size, with a population of over 100,000 inhabitants) and non-self-representative (cities with 1,000 – 100,000 inhabitants) belonging to the different provinces (two cities per province). Each of these chosen cities then underwent the selection of the second stage statistical units (residents) divided into strata according to age group through a simple random sampling procedure in order to guarantee the random nature of the statistical units selected.

Table 2.1: Distribution of subjects to be interviewed as part of the postal population survey - GPS-DPA 2012 – according to the sample design, by age and geographic area

| Geographic area | 18-24 | 25-34 | 35-64 | Total |
|---------------------|--------------|---------------|---------------|---------------|
| North-western Italy | 1,628 | 3,566 | 11,767 | 16,961 |
| North-eastern Italy | 928 | 1,968 | 6,467 | 9,363 |
| Central Italy | 1,780 | 3,600 | 11,427 | 16,807 |
| Southern Italy | 1,294 | 2,272 | 6,152 | 9,718 |
| Italian islands | 952 | 1,657 | 4,544 | 7,153 |
| Total | 6,582 | 13,063 | 40,357 | 60,002 |

Survey conducted
among 60,000
Italians between the
ages of 18-64

Source: GPS-DPA Survey 2012 – Department for Anti-drug Policies

The survey was conducted during the first half of 2012 by mailing of the postal questionnaire to 60,000 Italian citizens (Table 2.1). 19,294 questionnaires were completed and submitted to the Department

High percentage of
response for the
postal questionnaire

for Anti-drug Policies, with an overall percentage of response to the survey of 33.4%.

Table 2.2: Distribution of percentage of response for the postal population survey - GPS-DPA 2012 by geographic area

| Geographic area | Questionnaires sent | Questionnaires undelivered | Questionnaires received | % of response for survey |
|---------------------|---------------------|----------------------------|-------------------------|--------------------------|
| North-western Italy | 16,961 | 648 | 5,892 | 36.1 |
| North-eastern Italy | 9,363 | 244 | 3,634 | 39.9 |
| Central Italy | 16,807 | 560 | 5,362 | 33.0 |
| Southern Italy | 9,718 | 543 | 2,439 | 26.6 |
| Italian islands | 7,153 | 262 | 1,571 | 22.8 |
| Total | 60,002 | 2,257 | 18,898 | 32.7 |

Response rate highest in the North-east, followed by the North-west

Source: GPS-DPA Survey 2012 – Department for Anti-drug Policies

The results contained in this document refer to 18,898 completed questionnaires (Table 2.2). 396 questionnaires were eliminated from subsequent analyses because they were found to be “unusable”, as they lacked information regarding the respondents’ ages or cities of residence, indispensable elements for calculating the sampling weights to use when estimating the prevalence of use among the entire Italian population of reference.

18,898 questionnaires completed

Unlike the results presented in Standard Table 1 – Standardised Results and Methodology of Adult National Population Surveys on Drug Use – version 1/2012, which refer to the general population 18-64 years of age, the following sections contain data gathered among the general population aged 18-64 integrated with the results of the student population survey for the age group 15-17, which can be considered a representative estimate of the resident population 15-17 years of age; this has been done in order to allow comparison and contrast with the population surveys conducted in the past.

Integration with the student population survey

A brief summary of drug use

A comprehensive analysis of trends in drug use (among individuals who used drugs one or more times in the 12 months prior to the survey) from 2010 to 2012 shows an overall decrease in use for all the drugs included in the study (Table 2.3).

Table 2.3: Prevalence of drug use in the general population aged 15-64 (one or more times in the last 12 months). The years 2010 and 2012

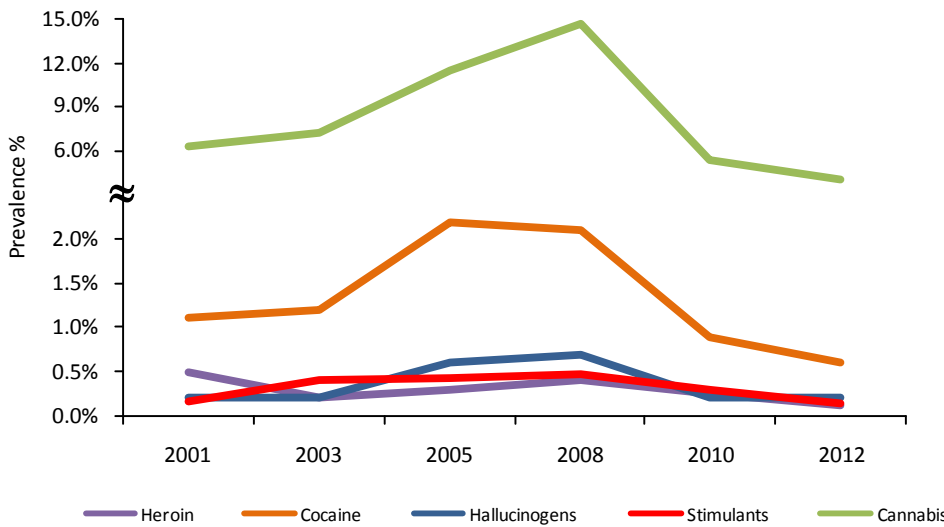
| Type of drug | Prevalence 2010 | Prevalence 2012 | Difference 2010-2012 |
|---------------|-----------------|-----------------|----------------------|
| Heroin | 0.24 | 0.12 | -0.12 |
| Cocaine | 0.89 | 0.60 | -0.29 |
| Cannabis | 5.33 | 4.01 | -1.32 |
| Stimulants | 0.29 | 0.13 | -0.16 |
| Hallucinogens | 0.21 | 0.19 | -0.02 |

Tendency towards a decrease in number of users over a twelve-month period between 2010 and 2012

Source: GPS-DPA 2010 and GPS-DPA 2012 Surveys – Department for Anti-drug Policies

Figure 2.2: Drug use in the general population aged 15-64 (at least once in the last 12 months). The years 2001 - 2012

Tendency towards an overall decrease in the number of users in the general population



Source: IPSAD* Italy 2001 – 2008, GPS-DPA 2010-2012 Surveys – Department for Anti-drug Policies

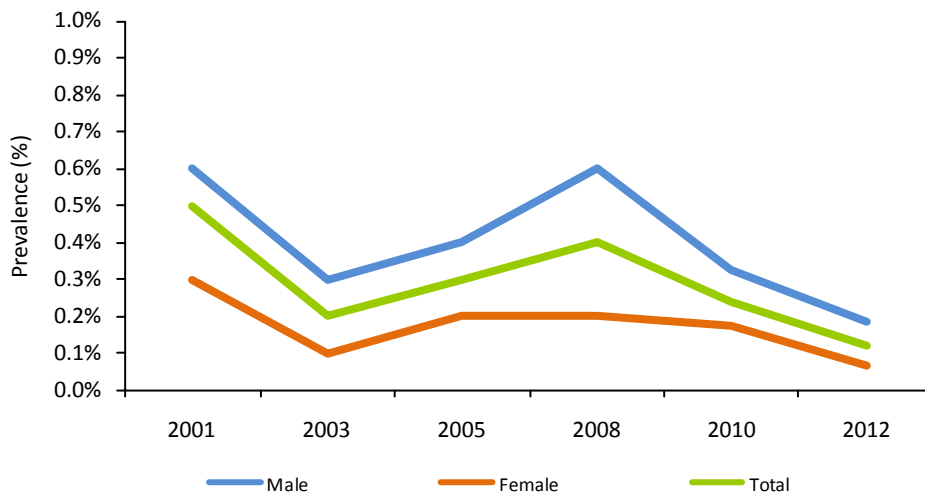
*IPSAD= Italian Population Survey on Alcohol and other Drugs, conducted by the National Research Council

Heroin use

According to the results of the general population studies conducted between 2001 and 2012, the percentage of subjects who had used heroin or other opiates (codeine, morphine, methadone, etc.) one or more times in the 12 months prior to the survey up until the year 2008 seemed to be quite variable. However, when examining more recent surveys conducted from 2008 on, opiate use seems to be steadily decreasing, with a tendency towards a steeper decline among males (Figure 2.3).

Figure 2.3: Heroin use (% prevalence) in the general population aged 15-64 (at least once in the last 12 months). The years 2001 - 2012

Number of heroin users decreasing since 2008



Source: IPSAD* Italy 2001 – 2008, GPS-DPA 2010-2012 Surveys – Department for Anti-drug Policies

According to the results from the last general population survey, 1.2% of the Italian population between 18-64 years of age appears to have tried heroin at least once in their lives, with a greater prevalence among men (Table 2.4). 0.1% of the Italian population had used it over the course of the twelve months prior to filling out the questionnaire, while 0.06% had used heroin in the 30 days prior to it as well, with a higher prevalence for males in this category as well (0.2% and 0.08% for men, respectively, as opposed to 0.06% and 0.04% for women, respectively).

Analysing opiate use over the 12 months prior to the survey according to gender and age, we find that there is a marked difference between men and women in the youngest age groups (0.3% of men vs. 0.02% of women aged 18-24 and 0.5% of men vs. 0.04% of women aged 25-34), but that the estimate of opiate use in the in the age group 35-64 revealed no difference between the genders (0.06% vs. 0.07%).

Furthermore, among users who reported having used opiates during the 12 months prior to the survey, 69.6% of men and 77.5% of women reported occasional use (1 to 10 times); more frequent use seems to be found more often among men than among women.

Table 2.4: Use of heroin and other opiates (% prevalence) in the general population aged 18-64. The year 2012

| Use of heroin or other opiates (%) | Men | Women | Total |
|---|-------|-------|-------|
| At least once in their lifetimes (LTP) | 1.47 | 0.89 | 1.16 |
| At least once in the last 12 months (LYP) | 0.18 | 0.06 | 0.11 |
| At least once in the last 30 days (LMP) | 0.08 | 0.04 | 0.06 |
| Age group (Last Year Prevalence) (%) | | | |
| 18-24 years of age | 0.26 | 0.02 | 0.13 |
| 25-34 years of age | 0.54 | 0.04 | 0.26 |
| 35-64 years of age | 0.06 | 0.07 | 0.07 |
| Frequency of use (Last Year) (%) | | | |
| 1-2 times | 28.14 | 20.10 | 25.94 |
| 3-10 times | 41.44 | 57.43 | 45.82 |
| At least once a month | 30.41 | 22.47 | 28.24 |

Source: GPS-DPA Survey 2012 – Department for Anti-drug Policies

Higher prevalence of heroin or other type of opiate use among men in all three lengths of time of reference

Opiate use more prevalent among men in the younger age groups

Occasional use is prevalent

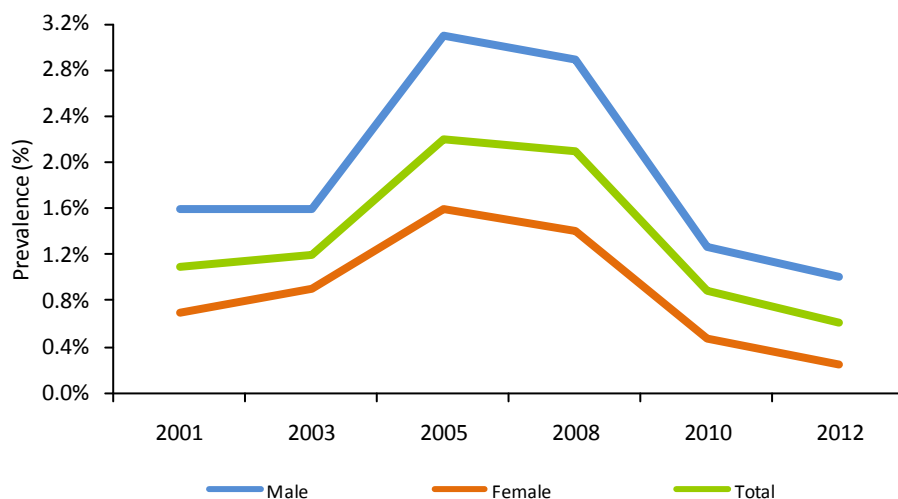
Cocaine use

The trend in the number of people who used cocaine or crack at least once in the 12 months prior to filling out the questionnaire has taken a downturn since 2005, following an initial increase in use, as revealed by the population surveys conducted over the last decade (Figure 2.4). Over the last year of reference, the decline seems to have become steady, and the difference in use patterns between the two genders also appears to have become stable.

4.2% of the Italian population between the ages of 18-64 have tried cocaine at least once in their lives, while 0.6% report that they had used it during the course of the year leading up to the survey (Table 2.5). 0.2% of subjects surveyed reported current cocaine or crack use, meaning that they had used in the 30 days prior to participating in the survey. As with heroin, significant differences can be found between the men and women surveyed, especially with reference to having tried cocaine at least once in their lifetimes, although the largest difference in terms of percentage can be found under the heading of use in the 30 days prior to participating in

the survey (women -83.3% compared to men).

Figure 2.4: Cocaine use (% prevalence) in the general population aged 15-64 (at least once in the last 12 months). The years 2001 - 2012



Decline in the number of cocaine or crack users since 2005

Source: IPSAD Italy 2001 – 2008, GPS-DPA 2010-2012 Surveys – Department for Anti-drug Policies

Analysing trends in cocaine or crack use over the 12 months prior to the survey according to gender and age group, we can see a marked difference between the genders among all age groups, with the difference being greatest in the age group 35-64 (women -87% compared to men). Moreover, among those who reported having used these substances in the 12 months prior to the survey, 52.4% of the men and 64.5% of the women reported sporadic use (1-2 time); more frequent use seems to be more common among men than among women.

Table 2.5: Use of cocaine or crack (% prevalence) in the general population aged 18-64. The year 2012

| Use of cocaine or crack (%) | Men | Women | Total |
|---|-------|-------|-------|
| At least once in their lifetimes (LTP) | 6.00 | 2.72 | 4.23 |
| At least once in the last 12 months (LYP) | 0.98 | 0.21 | 0.57 |
| At least once in the last 30 days (LMP) | 0.42 | 0.07 | 0.23 |
| Age group (Last Year Prevalence) (%) | | | |
| 18-24 years of age | 2.27 | 0.73 | 1.44 |
| 25-34 years of age | 2.11 | 0.43 | 1.17 |
| 35-64 years of age | 0.46 | 0.06 | 0.25 |
| Frequency of use (Last Year) (%) | | | |
| 1-2 times | 52.37 | 64.50 | 54.84 |
| 3-10 times | 33.32 | 29.74 | 32.59 |
| At least once a month | 14.31 | 5.75 | 12.57 |

Higher prevalence of cocaine or crack users among men in all three lengths of time of reference and in all age groups

Occasional use is prevalent for both genders

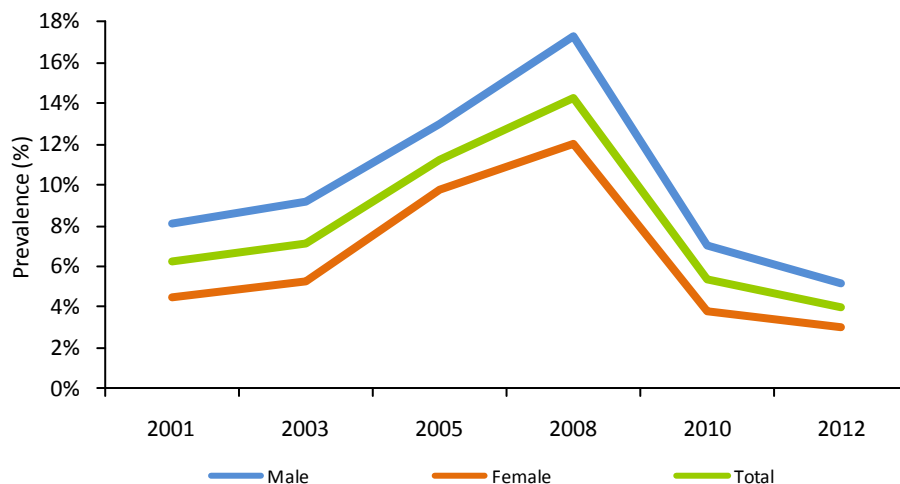
Source: GPS-DPA Survey 2012 – Department for Anti-drug Policies

Cannabis use

Of all illicit drugs, the one most used by the Italian population over the last ten years is cannabis; the trend in the number of people between the ages of 15-64 who used this drug at least once in the twelve months prior to completing the questionnaire shows an increase in users until the year

2008, followed by a decrease in following years (2008-2012), even more marked in the two-year period from 2008-2010 (Figure 2.5).

Figure 2.5: Cannabis use (marijuana or hashish) (% prevalence) in the general population aged 15-64 (at least once in the last 12 months). The years 2001 - 2012



Increase in cannabis use until 2008, followed by a marked decrease in the following period

Source: IPSAD Italy 2001 – 2008, GPS-DPA 2010-2012 Surveys – Department for Anti-drug Policies

In Italy, according to data gathered in 2012, 21.7% of the population aged 18-64 has tried cannabis (hashish or marijuana), while 3.5% had continued to use it during the course of the year prior to the survey (Table 2.6). Prevalence of use declines further when observing the number of respondents who had used cannabis in the previous month, who numbered only 1.5% of the Italian population of reference. Patterns of use of hashish or marijuana by gender show lower use among women than in among men for all lengths of time considered, with an even more marked difference when observing the 30 days prior to participating in the survey (women -53.8% compared to men).

Table 2.6: Use of cannabis (hashish or marijuana) (% prevalence) in the general population aged 18-64. The year 2012

| Cannabis use (%) | Men | Women | Total |
|---|-------|-------|-------|
| At least once in their lifetimes (LTP) | 27.25 | 16.97 | 21.70 |
| At least once in the last 12 months (LYP) | 4.57 | 2.65 | 3.53 |
| At least once in the last 30 days (LMP) | 2.08 | 0.96 | 1.47 |
| Age group (Last Year Prevalence) (%) | | | |
| 18-24 years of age | 14.36 | 10.22 | 12.12 |
| 25-34 years of age | 7.92 | 3.86 | 5.66 |
| 35-64 years of age | 2.07 | 1.00 | 1.50 |
| Frequency of use (Last Year) (%) | | | |
| 1-2 times | 51.28 | 56.47 | 53.38 |
| 3-10 times | 19.44 | 29.14 | 23.36 |
| At least once a month | 29.27 | 14.39 | 23.26 |

Higher prevalence of hashish or marijuana users among men in all three lengths of time of reference and in all age groups
1-2 times in the last 12 months is the prevalent pattern of use

Source: GPS-DPA Survey 2012 – Department for Anti-drug Policies

Moreover, among those who reported having used this substance in the 12 months prior to the survey, most reported a use pattern of 1-2 times in the year (51.3% of the men and 56.5% of the women); more men than women seem to engage in the most frequent use pattern (at least once a

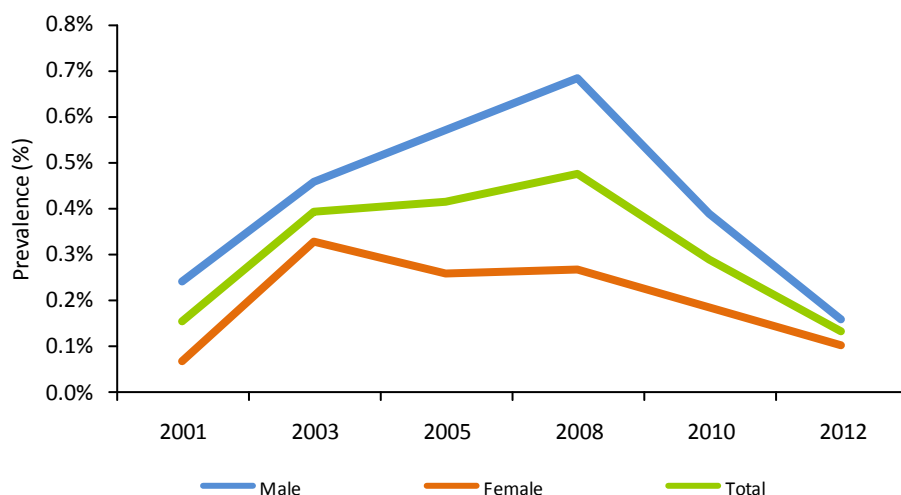
month).

Analysing use trends over the 12 months prior to the survey according to gender and age group, we can see a marked difference between the genders in all age groups, with the difference being greatest in the age group 35-64 (women -51.7% compared to men).

Stimulant use

The trend in the number of people who used stimulant drugs at least once in the 12 months prior to participating in the survey, as revealed by the population surveys conducted over the last decade, has taken a downturn since 2008, following an initial increase in use, more marked among the male population (Figure 2.6).

Figure 2.6: Stimulant use (ecstasy or amphetamines) (% prevalence) in the general population aged 15-64 (at least once in the last 12 months). The years 2001 - 2012



Increase in the number of stimulant users until 2008, followed by a marked decline in the following years

Source: IPSAD Italy 2001 – 2008, GPS-DPA 2010-2012 Surveys – Department for Anti-drug Policies

2.4% of the Italian population between the ages of 18-64 have tried stimulant drugs (ecstasy or amphetamines) at least once in their lives, while 0.1% had used them during the course of the year leading up to the survey and 0.02% in the 30 days prior to the survey (Table 2.7). Among the population aged 18-64, more men than women had used stimulants in the year leading up to the survey, a difference that decreased in older age groups.

Moreover, among those who reported having used ecstasy or amphetamines in the 12 months prior to the survey, more women (90.4%) reported having used them occasionally (1-10 times during the course of the year), while more frequent use seems to be more common among men (at least once a month: 14.2% of men vs. 9.6% of women).

When drawing a distinction between different types of psychoactive stimulant drugs used, it appears that more women than men had used amphetamines in the 12 months prior to the survey within the age group 35-64, while more men than women report using these stimulant drugs (ecstasy or amphetamines) in the younger age groups. As many differences can be found with respect to frequency of use of these substances: more women had used ecstasy only 1-2 times in the 12 months prior to the survey (62.3% of women vs. 35.5% of men), but

women also reported more frequent use of amphetamines (3-10 times in the year prior to the survey) (84.1% of women vs. 36.0% of men).

Table 2.7: Use of stimulant drugs (% prevalence) in the general population aged 18-64. The year 2012

| Use of stimulants (%) | Men | Women | Total |
|---|-------|-------|-------|
| At least once in their lifetimes (LTP) | 3.28 | 1.74 | 2.45 |
| At least once in the last 12 months (LYP) | 0.12 | 0.08 | 0.10 |
| At least once in the last 30 days (LMP) | 0.03 | 0.01 | 0.02 |
| Age group (Last Year Prevalence) (%) | | | |
| 18-24 years of age | 0.501 | 0.037 | 0.250 |
| 25-34 years of age | 0.081 | 0.011 | 0.042 |
| 35-64 years of age | 0.065 | 0.107 | 0.088 |
| Frequency of use (Last Year) (%) | | | |
| 1-2 times | 40.76 | 6.59 | 25.70 |
| 3-10 times | 45.04 | 83.77 | 62.12 |
| At least once a month | 14.20 | 9.64 | 12.19 |

Higher prevalence of stimulant users among men in all three lengths of time of reference

Ecstasy or amphetamine use more prevalent among men in the younger age groups

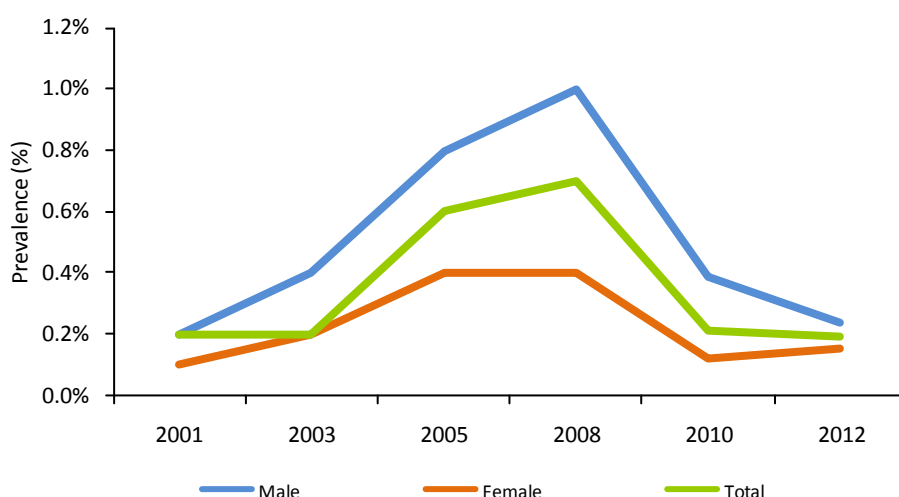
Occasional use over the last 12 months is the prevalent pattern of use

Source: GPS-DPA Survey 2012 – Department for Anti-drug Policies

Hallucinogen use

The trend in the number of people who used hallucinogens at least once in the 12 months prior to participating in the survey, as revealed by the population surveys conducted over the last decade, has taken a downturn since 2008, following an initial increase in use (Figure 2.7). Over the last year of reference, the decline in the use of these substances seems to have become more marked among the male population, while use has increased slightly among the female population. The overall trend remains stable.

Figure 2.7: Use of hallucinogens (% prevalence) in the general population aged 15-64 (at least once in the last 12 months). The years 2001 – 2012



Increase in the number of hallucinogen users until 2008, followed by a marked decline in following years

During the last year of reference the number of male users has dropped. The number of female users remain stable.

Source: IPSAD Italy 2001 – 2008, GPS-DPA 2010-2012 Surveys – Department for Anti-drug Policies

In Italy, according to data gathered in 2012, 1.6% of the population aged 18-64 has tried hallucinogens, while 0.1% had continued to use it during the course of the year prior to the survey (Table 2.8). Prevalence of use declines further when observing the number of respondents who had used

hallucinogens in the previous month, who numbered only 0.02% of the Italian population of reference. Patterns of use of these drugs by gender show lower use among women than among men for all lengths of time considered, with an even more marked difference when observing the 30 days prior to participating in the survey (women -75% compared to men). Among those who reported having used this type of drug in the year prior to the survey, sporadic use (1-2 times in a year) was the most frequent pattern (90.7% of men and 99.8% of women); more frequent use (at least once a month) seems to be more common among women than among men.

Analysing trends in use over the 12 months prior to the survey according to gender and age group, we can see a marked difference between the genders among all age groups, with the difference being greatest in the oldest age group (women -66.7% compared to men).

Table 2.8: Use of hallucinogen (% prevalence) in the general population aged 18-64. The year 2012

| Use of hallucinogens (%) | Men | Women | Total |
|---|-------|-------|-------|
| At least once in their lifetimes (LTP) | 2.38 | 0.94 | 1.61 |
| At least once in the last 12 months (LYP) | 0.16 | 0.12 | 0.14 |
| At least once in the last 30 days (LMP) | 0.04 | 0.01 | 0.02 |
| Age group (Last Year Prevalence) (%) | | | |
| 18-24 years of age | 0.75 | 0.63 | 0.68 |
| 25-34 years of age | 0.31 | 0.21 | 0.26 |
| 35-64 years of age | 0.03 | 0.01 | 0.02 |
| Frequency of use (Last Year) (%) | | | |
| 1-2 times | 90.66 | 99.77 | 94.86 |
| 3-10 times | 9.34 | 0.00 | 5.03 |
| At least once a month | 0.00 | 0.23 | 0.11 |

Source: GPS-DPA Survey 2012 – Department for Anti-drug Policies

Higher prevalence of hallucinogen users among men in all three lengths of time of reference

1-2 times over the last 12 months is the prevalent pattern of use

Polydrug use

The assessment of polydrug use gives a complete picture of the overall prevalence of illegal psychoactive substance use in the general population aged 18-64. Table 2.9 shows the distribution of prevalence of the concomitant or consecutive use of two different licit and illicit drugs among the population sample who reported having used illicit drugs in the 30 days prior to the survey.

It is estimated that 1.5% of the Italian population used cannabis in the month prior to the survey, of whom 82.1% had also consumed alcoholic beverages during the same time period, 77.7% had smoked tobacco, 6.0% had used cocaine and 1.4% had used heroin.

0.2% of subjects between 18 and 64 years of age reported having used cocaine at least once during the 30 days prior to the survey. Of these, 73.0% had also consumed alcoholic beverages, 55.3% had smoked, 37.9% had used cannabis and 10.5% had made concomitant or consecutive use of heroin.

Of all the Italian population of reference, 0.06% having used heroin during the 30 days prior to the survey. Of these users, 82.6% reported having consumed alcohol during the same period, while 80.8% reported having smoked cigarettes, 35.6% had used cannabis and 41.6% had used cocaine.

Cannabis users:
6.0% also use cocaine;
1.4% also use heroin

Cocaine users:
37.9% also use cannabis
10.5% also use heroin

Heroin users:
35.6% also use cannabis
41.6% also use cocaine

Table 2.9: Conditional prevalence distribution of polydrug users in the general population aged 18-64 who had used drugs in the 30 days prior to the survey. The year 2012

| Drug type | Alcohol | Tobacco | Cannabis | Cocaine | Heroin |
|----------------------|---------|---------|----------|---------|--------|
| Cannabis (LMP 1.47%) | 82.1% | 77.7% | | 6.0% | 1.4% |
| Cocaine (LMP 0.23%) | 73.0% | 55.3% | 37.9% | | 10.5% |
| Heroin (LMP 0.06%) | 82.6% | 80.8% | 35.6% | 41.6% | |

Source: GPS-DPA Survey 2012 – Department for Anti-drug Policies

Strong trend toward the concomitant or consecutive use of alcohol and tobacco in association with cannabis, cocaine and heroin

2.2. Drug use in the school and youth population (SPS-DPA Survey)

Data regarding the prevalence of licit and illicit psychoactive substance use among the Italian student population between 15-19 years of age was taken from the SPS-DPA (Student Population Survey) conducted in the first half of 2012 by the Department for Anti-drug Policies in collaboration with the Ministry of Education, Universities and Research and with the participation of the Regional Representatives for Health Education. The objective of the sample survey, conducted using a self-reported anonymous questionnaire, was to provide an estimate of the number of 15-19 year-old students who used psychoactive substances, in accordance with the ESPAD protocol.

Study of 35,980 young students between 15-19 years of age

The results with respect to prevalence of drug users for the lengths of time defined as LTP, LYP, LMP within the student population aged 15-18 are reported in STANDARD TABLE 02 METHODS AND RESULTS OF SCHOOL SURVEYS ON DRUG USE.

Standard Table 02

Description of methods

As in previous editions of this survey, the population sample was selected using a two-stage sampling model, where the first stage units were higher secondary schools and the second-stage units were students attending those schools for the duration of the curriculum. The following table shows the distribution of schools included in the sample by region and type of academic institution.

Chosen sampling techniques ideal for ensuring reliability of data gathered

This procedure allowed, on the one hand, the design of a sample that faithfully represents the student population and, on the other hand, significantly improved sampling efficiency.

The variables taken into consideration for the stratification of the first-stage units (Region and type of academic institute) were held to be of particular importance in reaching the objective of representing the entire population in relation to the phenomenon being assessed.

The decision to stratify by region and type of institute (secondary school or high school formerly specializing in education, polytechnic institute, vocational institute or arts institute) is a response to the need to use a sample representative of the entire student population nationwide with the hypothesis that the morphological characteristics of the different geographic areas and the different types of academic career choices might influence drug use prevalence.

During the second stage of sampling, the statistical units represented by the students attending classes as part of a complete four- or five-year academic curriculum were selected using the bunching method, where the bunch was the class in which they were enrolled.

Table 2.10: Distribution of the first-stage units by region and type of academic institution. The year 2012

| Region | Secondary schools | Polytechnic institutes | Vocational institutes | Arts high secondary schools and colleges | Total |
|-------------------------|-------------------|------------------------|-----------------------|--|------------|
| Abruzzo | 7 | 7 | 3 | 2 | 19 |
| Basilicata | 3 | 4 | 2 | 2 | 11 |
| Calabria | 13 | 9 | 8 | 4 | 34 |
| Campania | 26 | 28 | 17 | 7 | 78 |
| Emilia Romagna | 9 | 12 | 8 | 2 | 31 |
| Friuli Venezia Giulia | 4 | 4 | 3 | 1 | 12 |
| Lazio | 22 | 17 | 9 | 6 | 54 |
| Liguria | 6 | 4 | 6 | 1 | 17 |
| Lombardy | 32 | 27 | 17 | 8 | 84 |
| Marche | 4 | 5 | 5 | 2 | 16 |
| Molise | 4 | 1 | 3 | 1 | 9 |
| Piedmont/ Valle-D'Aosta | 11 | 11 | 10 | 6 | 38 |
| Apulia | 12 | 14 | 10 | 6 | 42 |
| Sardinia | 6 | 6 | 4 | 3 | 19 |
| Sicily | 21 | 22 | 12 | 6 | 61 |
| Tuscany | 12 | 10 | 4 | 5 | 31 |
| Trentino Alto Adige | 3 | 6 | 2 | 1 | 12 |
| Umbria | 2 | 4 | 2 | 1 | 9 |
| Veneto | 13 | 14 | 9 | 5 | 41 |
| Total | 210 | 205 | 134 | 69 | 618 |

Source: SPS-DPA Survey 2012 – Department for Anti-drug Policies

In order to guarantee that information collection could be compared to other EU Member States, the tool used for the study was designed in accordance with the European ESPAD protocol, integrated and slightly modified in order to better adapt the instrument to the Italian context.

In 2012, as in 2011, the SPS-DPA Student Population Survey 2012 was conducted with the support of computer technology. The C.A.S.I. (Computer-Aided Self-Completed Interview) method was adopted, which made it possible to fill out the questionnaire online using a nonreplicable, unique and anonymous access ID.

The study was conducted during the first half of 2012, with the participation of 490 higher secondary schools, equivalent to 79.3% of the sample of schools which had been planned.

A brief summary of drug use

The results of the study which will be presented in the following sections are the results of analyses conducted on the information collected from a sample of 35,980 questionnaires completed by Italian students aged 15-19 (following an assessment of data quality, approximately 4,000 students were eliminated from the original sample, most of whom (approximately 3,000) were older than the target age of the survey.

The use of European protocols

Electronic innovation

High percentages of response

Large sample: 35,980 subjects aged 15-19 on 30 June 2012

Table 2.11: Drug use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2011 and 2012

| Type of drug | Prevalence 2011 | Prevalence 2012 | Difference 2011-2012 |
|---------------|-----------------|-----------------|----------------------|
| Heroin | 0.41 | 0.32 | -0.09 |
| Cocaine | 2.00 | 1.86 | -0.14 |
| Cannabis | 17.91 | 19.14 | 1.23 |
| Stimulants | 0.92 | 1.12 | 0.20 |
| Hallucinogens | 1.88 | 1.72 | -0.16 |

Used in the last 12 months:

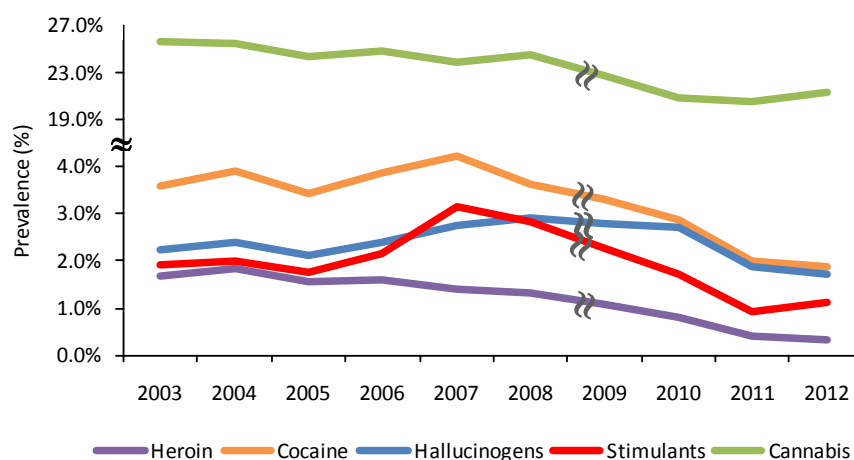
- heroin: -0.09
- cocaine: -0.14
- cannabis: +1.23
- stimulants: +0.94
- hallucinogens: -0.16

Source: SPS-DPA 2011 and SPS-DPA 2012 Surveys – Department for Anti-drug Policies

An general assessment of patterns of drug use in the 12 months prior to the survey for surveys conducted between 2003 and 2012 reveals an overall decline in the use of most illicit drugs. Comparing drug use data for the last 10 years, we can see a progressive decrease in the number of users of heroin, cocaine and hallucinogens, while the number of cannabis users remains largely stable (with a statistically significant tendency to increase in 2012); there has been a slight increase in stimulant, ecstasy and amphetamine use in 2012 as well, although it only involves 2% of students participating in the study.

Use patterns decreasing for cocaine, heroin and hallucinogens, stable for cannabis, increasing for stimulants.

Figure 2.8: Drug use in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2012



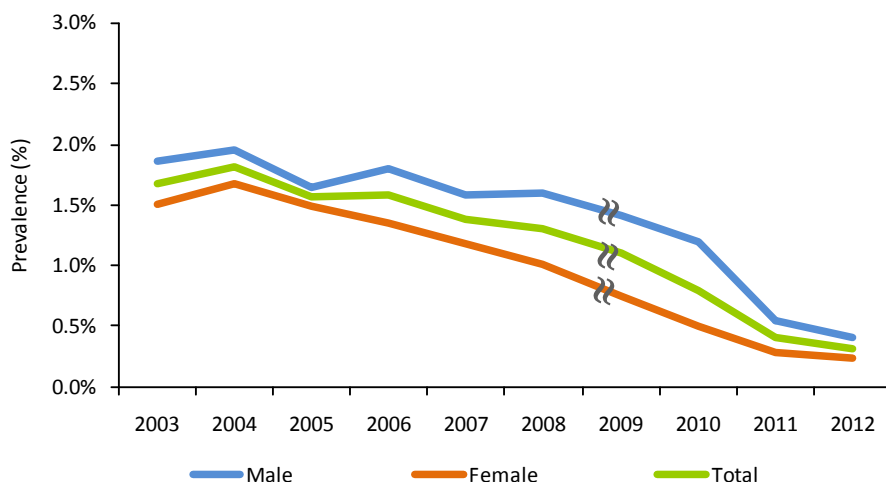
Source: ESPAD Italy 2003-2008, SPS-DPA Surveys 2010-2012 – Department for Anti-drug Policies

Heroin use

The trend in the number of students who had used heroin at least once in the 12 months prior to participating in the survey, as revealed by the students who participated in the surveys conducted between 2003 and 2012, reveals a steady decline since the beginning of the last decade; this decrease appears to have been less marked during the last year, and the difference in use patterns between the two genders was also less significant.

Decrease in heroin use, especially among female students

Figure 2.9: Heroin use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2012



Source: ESPAD Italy 2003-2008, SPS-DPA Surveys 2010-2012 – Department for Anti-drug Policies

In 2012, the percentage of Italian students who reported having used heroin was exceptionally low: 0.51% reported having used it at least once in their lives and 0.32% stated that they had used it at least once in the 12 months prior to the survey, while 0.23% reported having used it at least once in the month prior to filling out the questionnaire (Table 2.12). In comparison with 2011, heroin use is shown to have declined for all lengths of time of reference, in particular among male students, even if that decline was not statistically significant.

An examination of patterns in numbers of 16-year-old students who had used heroin at least once in their lives as shown in ESPAD studies reveals a decline over the last 9 years, with very low numbers (2%) in 2011, which is comparable with use figures for Italian 16-year-olds' European peers.

Heroin use among 16-year-old Italian students comparable to heroin use among their European peers

Table 2.12: Heroin use (% prevalence) in the student population aged 15-19. The years 2011 and 2012

| Heroin use (%) | 2011 | | | 2012 | | |
|--|-------|-------|-------|-------|-------|-------|
| | M | F | Tot | M | F | Tot |
| At least once in their lifetimes (LTP) | 0.85 | 0.44 | 0.64 | 0.61 | 0.50 | 0.51 |
| At least once in the last 12 months (LYP) | 0.54 | 0.29 | 0.41 | 0.40 | 0.23 | 0.32 |
| At least once in the last 30 days (LMP) | 0.42 | 0.16 | 0.29 | 0.30 | 0.17 | 0.23 |
| Age (Last Year Prevalence) (%) | | | | | | |
| 15 years of age | 0.30 | 0.22 | 0.26 | 0.09 | 0.14 | 0.12 |
| 16 years of age | 0.39 | 0.35 | 0.37 | 0.43 | 0.30 | 0.36 |
| 17 years of age | 0.59 | 0.31 | 0.45 | 0.48 | 0.29 | 0.39 |
| 18 years of age | 0.62 | 0.31 | 0.46 | 0.49 | 0.19 | 0.34 |
| 19 years of age | 0.79 | 0.27 | 0.51 | 0.46 | 0.24 | 0.35 |
| Frequency of use (Last Year) (% of total LYP users) | | | | | | |
| 1-9 times | 86.76 | 93.75 | 89.35 | 75.00 | 83.33 | 78.07 |
| 10-19 times | 5.88 | 2.50 | 4.63 | 4.17 | 4.76 | 4.39 |
| 20 times or more | 7.35 | 3.75 | 6.02 | 20.83 | 11.90 | 17.54 |

99.5% of students have never tried heroin, while 0.5% have tried heroin at least once in their lives

Only 0.2% had used heroin in the 30 days prior to participating in the survey

Source: SPS-DPA 2011 and SPS-DPA 2012 Surveys – Department for Anti-drug Policies

An examination of data from different geographical areas (the north-west, the north-east, central Italy, southern Italy and the Italian islands) from 2012 reveals that the trend in the number of students who had used heroin at least once over the 12 months prior to participating in the survey had taken a downturn in heroin in comparison with the previous year's data in all geographical areas, with the decrease being more marked in central Italy.

In 2012, among male students, numbers for this type of use remained largely stable for all ages, with the exception of the 15-year-old age group, whose heroin use was decidedly lower than that of 16- to 19-year-olds; the same stability was found among female students, as had already been seen in 2011 (Table 2.12).

Decline in the number of users more significant among 15-year-olds, and especially among male students

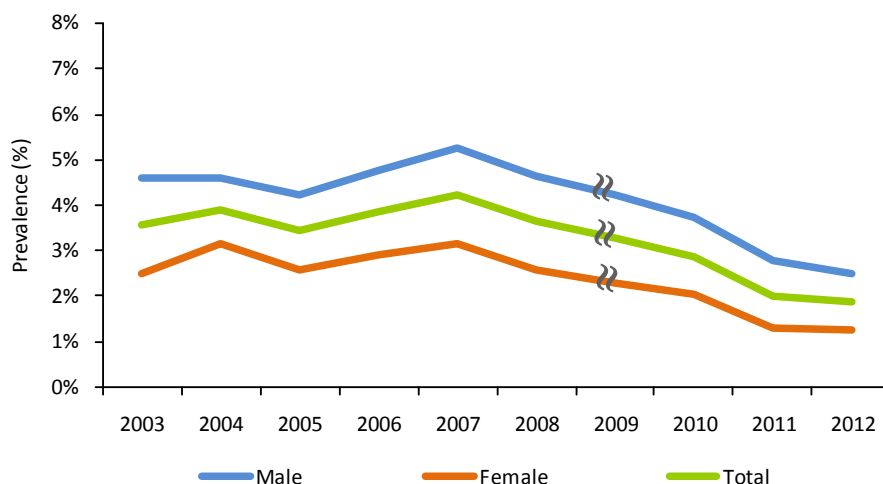
Of those students who had used heroin during the course of the year leading up to the survey, approximately 20% had used the drug 20 or more times (a level of frequency more common among male students), while 80% reported less frequent use (1-9 times). Frequent use of heroin, although it applies to a smaller number of users, has nonetheless significantly increased in comparison with the previous year (Table 2.12).

Cocaine use

According to information reported by students involved in the surveys conducted over the last ten years, less than 5% of students participating in the surveys had used cocaine at least once in the 12 months leading up to those surveys; use patterns have fallen since 2007 but remained stable over the last two-year period of reference for both genders.

Cocaine use falling since 2007

Figure 2.10: Cocaine use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2012



Source: ESPAD Italy 2003-2008 –SPS-DPA Surveys 2010-2012 – Department for Anti-drug Policies

In 2012, 2.6% of students filling out the questionnaire had tried cocaine, a percentage which falls to 1.9% when considering only those who had used the drug in the year prior to the survey and to approximately 1% when considering only those who had used in the previous 30 days (at least once) (Table 2.13). None of the data for cocaine use differs in any statistically significant way from the data from the previous year.

With reference data available throughout Europe as collected in ESPAD studies, we can see that there was an increase in the number of 16-year-

old cocaine users from 1999 (1%) to 2007 (3%), followed by a drop which continued until 2011, before reaching the levels observed in the previous ten-year period (2%).

Table 2.13: Cocaine use (% prevalence) in the student population aged 15-19. The years 2011 and 2012

| Cocaine use (%) | 2011 | | | 2012 | | |
|--|-------|-------|-------|-------|-------|-------|
| | M | F | Tot | M | F | Tot |
| At least once in their lifetimes (LTP) | 3.99 | 1.97 | 2.95 | 3.36 | 1.90 | 2.61 |
| At least once in the last 12 months (LYP) | 2.77 | 1.28 | 2.00 | 2.48 | 1.25 | 1.86 |
| At least once in the last 30 days (LMP) | 1.62 | 0.75 | 1.17 | 1.39 | 0.72 | 1.06 |
| Age (Last Year Prevalence) (%) | | | | | | |
| 15 years of age | 0.88 | 0.53 | 0.70 | 0.80 | 0.78 | 0.79 |
| 16 years of age | 1.74 | 0.98 | 1.35 | 1.60 | 1.13 | 1.36 |
| 17 years of age | 3.24 | 0.91 | 2.05 | 2.45 | 1.40 | 1.93 |
| 18 years of age | 3.24 | 1.71 | 2.45 | 3.36 | 1.54 | 2.46 |
| 19 years of age | 4.70 | 2.23 | 3.40 | 4.06 | 1.40 | 2.75 |
| Frequency of use (Last Year) (% of total LYP users) | | | | | | |
| 1-9 times | 86.13 | 85.84 | 86.04 | 80.49 | 84.89 | 81.97 |
| 10-19 times | 5.59 | 7.31 | 6.16 | 8.07 | 4.44 | 6.86 |
| 20 times or more | 8.28 | 6.85 | 7.81 | 11.43 | 10.67 | 11.18 |

Source: SPS-DPA 2011 and SPS-DPA 2012 Surveys – Department for Anti-drug Policies

In 2012, the number of students who had used cocaine in the year prior to the survey seemed to be greater in central Italy, followed by southern Italy/the Italian islands and by the northwest. The phenomenon seems to involve less students in the northeast of Italy, where there was found to be a statistically significant decrease in the number of users in comparison with 2011, while other geographic areas presented no significant variability.

Numbers of cocaine users are greater among the older students, in particular among male students, who have a higher prevalence of use (LYP) than their female peers (Table 2.13). Prevalence of use among males rises from 0.8% of 15-year-olds to 1.6% of 16-year-olds, 2.5% of 17-year-olds, 3.4% of 18-year-olds and 4.1% of 19-year-olds. Among female students, we can see an increase among the younger-aged, levelling off between 17-19 years of age, unlike in the previous year.

Of those students who reported having used cocaine in the year leading up to the survey in 2012, about 12% of users of both genders were regular users (20 times or more), a higher percentage than was found in 2011. (Table 2.13).

Cannabis use

The illicit drug most often used by students over the last decade was found to be cannabis. From 2003, the percentage of students who had used cannabis at least once in the 12 months leading up to the various surveys had been in steady decline until 2010. Then a (statistically significant) upswing began to take place over the last two-year period (2011-2012). Since 2005, trends among adolescent boys and girls have kept pace with each other.

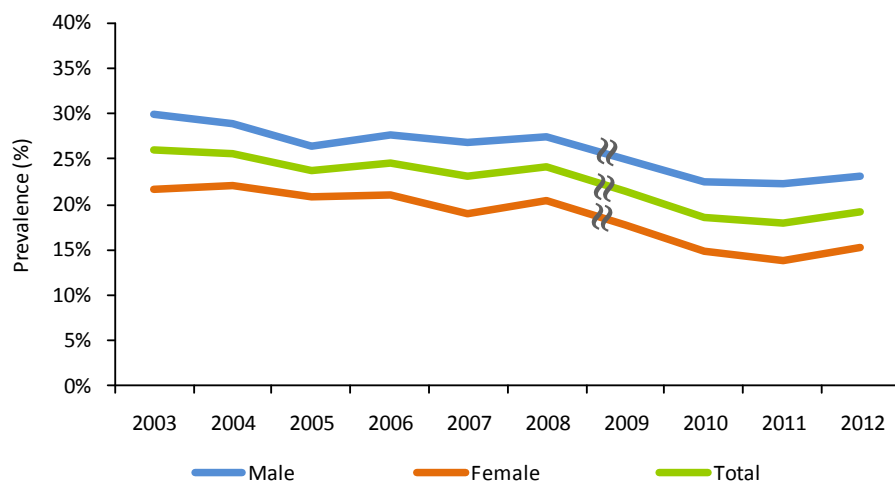
97.4% of students have never tried cocaine, while 2.6% have used cocaine at least once in their lives

Only 1% had used cocaine in the 30 days prior to the survey

Cocaine use more prevalent among male students

Cannabis is the illicit drug most used by students

Figure 2.11: Cannabis use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2012



Source: ESPAD Italy 2003-2008 – SPS-DPA Surveys 2010-2012 – Department for Anti-drug Policies

22.6% of Italian students who filled out the questionnaire had tried cannabis at least once in their lives, while 19.1% reported have used it at least once during the year leading up to the survey (Table 2.14). Nearly 13% of Italian students report having used cannabis in the 30 days before filling out the questionnaire.

According to data from ESPAD studies conducted between 1995-2011, both Italian and European 16-year-olds who reported having tried cannabis at least once in their lives had been increasing until 2003, from 13% in 1995 to 22% in 2003 for European students and from 21% in 1995 to 28% in 2003 for Italian students. In following years, we can see decline in use until the year 2011, when there was a more marked drop in use trends among Italian students (22% for Italian students and 18% for European students).

Drop in use trends for cannabis among both Italian and European 16-year-olds

Table 2.14: Cannabis use in the student population aged 15-19. The years 2011 and 2012

| Cannabis use (%) | 2011 | | | 2012 | | |
|--|-------|-------|-------|-------|-------|-------|
| | M | F | Tot | M | F | Tot |
| At least once in their lifetimes (LTP) | 26.62 | 17.21 | 21.77 | 26.95 | 18.40 | 22.63 |
| At least once in the last 12 months (LYP) | 22.33 | 13.75 | 17.91 | 23.10 | 15.18 | 19.14 |
| At least once in the last 30 days (LMP) | 16.09 | 9.40 | 12.65 | 15.95 | 9.93 | 12.95 |
| Age (Last Year Prevalence) (%) | | | | | | |
| 15 years of age | 7.59 | 4.60 | 6.03 | 7.99 | 5.70 | 6.80 |
| 16 years of age | 16.73 | 10.16 | 13.39 | 17.98 | 12.03 | 14.99 |
| 17 years of age | 23.68 | 13.93 | 18.72 | 24.87 | 16.86 | 20.94 |
| 18 years of age | 29.44 | 19.06 | 24.13 | 30.70 | 20.03 | 25.41 |
| 19 years of age | 33.38 | 20.37 | 26.54 | 32.52 | 21.36 | 27.02 |
| Frequency of use (Last Year) (% of total LYP users) | | | | | | |
| 1-9 times | 60.45 | 71.14 | 64.68 | 58.54 | 69.93 | 63.05 |
| 10-19 times | 9.52 | 10.48 | 9.90 | 10.32 | 10.95 | 10.57 |
| 20 times or more | 30.03 | 18.38 | 25.42 | 31.14 | 19.12 | 26.38 |

Source: SPS-DPA 2011 and SPS-DPA 2012 Surveys – Department for Anti-drug Policies

77.4% of students have never tried cannabis, while 22.6% have used it at least once in their lives

23.9% had used it in the 30 days prior to the survey

The number of cannabis users in north-eastern Italy and in southern Italy/the islands remained more or less stable compared to 2011 and

numbered fewer (17.4% and 16.7% LYP respectively) than in the other two geographic areas (21.5% in the north-west and 22.7% in central Italy). Specifically, we can see a statistically significant increase in cannabis use in north-western Italy.

In 2012, as had already been seen in 2011, the number of cannabis users increase with age for both genders. Among male students, prevalence of use increases from 8.0% at 15 years of age to 32.5% at 19 years of age, while it rises from 5.7% to 21.4% respectively among female students (Table 2.14). The prevalence of users increases progressively both among male and female students, especially in the span of time between 15 and 17 years of age.

Approximately 10% of cannabis users report having used cannabis 10 to 19 times over the 12 months prior to the survey. More intense cannabis use (20 times or more in a year) was reported by 31.1% of male students and 19.1% of female students who participated in the survey (Table 2.14).

Highest use among students aged 19: 27.0%

26.3% of students used more intensely

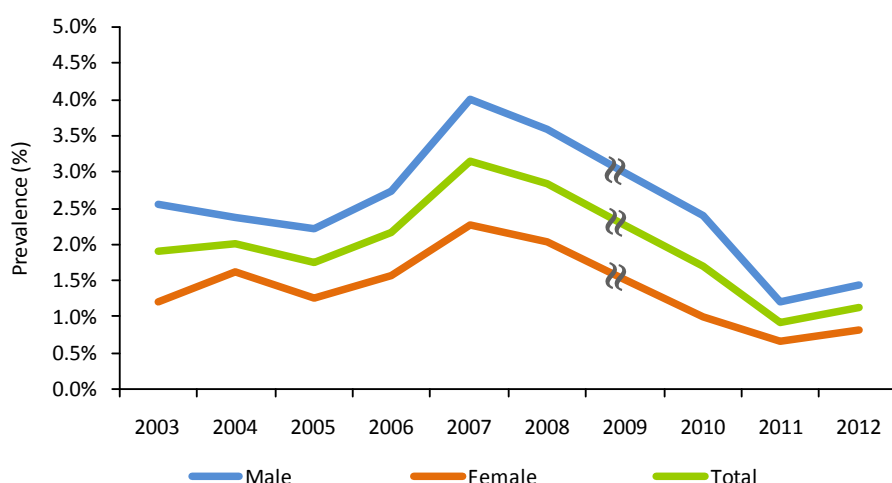
Stimulant use

Over the last ten years, the trend in the number of students who had used stimulant drugs (ecstasy and amphetamines) at least once in the 12 months prior to participating in surveys was largely stable until 2006, followed by an upturn in 2007. Over the following five years there was a steady decline in the number of users until 2011. Then, in 2012, there was a rising trend, at the limits of statistical significance, for both genders.

1.8% of Italian students report having used stimulant drugs at least once in their lives and 1.1% reported having used those substances during the course of the year leading up to their survey (Tabella 2.15). A notably low percentage (0.6%) of Italian students aged 15-19 reported having used stimulants recently, in the 30 days prior to participating in the survey. If we differentiate between different types of psychoactive stimulant drugs, we find equal percentages of users of ecstasy and amphetamines.

Rising trend for stimulants in 2012

Figure 2.12: Stimulant use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2012



Source: ESPAD Italy 2003-2008 – SPS-DPA Surveys 2010-2012 – Department for Anti-drug Policies

An examination of data on ecstasy use among 16-year-olds as reported in ESPAD studies reveals a decline in use over the last 5 years among European students and their Italian peers, with lower prevalence of use among the latter (LTP 2% in 2011). A decline in amphetamine use was also observed, both among Italian and European students, in the period from 2007-2011, according to information reported by ESPAD studies (LYP falling from 4% in 2007 to 2% in 2011).

Table 2.15: Stimulant use (% prevalence) in the student population aged 15-19. The years 2011 and 2012

| Stimulant use (%) | 2011 | | | 2012 | | |
|--|-------|-------|-------|-------|-------|-------|
| | M | F | Tot | M | F | Tot |
| At least once in their lifetimes (LTP) | 1.97 | 1.26 | 1.61 | 2.21 | 1.40 | 1.78 |
| At least once in the last 12 months (LYP) | 1.20 | 0.67 | 0.92 | 1.43 | 0.81 | 1.12 |
| At least once in the last 30 days (LMP) | 0.63 | 0.37 | 0.50 | 0.72 | 0.42 | 0.57 |
| Age (Last Year Prevalence) (%) | | | | | | |
| 15 years of age | 0.27 | 0.44 | 0.36 | 0.59 | 0.58 | 0.58 |
| 16 years of age | 0.96 | 0.52 | 0.74 | 0.92 | 0.72 | 0.82 |
| 17 years of age | 1.21 | 0.63 | 0.91 | 1.15 | 0.71 | 0.93 |
| 18 years of age | 1.56 | 0.81 | 1.18 | 2.00 | 0.91 | 1.46 |
| 19 years of age | 1.94 | 0.92 | 1.40 | 2.45 | 1.16 | 1.82 |
| Frequency of use (Last Year) (% of total LYP users) | | | | | | |
| 1-9 times | 95.34 | 88.60 | 92.83 | 90.77 | 94.74 | 92.23 |
| 10-19 times | 2.59 | 6.14 | 3.91 | 3.08 | 1.32 | 2.43 |
| 20 times or more | 2.07 | 5.26 | 3.26 | 6.15 | 3.95 | 5.34 |

98.2% of students have never tried stimulants, while 1.8% have used them at least once in their lives

0.6% had used them in the 30 days prior to the survey

Source: SPS-DPA 2011 and SPS-DPA 2012 Surveys – Department for Anti-drug Policies

A comparison of stimulant use in different geographic areas reveals largely comparable prevalence patterns and a rising trend in all areas of the country.

Stimulant users, like the users of other drugs, become more numerous in older age brackets: 0.6% of 15-year-olds, slightly fewer than 1% of 16- to 17-year-olds, 1.5% of 18-year-olds and 1.8% of 19-year-olds reported having used stimulants in the 12 months prior to the survey (Table 2.15). If we separate data on stimulant use over the 12 months prior to the survey by age and gender, we can see a marked difference between male and female students, especially among 18-year-olds (equal to 2.0% and 0.9% respectively) and among 19-year-olds (equal to 2.5% and 1.2% respectively).

Highest student use among 19-year-old males: 2.5%

More male students reported frequent stimulant use (over 10 times over the 12 months prior to the survey) than their female peers (9.2% and 5.3% respectively).

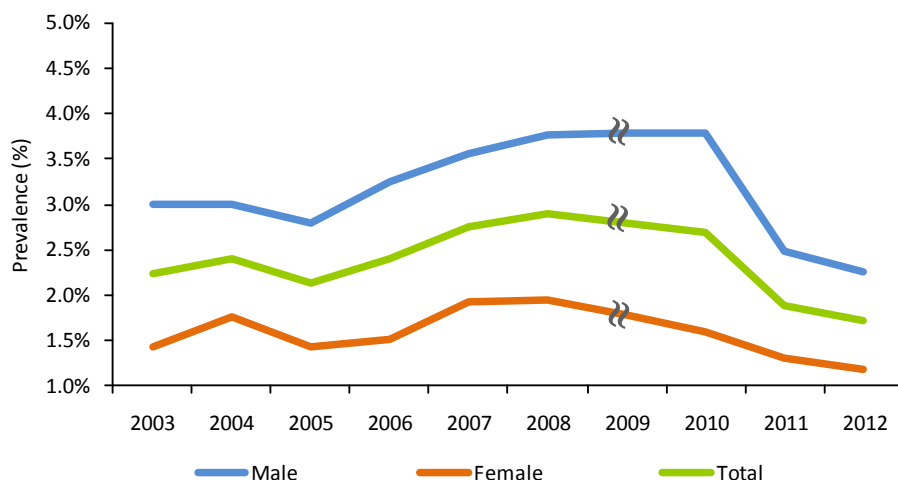
9.2% of male students use frequently

Hallucinogen use

The use of hallucinogenic drugs (including LSD, Ketamine, hallucinogenic mushrooms and other hallucinogens) rose among both genders from 2005 to 2010, with higher prevalence of use for male students than for female. This was followed by a decline, confirmed in 2012, in hallucinogen use among high secondary school students.

Numbers of hallucinogen users declining

Figure 2.13: Hallucinogen use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2012



Source: ESPAD Italy 2003-2008 – SPS-DPA Surveys 2010-2012 – Department for Anti-drug Policies

In 2012, 2.6% of Italian students reported having tried hallucinogens at least once in their lives and 1.7% reported having used these types of drugs in the 12 months prior to participating in the survey. 0.9% of students who participated in the survey reported having used hallucinogens recently, in the month leading up to the survey (Table 2.16). Data from ESPAD European studies regarding the number of Italian 16-year-old students who had used hallucinogens at least once in their lives confirmed a decrease in prevalence of users in 2011 (3%), while the prevalence rate remained stable among European students (2%) for the entire period of examined.

In 2012 hallucinogen use was found to be the same in all geographic areas (at around 2%) with the exception of southern Italy/the islands (1%). An examination of all the geographic areas, moreover, reveals an increase in prevalence of hallucinogen users (LYP) in all areas of the country, with statistically significant differences in comparison with 2011.

Table 2.16: Hallucinogen use (% prevalence) in the student population aged 15-19. The years 2011 and 2012

| Hallucinogen use (%) | 2011 | | | 2012 | | |
|--|-------|-------|-------|-------|-------|-------|
| | M | F | Tot | M | F | Tot |
| At least once in their lifetimes (LTP) | 3.85 | 1.98 | 2.89 | 3.47 | 1.70 | 2.58 |
| At least once in the last 12 months (LYP) | 2.49 | 1.30 | 1.88 | 2.26 | 1.17 | 1.72 |
| At least once in the last 30 days (LMP) | 1.32 | 0.74 | 1.02 | 1.10 | 0.61 | 0.86 |
| Age (Last Year Prevalence) (%) | | | | | | |
| 15 years of age | 1.01 | 0.81 | 0.91 | 0.80 | 0.58 | 0.69 |
| 16 years of age | 1.65 | 1.04 | 1.34 | 1.65 | 1.10 | 1.38 |
| 17 years of age | 3.18 | 1.39 | 2.27 | 2.52 | 1.37 | 1.96 |
| 18 years of age | 2.79 | 1.46 | 2.11 | 2.82 | 1.40 | 2.12 |
| 19 years of age | 3.75 | 1.75 | 2.70 | 3.37 | 1.40 | 2.40 |
| Frequency of use (Last Year) (% of total LYP users) | | | | | | |
| 1-9 times | 86.76 | 93.75 | 89.35 | 92.87 | 93.84 | 93.20 |
| 10-19 times | 5.88 | 2.50 | 4.63 | 3.19 | 2.37 | 2.91 |
| 20 times or more | 7.35 | 3.75 | 6.02 | 3.93 | 3.79 | 3.88 |

97.4% of students have never used hallucinogens, while 2.6% have tried hallucinogens at least once in their lives

Less than 1% had used them in the 30 days prior to the survey

Source: SPS-DPA 2011 and SPS-DPA 2012 Surveys – Department for Anti-drug Policies

Among male students, hallucinogen use was found to be directly linked to subjects' age. Prevalence of use rises from 0.8% among 15-year-olds to 1.6% among 16-year-olds, 2.5% among 17-year-olds, 2.8% among 18-year-olds and 3.4% among 19-year-olds. Among female students, however, prevalence of use rises most during the span of time between 15 years of age (0.7%) and 17 years of age (1.4%), then levels off in the period between 17 and 19 years of age (Table 2.16).

Highest student use among 19-year-old males: 3.4%

With respect to frequency of use, the most common frequency for both genders, reported by 7% of students, was 10 or more times in the 12 months prior to the sample survey.

Polydrug use among 15- to 19-year-olds

The concomitant or consecutive use of different licit and illicit psychoactive drugs is the most characteristic and widespread pattern of drug use among adolescents and young adults.

Table 2.17 shows the distribution of conditional prevalence of licit and illicit drug use among those who reported having used illegal drugs during the 30 days prior to the survey.

19.1% of students reported having used cannabis during the year prior to the survey, and of these 90.9% had consumed alcoholic beverage during the same period, 89.6% had smoked at least one cigarette per day, 6.8% had used cocaine and 1.3% had used heroin.

Of the students surveyed, 1.9% reported having used cocaine in the 30 days prior to the survey. Of these cocaine users, 92.4% had also consumed alcoholic beverages and smoked cigarettes on a daily basis, 83.4% had also used cannabis and 18.2% had used heroin.

0.3% reported having used heroin at least once during the 30 days prior to the survey. 91.7% of these had consumed alcohol during the same period, while 88.1% had smoked cigarettes on a daily basis, 70.2% had used cannabis and 82.1% had used cocaine. These results make it evident that a high percentage of subjects who use heroin as their primary drug also use cocaine, in contrast with subjects whose primary drug is cocaine, of whom a smaller percentage use heroin concomitantly or consecutively.

Strong trend towards polydrug use:
- Strong trend toward the concomitant or consecutive use of alcohol and tobacco with all of the other drugs
- Cannabis users: 6.8% also use cocaine
1.3% also use heroin
- Cocaine users: 83% also use cannabis
18% also use heroin
- Heroin users 70% also use cannabis
82% also use cocaine

Table 2.17: Distribution of conditional prevalence of polydrug users in the student population aged 15-19 in the 30 days prior to the survey. The year 2012

| Drug type | Alcohol | Tobacco | Cannabis | Cocaine | Heroin |
|-----------------------|---------|---------|----------|---------|--------|
| Cannabis (LMP 12.94%) | 90.88% | 89.63% | | 6.81% | 1.27% |
| Cocaine (LMP 1.06%) | 92.37% | 92.37% | 83.42% | | 18.16% |
| Heroin (LMP 0.23%) | 91.67% | 88.10% | 70.24% | 82.14% | |

Strong concomitant or consecutive use of alcohol and tobacco with cannabis, cocaine and heroin

Source: SPS-DPA Survey 2012 – Department for Anti-drug Policies

2.3. Drug use in the general population (wastewater analyses)

Parallel to the classic epidemiological studies, the Mario Negri Pharmacological Research Institute of Milan has recently developed and proposed to the scientific community an alternative method for estimating drug use in the population, a method no longer based on subjective factors but on objective findings. This method exploits a well-known characteristic of these substances: a drug, after being taken, is partly

excreted as such or as metabolite(s) in users' urine. Urine, together with waste water, goes to urban treatment plants, where the water can be sampled and drug residues can be measured. Concentrations thus obtained make it possible to calculate the total amount of drugs used by the population who rely on a given water treatment plant. This method therefore makes it possible to perform a collective test of the urine of all the inhabitants of a city. This method preserves anonymity, since it is not possible to identify which persons used drugs, but only to measure how many drugs are used overall by the population as a whole.

A method that
protects anonymity

This method was applied for the first time in 2005 (December) and 2006 (March and April) in the city of Milan, where it was used to analyse the water from the Milano Nosedo treatment plant.

In 2010, the Department for Anti-drug Policies promoted a pilot study (AQUA DRUGS Pilota), created by the Mario Negri Institute. This study's results supported the hypothesis of applying this approach to the study of drug use in the Italian population. During the course of this study, eight major cities were identified to participate. Drug use in these cities was studied for both the general and student populations for one week, using samples of wastewater entering the principal urban treatment plants and from collectors for wastewater exiting secondary schools.

The pilot study thus proved that it was possible to use this method to obtain sensitive "evidence-based" data on the use of the principal types of drugs (cocaine, amphetamines, ecstasy, methamphetamines, heroin and cannabis) as well as obtain information on the spread of new drugs, especially in the general population.

In 2011, the Department for Anti-drug Policies promoted a new edition of this study, larger than in 2010, with the addition of 4 more large urban areas (Perugia, Pescara, Cagliari, Bari) and 5 minor cities (Merano, Gorizia, Terni, Nuoro, Potenza).

This study aims to monitor drug use on a national level over the two-year period from 2011 to 2013, differentiating between large-scale urban areas and those of small-to-medium size, while at the same time paying close attention to possible "sentinel events", including the appearance of new drugs or changes in use profiles, periodically monitoring specific sites chosen ad hoc.

The three "sentinel" cities, where sampling will occur for one week three times per year in order to monitor possible changes in drug use profiles, are respectively Milan, Rome and Naples. Wastewater from a number of schools was also sampled in these three cities.

In each of these cities, in order to carry out the study on a national level, city water treatment plants were selected which would be most likely to provide representative samples. Furthermore, for each city, the period of time most suitable for conducting sampling was identified. Specifically, composite samples were taken from 24 hours' worth of wastewater entering each chosen city treatment plant for seven consecutive days while composite wastewater samples were collected from each of the schools for five or six consecutive days during school hours. Samples were immediately frozen after collection in order to prevent the degradation of the substances that were to be measured. The frozen samples were then transported to the Mario Negri Institute, where the analyses were conducted. The analyses of the samples in the laboratory made it possible to measure the concentrations of specific residues for each principal drug type. Specifically, measurements were taken of the levels of: benzoylecgonine (BE) for cocaine, the THC-COOH metabolite for cannabis, metabolic morphine and 6-acetylmorphine for heroin and of

parent drugs for amphetamines, methamphetamines and MDMA (ecstasy).

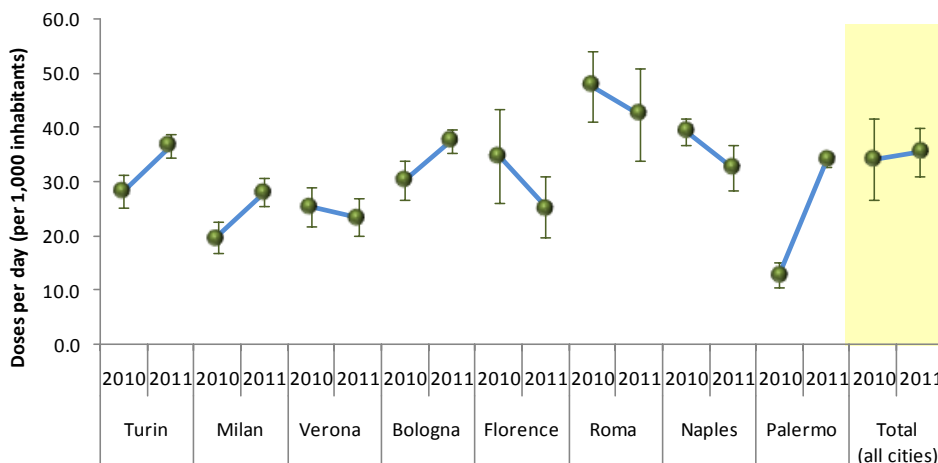
The different drugs were measured using mass spectrometry (HPLC-MS/MS) techniques, and concentrations of target residues made it possible to calculate the average amounts and number of doses taken by a part of the population.

In order to make a direct comparison between different use levels found in the cities selected for the study, total doses were first calculated then normalized by the number of inhabitants who used each treatment plant analysed. Average weekly values of doses per day per 1000 inhabitants were then calculated, with the exception of for Ketamine for which, in light of the meagre concentrations found, standardization was carried out using grams per day as the unit of measure.

Figures 2.14 – 2.19 show the comparisons between the use levels obtained from the first analysis campaign carried out as part of the AQUA DRUGS pilot project in May 2010 and those obtained from the collection campaign conducted in October of 2011.

The drug used in the most substantial amounts was cannabis, with an average of 35.6 doses per day per 1,000 inhabitants in 2011, a number which had remained more or less the same in comparison with the average number of doses found in 2010 (34.2). Trends differed among the cities from which samples were taken, with use on the rise in Milan, Turin, Bologna and Palermo, but a decline in use levels detected in Rome, Naples, Verona and Florence.

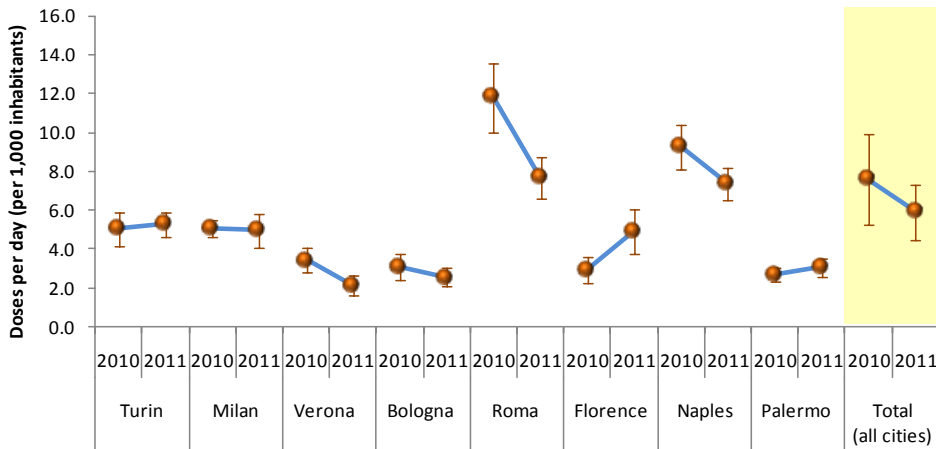
Figure 2.14: Distribution of the average number of doses of CANNABIS consumed per day (per 1,000 inhabitants) in each city over the two-year period 2010-2011 and corresponding confidence intervals



Source: AquaDrugs Study 2010-2011 – Department for Anti-drug Policies – Mario Negri Pharmacological Research Institute

In second place in terms of drug use detected through wastewater analyses was cocaine. In 2011, in the eight cities selected for the two-year study in 2010-2011, approximately 5.9 doses per day per 1,000 inhabitants were detected, a decrease in comparison with the 2010 campaign (7.6 doses per day per 1,000 inhabitants). If we consider the different cities being monitored, the decline occurred in four cities, Rome, Naples, Bologna and Verona. Use levels remained largely unchanged in Turin, Milan and Palermo, while Florence saw a rise in use trends (2.9 doses per day per 1,000 inhabitants vs. 4.9).

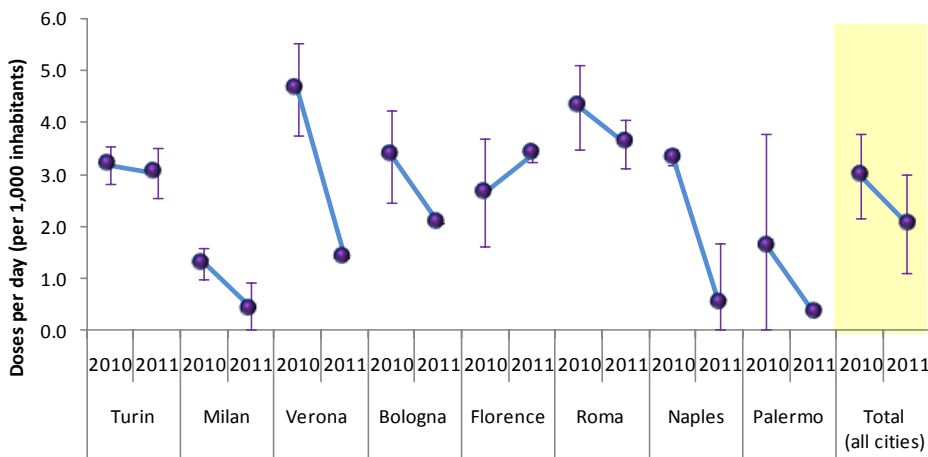
Figure 2.15: Distribution of the average number of doses of COCAINE consumed per day (per 1,000 inhabitants) in each city over the two-year period 2010-2011 and corresponding confidence intervals



Source: AquaDrugs Study 2010-2011 – Department for Anti-drug Policies – Mario Negri Pharmacological Research Institute

In comparison with the two drugs already discussed, heroin use was more limited, with average concentrations found in the cities sampled in 2011 of 2 doses per day per 1,000 inhabitants. In comparison with 2010, there were steep drops in use in the cities of Naples and Verona and less dramatic decreases in the cities of Milan, Rome, Bologna and Turin. The only city where there was an increase in use was Florence.

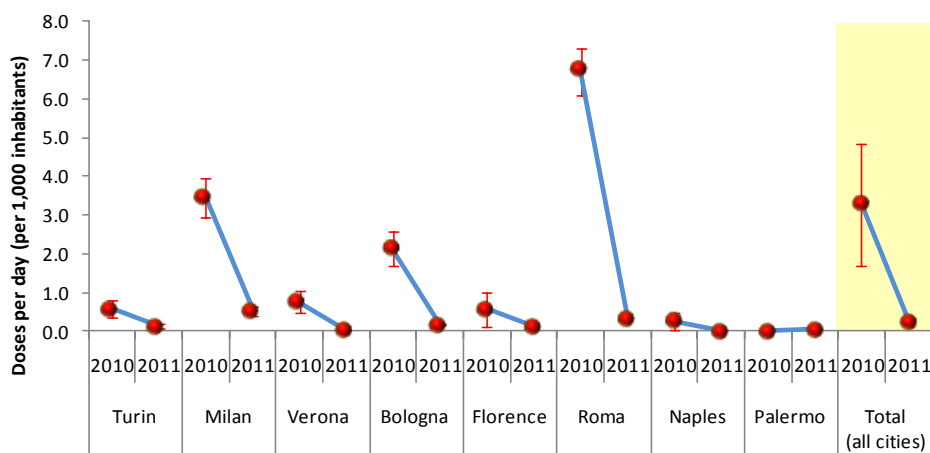
Figure 2.16: Distribution of the average number of doses of HEROIN consumed per day (per 1,000 inhabitants) in each city over the two-year period 2010-2011 and corresponding confidence intervals



Source: AquaDrugs Study 2010-2011 – Department for Anti-drug Policies – Mario Negri Pharmacological Research Institute

A substantial decrease in the use of stimulant drugs was observed in 2011 in all locations being monitored, with residue concentrations of nearly zero found in the samples analysed, an indication that these drugs are being “abandoned” by users, which could be evidenced by their switching to other drugs.

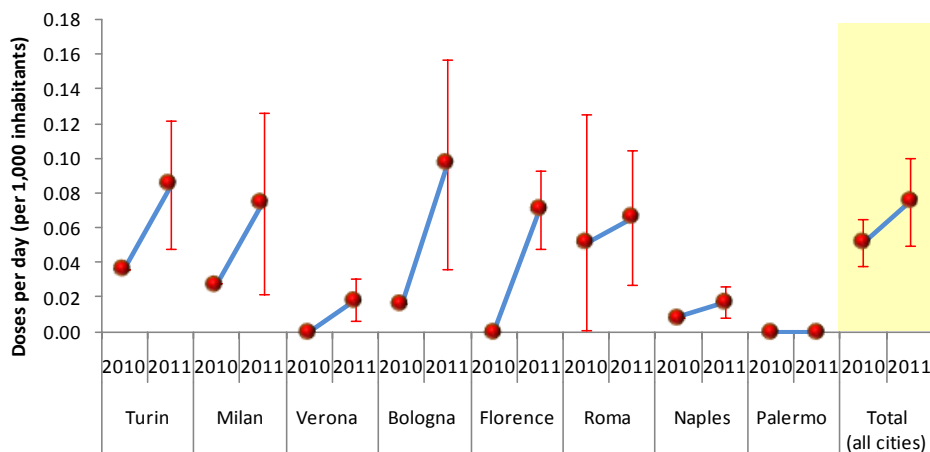
Figure 2.17: Distribution of the average number of doses of METHAMPHETAMINE consumed per day (per 1,000 inhabitants) in each city over the two-year period 2010-2011 and corresponding confidence intervals



Source: AquaDrugs Study 2010-2011 – Department for Anti-drug Policies – Mario Negri Pharmacological Research Institute

MDMA, more commonly known as Ecstasy, is another of the drugs set to be detected in wastewaters. Only meagre concentrations of this drug were found, equal to 0.07 of a dose per day per 1,000 inhabitants, corresponding to a ratio of 1/475 in comparison with average doses of cannabis detected in 2011. Nonetheless, in all the cities being monitored, with the exception of Palermo, there was a slight increase in comparison with 2010, associated with higher variability.

Figure 2.18: Distribution of the average number of doses of MDMA (ECSTASY) consumed per day (per 1,000 inhabitants) in each city over the two-year period 2010-2011 and corresponding confidence intervals

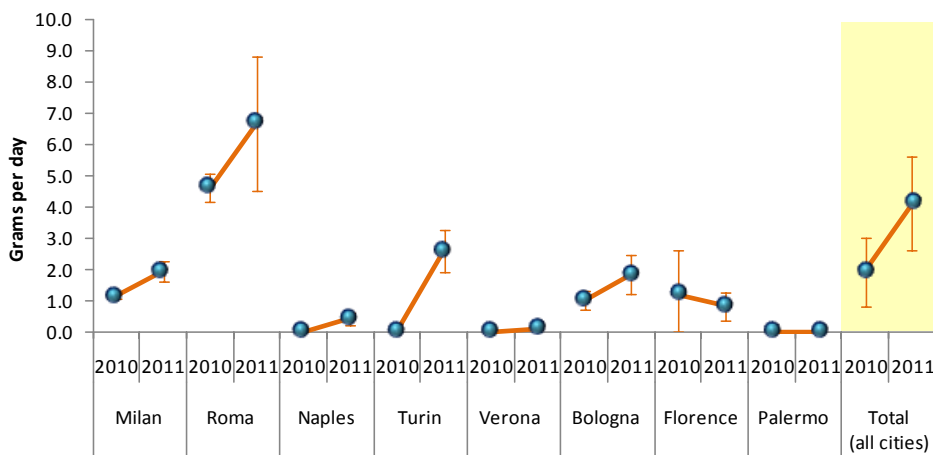


Source: AquaDrugs Study 2010-2011 – Department for Anti-drug Policies – Mario Negri Pharmacological Research Institute

Levels of Ketamine found in the samples collected from the water treatment plants in the eight cities were even lower than those of MDMA (3.23 grams per day of Ketamine vs. 6.36 grams per day of Ecstasy). There was no evidence of any use of Ketamine in the cities of Verona or Palermo, but a limited increase was detected in the cities of Milan, Rome,

Turin, Naples and Bologna, in contrast with a drop in use in Tuscany's main city, Florence.

Figure 2.19: Distribution of grams per day of KETAMINE detected in each city over the two-year period 2010-2011 and corresponding confidence intervals



Source: AquaDrugs Study 2010-2011 – Department for Anti-drug Policies – Mario Negri Pharmacological Research Institute

2.4. Drug Use among targeted groups (Drug tests of workers in high-risk professions)

Over the course of 2011, the DPA continued its planned activities in the context of the DTLP (Drug Testing for Workers in High-Risk Professions) Project), improving and expanding its database and exchanging views with all institutional representatives in the interests of developing proposals for revision to the State-Regional Accord currently in force.

Preface

2.4.1. Preliminary results

The data available to the Department for Anti-drug Policies, gathered through the DTLR project entrusted to the RFI (Italian State Railway System) – Gruppo Ferrovie dello Stato (The Italian State Railways Group), were provided, in addition to the RFI, by the Italian Association of Public Transport (ASSTRA), the S.I.M.L.I.I. (The Italian Society for Occupational Health and Industrial Hygiene), the A.N.M.A. (National Association of Company Doctors), ENAV S.p.A. (t.n. the National Agency for Flight Assistance) and the Trento Public Health Laboratory (LPST). 2011 data contains information about 88,058 individuals subjected to 1st level testing (1.2% more than were tested in 2010, when 86,987 subjects were tested), of whom nearly 5% were women.

88,058 subjects screened:
1.2% more than were screened in 2010

Table 2.18: Provenance and number of subjects on whom data was provided. The year 2011

| Data Provenance | Subjects |
|---|----------|
| RFI (Italian State Railway System) – Gruppo Ferrovie dello Stato – Health Management Department | 43,998 |
| The Italian Association of Public Transport (ASSTRA) | 23,593 |

continue

continue

| Data Provenance | Subjects |
|---|-----------------|
| S.I.M.L.I.I. (The Italian Society for Occupational Health and Industrial Hygiene) | 11,162 |
| A.N.M.A. (National Association of Company Doctors) | 7,687 |
| ENAV S.p.A. (The National Agency for Flight Assistance) | 1,064 |
| Trento Public Health Laboratory (LPST) | 554 |
| Total number of individuals subjected to 1st level testing | 88,058 |

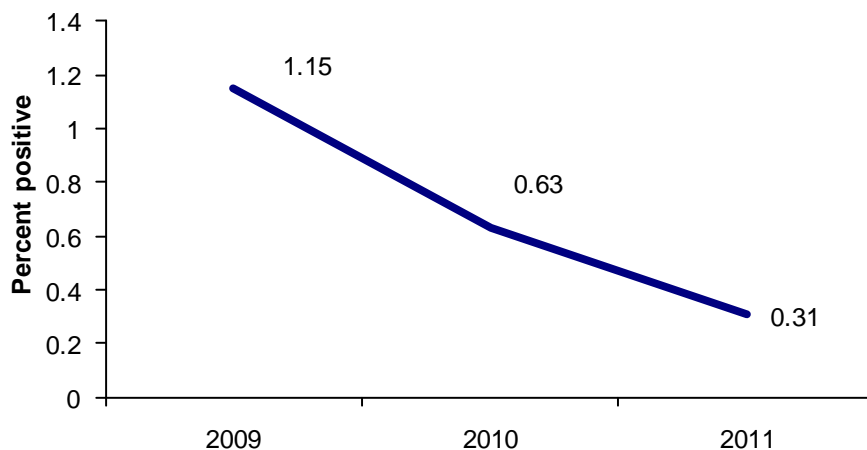
Source: Department for Anti-drug Policies

When analysing the data by geographic provenance, one can see clearly that, as had already been seen in 2010, the clear majority of tests, nearly 63%, were performed in northern Italy, followed by 20.6% in the centre and 16.3% in the south and the islands. The number of subjects screened in central Italy rose in comparison with 2010 when the ATAC company – ASSTRA Group, which is responsible for public transport in the city of Rome, joined the initiative. Workers in the public transportation sector are, by a large margin, those to whom screening most applies, followed by forklift / fork truck operators.

Findings which emerged from first level testing (confirmed by laboratory testing of the samples collected) revealed that 0.31% of subjects had tested positive, to which we can add the group of subjects who “opted out” and those held to be temporarily unfit for their duties, which raises the number of positive test results to 0.32%.

In 2011, 0.31% of subjects tested positive in first level testing, half as many as in 2010.

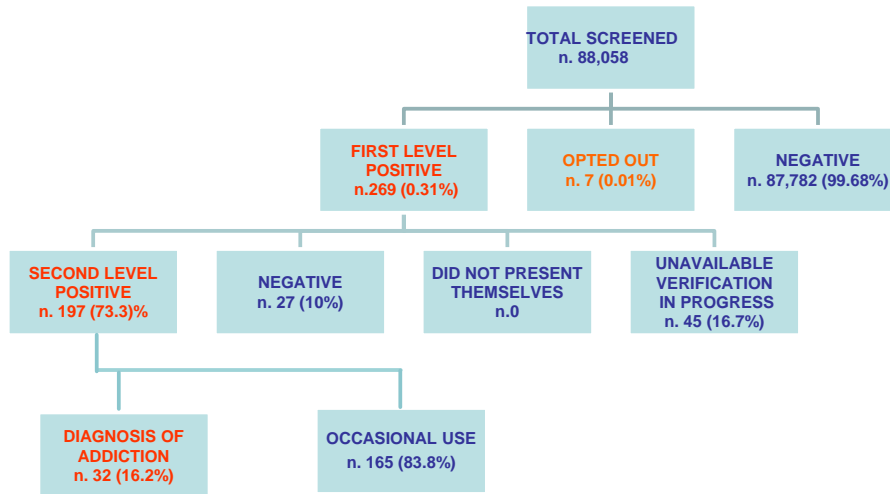
Figure 2.20: 1st level Drug testing, positive results comparison 2009-2011



Source: Department for Anti-drug Policies

There was found to be a decrease of 50.8% in comparison with the year 2010, when the number of subjects testing positive was 0.63%, (Figure 2.20)

Figure 2.21: Flow of subjects subjected to testing and verification – The year 2011



Source: Department for Anti-drug Policies

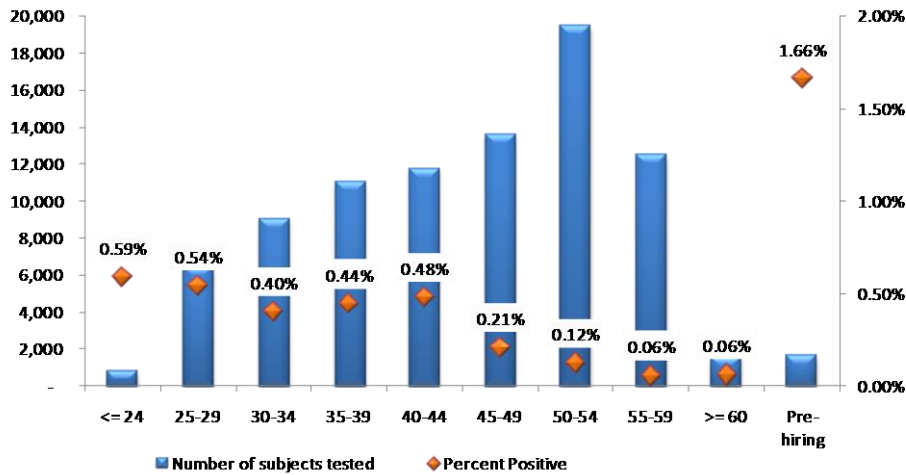
The 2011 data flow is represented in Figure 2.21, where numbers of subjects are reported.

An analysis by age group shows that approximately most of the subjects in the sample assessed are between 45-59 years of age. Among age groups, it is the younger ones which present higher prevalences of positive test results, especially those under the age of 30. In comparison with 2010, there was a drop in the number of positive results for all age groups, more marked in workers 24 years of age or younger (1.34% in 2010 vs. 0.59% in 2011).

The figure for the number of subjects who tested positive during pre-hiring testing, 1.66%, is very interesting, as it is approximately three times the number of positives among workers under 35, which could be a comparable group. This phenomenon can most likely be attributed to partial ignorance on the part of some aspiring workers who do not realize they will also be subjected to this type of screening.

1.66% of subjects test positive in pre-hiring testing

Figure 2.22: 1st Level Drug Testing by age group and result. The year 2011



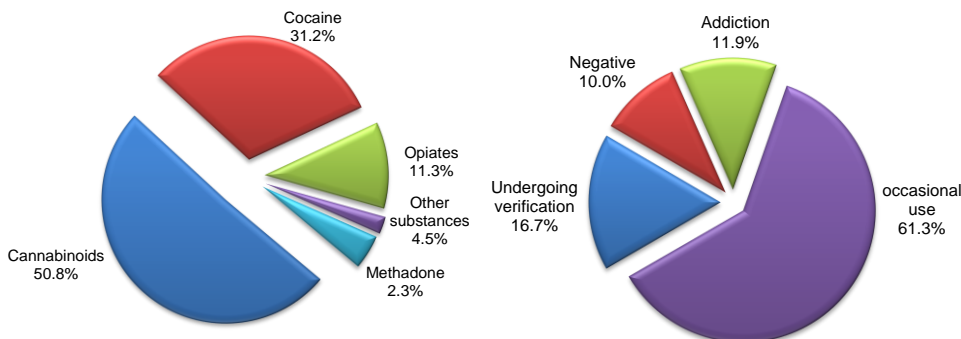
Source: Department for Anti-drug Policies

52% of subjects tested positive for cannabinoids, 26.8% for cocaine and 5.9% for opiates. Positive results for cannabinoids fell steeply in comparison with 2010 (64.6% in 2010 vs. 52% in 2011), while the number of positive results for cocaine increased greatly (double the 2009 figure, 19.6%), and positive results for opiates began to climb once more after the previous year's dramatic decline.

2nd level verification data for the year 2011 includes information on 224 subjects (83,3% of the 1st-level positive tests). The portion of the second-level verification data that is missing is undergoing verification, dependent upon the amount of time which, for technical purposes, must pass between the finding of a 1st-level positive result and the pronouncement of a final diagnosis.

Nearly 12% of the sample in question were diagnosed as having drug addictions, most of which were addictions to cannabinoids, followed by cocaine, opiates and methadone (Figure 2.23).

Figure 2.23: 2nd-level clinical verification – analysis by drug type and diagnosis – The year 2011



Over 60% were diagnosed as occasional users

Source: Department for Anti-drug Policies

2.4.2. Testing in the Armed Forces

The General Directorate of Military Health (DIFESAN) of the Ministry of Defence oversees numerous activities, including the collection, processing and assessment of statistical data relating to drug addiction and the principal health conditions associated with it.

The data for the number of tests¹ performed were made available by the Italian Army, the Navy and the Air Force (Table 2.19), while the Carabinieri Corp provided the figures for the number of subjects who underwent testing (Table 2.20).

Table 2.19: Drug tests performed on Armed Forces personnel. The years 2007 - 2011

| | 2007 | 2008 | 2009 | 2010 | 2011 |
|--|---------|---------|---------|---------|---------|
| Italian Army | | | | | |
| Tests performed | 39,523 | 48,306 | 42,417 | 57,034 | 23,376 |
| Positive tests | 340 | 54 | 446 | 204 | 68 |
| % Positive | 0.86 | 0.11 | 1.05 | 0.36 | 0.29 |
| Navy | | | | | |
| Tests performed | 43,747 | 41,476 | 43,958 | 43,752 | 17,998 |
| Positive tests | 19 | 15 | 7 | 4 | 2 |
| % Positive | 0.04 | 0.04 | 0.02 | 0.01 | 0.01 |
| Air Force | | | | | |
| Tests performed | 43,617 | 64,108 | 70,258 | 82,805 | 77,963 |
| Positive tests | 42 | 41 | 27 | 0 | 29 |
| % Positive | 0.10 | 0.06 | 0.04 | 0.00 | 0.04 |
| Total (Italian Army, Navy, Air Force) | | | | | |
| Tests performed | 126,887 | 153,890 | 156,633 | 183,591 | 119,337 |
| Positive tests | 401 | 110 | 480 | 208 | 99 |
| % Positive | 0.32 | 0.07 | 0.31 | 0.11 | 0.08 |

Source: Based on data from the Ministry of Defence

Testing using the urine sample drug-testing method was carried out on sample groups of active duty personnel serving abroad and on active duty personnel serving within Italy; moreover, individuals seeking to enrol voluntarily are also subjected to testing.

A total of 23,376 tests were performed on Italian Army personnel in 2011, of which 68 tests came back positive (0.29%). After the peak recorded in 2009, positive tests results in 2010 and 2011 have continued to drop.

An unequivocal prerequisite to qualify for enrolment in the Navy is a negative result for tests for all the most commonly used drugs (opiates, cannabinoids, cocaine and amphetamines) which is an obligatory part of every competitive entrance examination. In 2011, 17,998 tests were performed, of which only 2 came back positive (0.01%).

Italian Army:
a decrease in the number of tests and in the number of positive results

Navy: a decrease in the number of tests; number of positive results near zero.

¹ A subject undergoes an average of 4 to 7 tests

Table 2.20: Subjects tested within the Carabinieri Corp. The years 2007 - 2011

| | 2007 | 2008 | 2009 | 2010 | 2011 |
|---------------------------|------|-------|------|------|-------|
| Carabinieri Corp | | | | | |
| Subjects tested | 249 | 1,632 | 638 | 810 | 4,113 |
| Subjects testing positive | 6 | 14 | 6 | 2 | 5 |
| % positive | 2.41 | 0.86 | 0.94 | 0.25 | 0.12 |

Source: Based on data from the Ministry of Defence

The Air Force conducts periodic urinary catabolite drug testing of all its personnel assigned to drive automobiles as well as during medical selection in the enrolment process, the latter being the phase in which most positive results are found. Occasional testing is also performed on personnel who have declared of their own free will that they have taken drugs or who have been reported to their Unit's health services for behaviour presumably attributable to drug abuse. Testing is also performed during the competitive entrance examinations for this branch of the Armed Forces.

In 2011, 77,963 tests were performed, of which 29 came back positive, a figure which is similar to the one obtained in 2009 and worse than in 2010, when the number of positive results was zero.

In the three branches of the Armed Forces as a whole, a significantly lower number of tests was performed in 2011 than in 2010 (64,254 less tests, or -35%). There was also a decrease in the number of positive test results, which fell from 0.11% to 0.08%.

In accordance with drug addiction prevention activities in the Armed Forces as set forth in Article 1, Paragraph 9 of the Consolidation Act of the Drug Addiction Laws as provided for under the requirements of Presidential Decree (DPR) 309/90, 4,113 Carabinieri were subjected to drug testing in 2011, of whom 5 tested positive (0.12%). The effort made by the Carabinieri Corp is worthy of note: the number of tests carried out was more than five times as many as in 2010, and the percentage of positive test results obtained was equal to just 0.12% .

Air Force: more testing than in other branches of the Armed Forces

A 35% reduction in the number of tests performed in the three branches of the Armed Forces

Carabinieri: five times as many tests, half the number of positive results

3. PREVENTION

Primary prevention was the subject of a survey conducted by the Department for Anti-drug Policies of the Presidency of the Council of Ministers throughout the Regions and Autonomous Provinces. The survey was conducted using Structured Questionnaires (SQ) 25 and 26 provided by the European Monitoring Centre for Drugs and Drug Addiction in Lisbon regarding new or on-going prevention projects, evaluating them based on the following prevention aspects: universal, selective for at-risk groups or targeting nuclear family groups.

Based on the results which emerged from the use of the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) questionnaires, distributed and submitted online for the first time this year, this section provides a profile on the state of prevention initiatives according to the three areas defined by the Monitoring Centre in Lisbon.

An initial evaluation shows a notable increase in investments in the area of prevention (approximately +60%), with resources equal to approximately 48 million Euros being committed in 2011, particularly in the area of universal prevention. On the other hand, the number of activities, centres, courses and active plans and projects, such as communication campaigns, has fallen.

An increase in investment in prevention (+60%) and a decrease in the number of activities

3.1. Universal prevention

3.1.1. Schools

As part of the survey on psychotropic drug use conducted in upper secondary schools in 2012, school representatives were asked to fill out a questionnaire on universal and selective prevention activities conducted during the 2011/2012 academic year.

Of a sample group of 480 schools which had participated in the survey by 30 June 2012, 411 (85.6%) of these had filled out the aforementioned questionnaire, which was based on the questions contained in Structured Questionnaires 25 and 26.

During the 2011/2012 academic year, the most common types of psychotropic drug-use prevention campaigns employed in secondary schools were awareness days (66.8%), followed by regular lessons devoted to the topic of prevention (53.4%) and by the distribution of informational materials (53.4%).

66.8% of the sample of schools participating in the survey conducted awareness days

Informational materials were more widely distributed in technical institutes (60.7% of the sample group which replied to the questionnaire) and in vocational schools (57.3%). Among the schools which reported having distributed informational materials, art schools at the secondary level and art institutes devoted more attention to information on alcohol consumption (94.1%), while vocational schools focused more on drug-use prevention (90.2%). Among the different types of schools, technical institutes were the ones which focused most on prevention regarding tobacco and medications (89.0% and 32.9% respectively).

A larger amount of informational materials distributed in technical institutes

With regard to the organisation of awareness days focusing on the prevention of psychotropic drug use, we find that vocational schools are the schools which most often employed educational campaigns as forms of prevention (75.3%). 39.4% of institutes involved *law enforcement agencies* in their awareness days; technical institutes, in particular, were

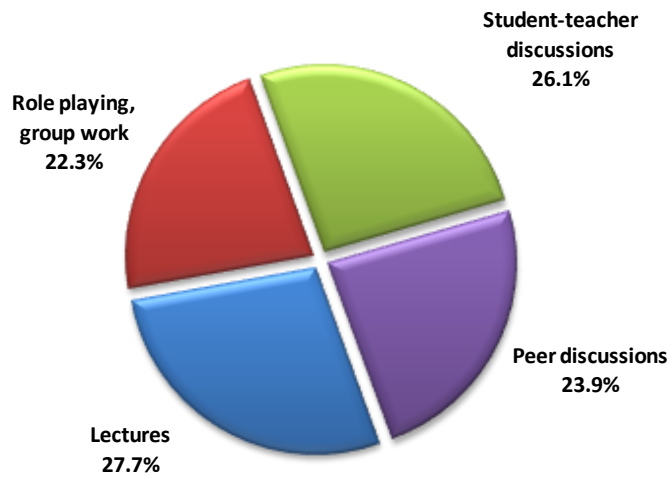
75.3% of vocational schools conducted awareness campaigns

the ones which most often involved law enforcement (44.7%). As far as didactic methodology is concerned, most of the information campaigns involved lessons in the form of *lectures* (33.9%) and *student-teacher discussions* (30.3%); Campaigns involving more student interaction, specifically *peer discussions* (18.4%) and *role playing, group work* (17.3%) were less common.

39.4% of schools organised awareness days involving Law Enforcement

Figure 3.1: Distribution of educational activities and didactic methodology employed in educational activities focusing on personal and/or social skills – the 2011/2012 academic year

17.6% of schools organised educational activities focusing on personal skills



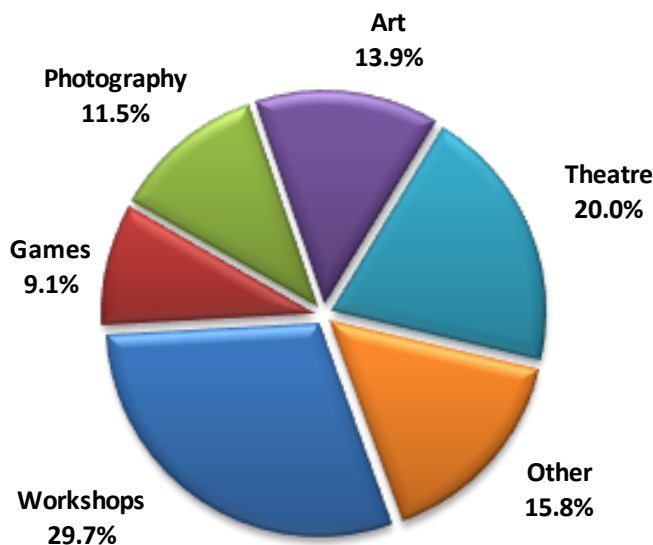
Source: SPS-DPA Survey 2012 – Department for Anti-drug Policies

During the 2011/2012 academic year, 62.7% of schools dealt with *prevention topics during the course of regular lessons*: technical institutes devoted more attention to alcohol consumption (97.4%) and vocational schools focused more on the prevention of tobacco and drug use (93.8% and 96.9% respectively).

62.7% of schools dealt with the topic of prevention in regular lessons

Figure 3.2: Distribution of creative activities to promote prevention conducted in higher secondary schools – the 2011/2012 academic year

19.8% of schools organized recreational activities to promote prevention



Source: SPS-DPA Survey 2012 – Department for Anti-drug Policies

17.6% of the schools participating in the survey had organised *educational activities focusing on personal and/or social skills*, with percentages varying slightly based upon school type (20.7% of technical institutes, 19.1% of vocational schools, 16.1% of secondary schools and secondary schools formerly specialising in education, 8.1% of secondary art schools and art institutes).

19.8% of the sample group of schools participating in the survey had organised in-school *creative activities to promote prevention*, with these activities being fairly uniformly distributed among the different types of schools.

3.1.2. Family

Prevention activities targeting the family, on the other hand, included projects/programmes based on self/reciprocal help among families (65% vs. 55% in 2010), projects/programmes for informational/educational meeting events for families and/or parents (55% vs. 75% in 2010) and intensive educational courses for families (35% vs. 30% in 2010).

From an operational point of view, during the course of 2011, a full 80% of Regions and Autonomous Provinces organised actions to develop plans which include a local-level drug prevention strategy.

Projects to encourage the making available of recreational and/or cultural venues were launched or were already on-going in many Regions and Autonomous Provinces. Specifically, of local-level universal prevention projects, the most common was the making available of social clubs and counselling centres (230).

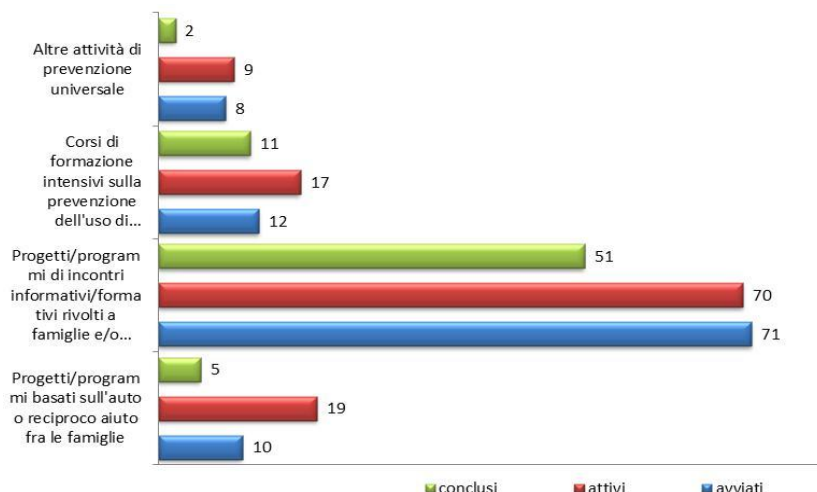
The Regions and Autonomous Provinces focused special attention on the drawing up of official documents concerning actions to be undertaken in order to develop plans which include local-level drug prevention strategies (a full 127 documents drawn up in 2011).

In 2011, as far as regards plans for universal prevention projects targeting nuclear families which had already been launched, were on-going and/or were completed during the course of the year in the Regions and Autonomous Provinces, there was a significant amount of turnover for projects consisting of informative/educational meeting events for families and/or parents (71 launched and 51 concluded in 2011) (Figure 3.3).

Projects and programmes based on self/reciprocal help among families were given high priority. Strong local commitment in the prevention field on the part of the Regions and Autonomous Provinces

Plans and programmes for families and parents

Figure 3.3: Number of universal prevention project plans targeting nuclear families launched, on-going or concluded in 2011



Source: Based on data from the survey conducted using EMCDDA questionnaires sent to the Regions

3.1.3. Community

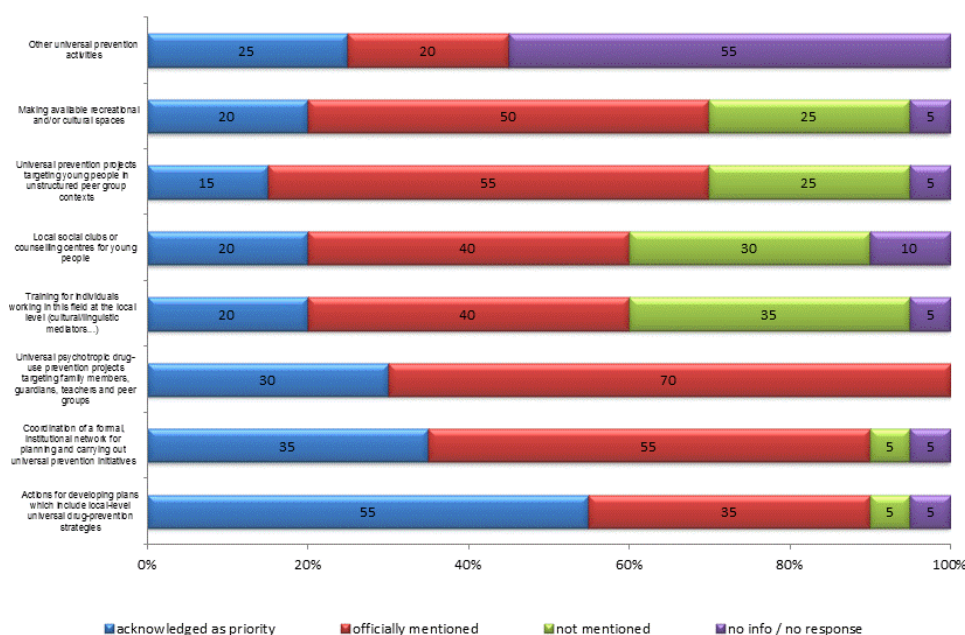
According to official documents on healthcare and/or social policies, universal prevention activities undertaken at the local-community level throughout the course of 2011 have consisted of the development of plans that include the following universal drug prevention strategies:

- universal drug prevention strategies targeting family members, guardians, teachers and peer groups (all of the Regions and Autonomous Provinces)
- local-level universal drug prevention strategies (90%)
- the coordination of a formal, institutional network for planning and carrying out universal prevention initiatives (90%), universal prevention projects targeting young people in unstructured peer group contexts (70%) the making available of recreational and/or cultural venues (70%), training for individuals working in this field at the local level (60%), the use of social clubs and counselling centres for young people at the local level (60%).

In 2011, over half (55%) of the Regions and Autonomous Provinces considered drug-prevention plans to be a priority goal, while a further 35% made official mention of this goal, for a total of 90% (Figure 3.4).

100% of Regions and Autonomous Provinces have universal prevention strategies targeting family members, guardians, teachers and peer groups

Figure 3.4: Percentage distribution of different programmes at the **local-community** level explicitly referred to in official documents on healthcare and/or social policies in 2011



Source: Based on data from the survey conducted using EMCDDA questionnaires sent to the Regions

3.2. Selective prevention in at-risk groups

In 2011, a total of nearly 20 million Euros in funding was set aside for selective prevention projects for at-risk groups and other specific groups, a 30.4% increase over 2010, concentrated in the Regions of Tuscany (20.7%), Lombardy (17% of the total) and Emilia Romagna (15.7%).

In comparison with 2010, according to available data, Sicily and Umbria were the Regions which showed the greatest increases in funding for these types of projects in terms of absolute values, each with increases of

over one million Euros.

In terms of comparison for the population 15-64 years of age, Tuscany and Emilia Romagna were in the lead.

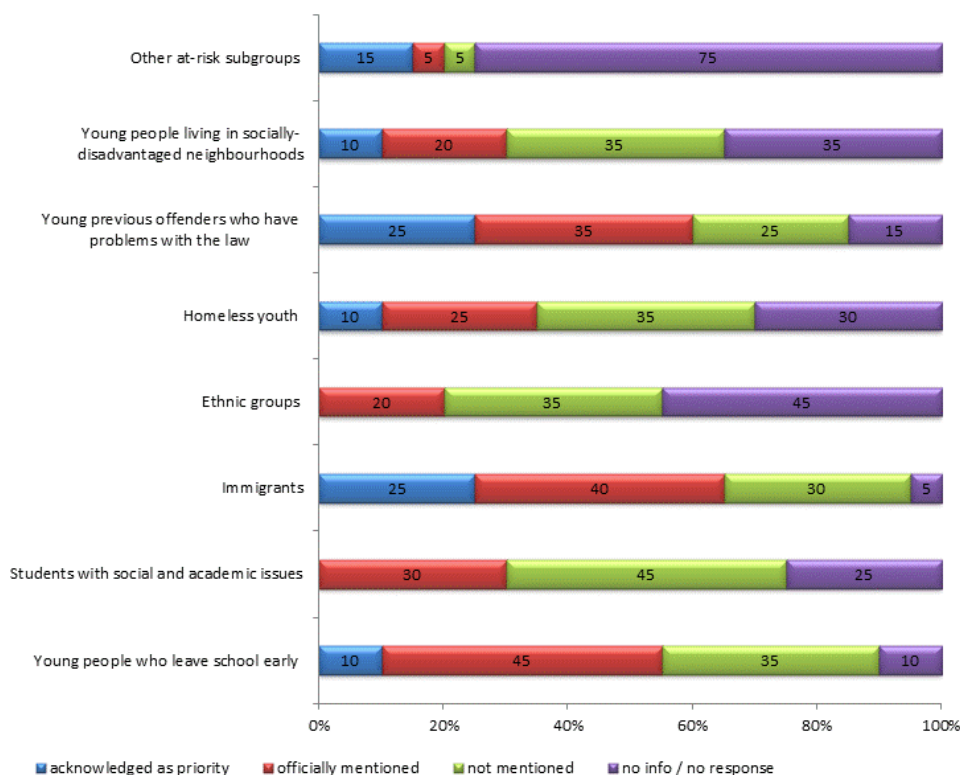
3.2.1. At-risk groups

Over the course of 2011, official healthcare and/or social policy documents made frequent reference to young party- and rave-goers (80% of Regions and Autonomous Provinces) and to selective prevention activities targeting immigrants (65%) (Figure 3.5).

Special attention reported concerning immigrants and young party- and rave-goers

There were very limited numbers of explicit references to the following categories: “other at-risk subgroups” and ethnic groups (20%), “students with social and academic issues” and “young people living in socially disadvantaged neighbourhoods” (30%).

Figure 3.5: Distribution of explicit references to prevention activities targeting **at-risk groups** in official documents on healthcare and/or social policies in 2011.



Source: Based on data from the survey conducted using EMCDDA questionnaires sent to the Regions

The total number of selective and targeted prevention initiatives which were either on-going or concluded by the Regions and Autonomous Provinces was high, 254 in all, and greater than the number for 2010 (242).

Over 200 active prevention projects

The categories for which the largest number of projects were launched (26) were the young party- and rave-goers category, followed by the category of “young people who leave school early” (23).

Prevention initiatives targeting the various at-risk groups were carried out largely in/by specialised facilities and services.

The categories for which the largest number of projects were on-going were the “other at-risk subgroups” (51), followed by “young party- and rave-goers” (46) and “young people who leave school early” (27) .

3.2.2. At-risk families

As far as regards selective prevention at a nuclear family level, programmes targeting “families with substance abuse (including alcohol) issues, siblings included” were the most frequently mentioned (in 55% of official documents); explicit references to the other at-risk categories included in the EMCDDA structured questionnaire are found in less than 50% of official documents (Figure 3.6).

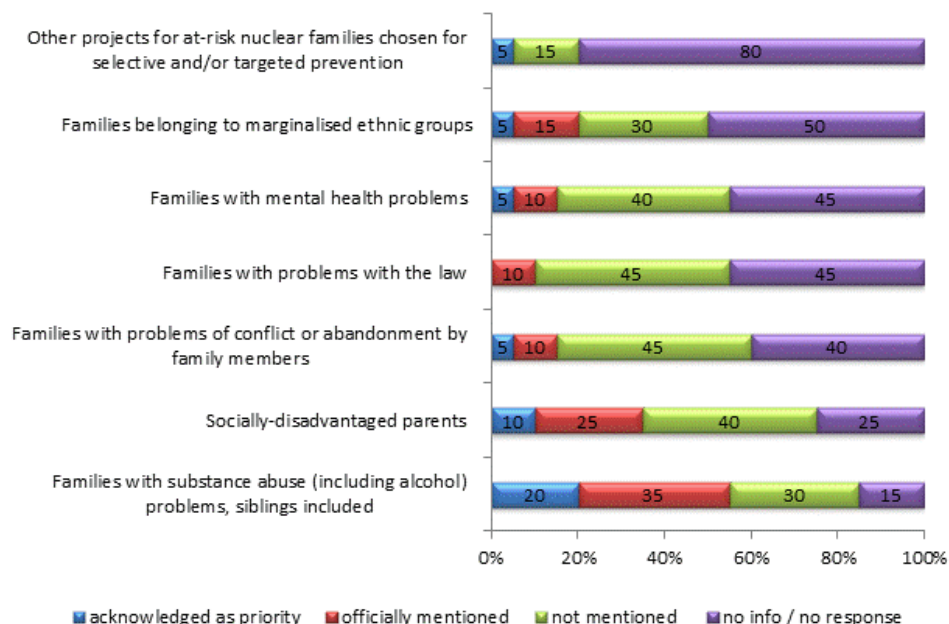
The Regions and Autonomous Provinces have a total of 98 on-going projects that fall under the category of selective prevention targeting families, over 70% of which fall under the category of “families with substance abuse (including alcohol) issues, siblings included”.

There was a sharp drop in the number of active projects (33.3% less than in 2010), especially those targeting socially disadvantaged parents.

For at-risk families as well, prevention initiatives were largely carried out in/by specialized facilities and services.

Projects launched for problem families, to whom special attention was reported as having been dedicated
98 selective prevention projects targeting families: 71 for families with substance abuse issues

Figure 3.6: Distribution of explicit references to prevention activities targeting families in official documents on healthcare and/or social policies in 2011



Source: Based on data from the survey conducted using EMCDDA questionnaires sent to the Regions

3.3. Prevention in specific target groups

3.3.1. In schools

Regarding selective narcotic drug-use prevention, approximately 4.6% of the sample group of schools participating in the survey about psychotropic drug use in secondary schools reported having used standard protocols and/or criteria for the early identification of students exhibiting at-risk behaviours for psychotropic drug use: 6.7% of technical institutes, 5.6% of vocational schools and 2.7% both for secondary schools formerly specialising in education and art institutes.

52.6% of the schools used *counselling centres* in their selective prevention programmes, 36.8% had initiated *protocols of understanding* and 26.3% employ *internal measures* implemented within the schools themselves.

Moreover, *health education counsellors* to deal with these issues are present in 68.4% of the schools, while another 47.4% have *psychopedagogists* available.

Other selective psychotropic drug-use prevention initiatives targeting students at a high risk of leaving school early were conducted by 35 of the sample schools (8.5% of schools which responded to the prevention questionnaire), with vocational schools conducting the highest number of such initiatives (13.5%), followed by technical institutes (10.4%), secondary schools and secondary schools formerly specialising in education (5.4%) and secondary art schools and art institutes (2.7%).

88.6% of the sample schools offered *educational psychology services which students could access directly or to which they could be referred to discuss these issues* and 28.6% provided *training courses for teachers*, while a further 31.4% of sample schools distributed *guidelines on ways of recognizing problem students, including those who use drugs*.

3.4. National and local media campaigns

In 2011, activities for the promotion and organization of information campaigns to raise awareness regarding drug-use prevention among the general population were conducted not only by the Regional Administrations, but also by the Department for Anti-drug Policies, which organized and launched five information campaigns.

The first institutional information campaign promoted by the Department for Anti-drug Policies in 2011, "Don't get high, live your life", targeted young people. Active from 1-30 March 2011, the campaign was active on National and local TV and radio stations, in cinema multiplexes, subways, train stations, national newspapers and magazines and on institutional websites, social networks and other internet sites whose principal targets are kids and young people.

The "Don't get high, live your life"
Institutional Campaign

The second initiative, the "Beaches campaign", involved beaches throughout the nation, including on islands. It consisted of the placing of posters for the Anti-drug Campaign on lifeguard stations and on auxiliary beach-safety stations (a.k.a. PASS stations). Posters were placed on a total of 240 lifeguard towers and 90 auxiliary beach-safety stations in the period of time from the second half of July 2011 through the second half of September 2011.

The "Beaches Campaign"
Institutional Campaign

The third initiative, the "Say Youth, Say Future" festival, organized by the Institute of Speech Therapy in Rome and by the Diregiovani.it web portal, took place from 9-12 November 2011. Its objective was to involve students from elementary, middle and secondary schools from all over the country. Each school had the opportunity to take the stage with performances of various kinds: concerts, video-art, dance, choral performances, musicals, theatrical performances and readings, the idea being that these types of activities encourage young people to understand their own individuality and the real or virtual world around them, thereby preventing the emergence of high-risk behaviours by providing young people with positive activities into which to channel their energies.

The "Say Youth, Say Future" Festival

Another prevention activity targeted the students of approximately 3000 specially chosen middle schools and higher secondary schools throughout the country. Its objective was to directly involve the students in the creation of anti-drug slogans and graphics. The Department created an experimental website devoted to this research project, called "Pins – Do you stand against drugs?" to collect the students' ideas. The best slogans

The "Pins – Do you stand against drugs?" Project

and graphics will be chosen by a panel of judges.

“Elementary, but not too elementary...” is a project promoted by the Department for Anti-drug Policies, the Higher Institute for Health and the Italian Parents Movement (a.k.a. MOIGE). Its goal is to raise awareness and provide information to minors, parents and Italian elementary school teachers about the risks linked to the use of cannabis and alcohol and the factors which increase the likelihood of young people beginning to use these substances.

This two-year project (2011-2012) targets 50 elementary schools throughout the country and involves approximately 15,000 children, 30,000 parents and 2,000 teachers.

On scheduled days, each school will hold an ‘open day’ which will permit children to learn more about the topic of the campaign through games overseen by experts from the Italian Parents Movement. Parents and teachers will also have the chance to learn about the topic of the campaign during evening meeting events. Each child will make a drawing about the topic and the 12 best will be included in a calendar which will then be sent to the schools. The drawing which best represents the topic will win a prize for the school from which it was submitted.

During the course of these drug and alcohol education days, material will be distributed to both children and adults containing useful advice to help prevent and fight drug and alcohol use and the types of situations which make their use more likely.

Most of the initiatives launched during 2011 by the Regions and Autonomous Provinces were universal prevention campaigns (40, equal to 70%) as opposed to selective prevention campaigns, and only three Regions launched at least one campaign for each of the two areas, in comparison with the 6 Regions which launched both types of campaigns in 2010 (Table 3.1).

Table 3.1: Number of universal and selective prevention information campaigns conducted by the Regions and Autonomous Provinces during the course of 2011

| Regions | Universal Prevention | Selective Prevention | Total |
|-----------------------|----------------------|----------------------|-------|
| Abruzzo | 1 | - | 1 |
| Bolzano | 2 | - | 2 |
| Calabria | - | 1 | 1 |
| Campania | 1 | 2 | 3 |
| Friuli Venezia Giulia | 5 | 1 | 6 |
| Lombardy | 23 | 1 | 24 |
| Marche | 1 | - | 1 |
| Apulia | 3 | - | 5 |
| Sicily | - | 11 | 11 |
| Trento | 4 | - | 4 |
| Umbria | - | 1 | 1 |
| Total | 40 | 17 | 57 |

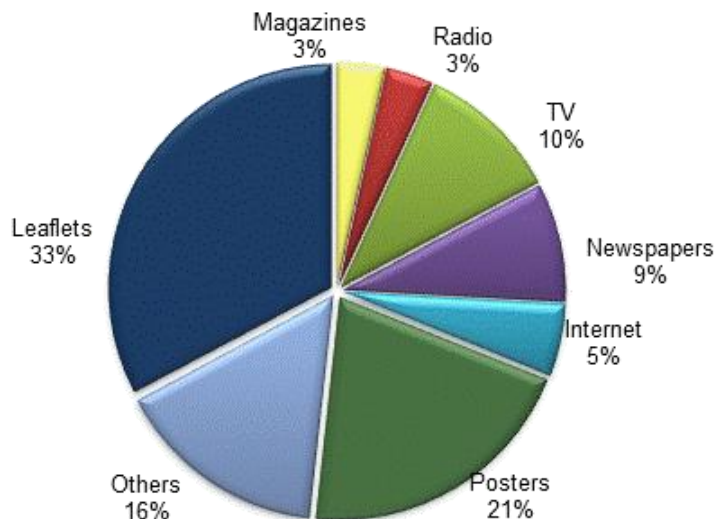
Source: Based on data from the survey conducted using EMCDDA questionnaires sent to the Regions

The “Elementary,
but not too
elementary.....”
Project

The most commonly employed information tool was once again the leaflet (33%) followed by posters; various types of performances were also used (musical events, theatrical performances), which fall under the category of “other”. The use of magazines and radio, at only 3%, continued to fall. (Figure 3.7).

A large number of universal prevention campaigns in Lombardy and of selective prevention campaigns in Sicily

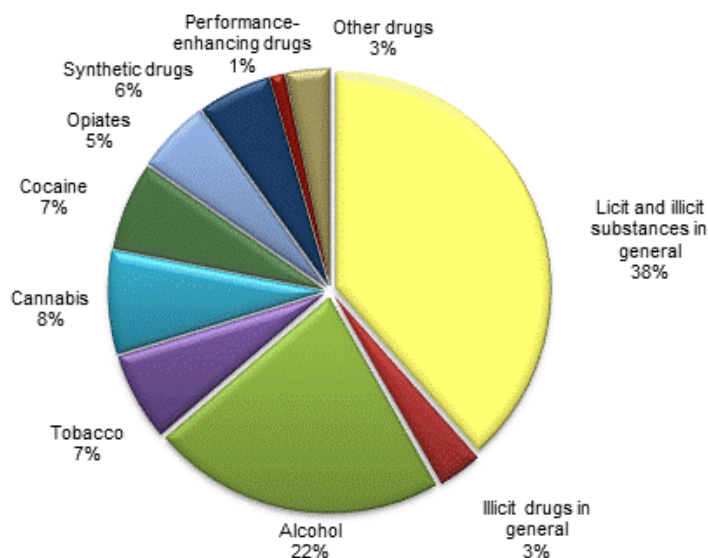
Figure 3.7: Percentage distribution of prevention campaigns conducted by the Regions and Autonomous Provinces in 2011, by type of mass media



Source: Based on data from the survey conducted using EMCDDA questionnaires sent to the Regions

The subject matter most frequently dealt with by prevention campaigns is clearly that of “licit and illicit substances in general”, which accounts for 38% of campaigns reported (Figure 3.8), followed by alcohol (22%). 3% of campaigns dealt with illicit drugs in general, while campaigns about specific drugs have better figures, such as campaigns against cannabis, which account for 8% of prevention campaigns.

Figure 3.8: Percentage distribution of prevention campaigns conducted by the Regions and Autonomous Provinces in 2011, by subject matter



Source: Based on data from the survey conducted using EMCDDA questionnaires sent to the Regions

4. PROBLEM DRUG USE

Problem drug use is one of the five key epidemiological indicators adopted by the European Monitoring Centre to monitor the drug phenomenon. The aim of this indicator is to estimate how great a part of the population is affected by serious, high-risk drug-use patterns.

Foreword

This chapter provides information on prevalence estimates for subjects in need of assistance for opiate or cocaine use, and draws on information from healthcare and other sources. One section is devoted specifically to the estimate of frequent cannabis users, an indicator which is not included in the definition of PDU.

4.1. Introduction

Over the years, panels of experts within the European Monitoring Centre in Lisbon have come to agree upon a definition for problem drug use¹, and they have also established methodologies for estimating the total fraction of the population who fit the PDU profile. The methods developed – which take full advantage of information gathered from the users who come into contact with treatment services or with other agencies responsible for the fight against drugs or for rehabilitation of users within a certain time frame – make it possible to calculate the numerical amount of problem drug users, both those already known or those still completely unknown who were never registered or counted during the period of time in question. All the methods which have been advanced for calculating these estimates attempt to take utmost advantage of the information available, and each adjusts itself to the level of detail of the information provided (aggregate or analytical data) and to whether it comes from multiple sources or from one source alone, mathematically modelling the data generation process of available data.²

The methods for estimating PDU, in particular multiple-source information capture-recapture methods, which have provided excellent results when estimating the number of heroin and opiate users in need of treatment, are not reliable when estimating numbers of cocaine or stimulant users, let alone of cannabis. For these same reasons, the use of the multiple indicator method is also no longer adequate for calculating the use of drugs other than opiates. On an international level, it is with increasing frequency that we observe the application of single-source capture-recapture methods, such as the truncated Poisson model or models based upon an analysis of time elapsed between three consecutive captures³.

New methods for estimating PDU

The application of these methods to national information flows is particularly well-suited to data gathered by the Ministry of the Interior, and specifically by the Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources regarding reports filed under Art. 75 of D.P.R. 309/90 for possession of drugs for personal use,

Information sources

¹ The classic definition of problem drug use, while currently undergoing revision, should be understood to mean injecting drug use or long-term/regular use of opiates, cocaine and/or amphetamines.

² For a description of different methods, consult the European guidelines at <http://www.emcdda.europa.eu/html.cfm/index65519EN.html>

³ For an example, see: Mascioli F. and Rossi C. (2008), *Capture-recapture methods to estimate prevalence indicators for evaluation of drug policies*. Bulletin on Narcotic Drugs, **1**, Issue LX, 5-25.

specifically cannabis and cocaine. In order to calculate prevalence estimates for subjects requiring assistance for opiate use, the data was obtained from the information flow of the Ministry of Health, which provided information on clients receiving assistance from drug addiction services, as well as from Regional and Provincial Administrations which, via Regional monitoring centres, provided estimates – obtained from local-level application of the multiple-source information capture-recapture method – of the multiplier coefficient of clients in need of treatment for opiate use.

Table 4.1: Prevalence estimates of subjects requiring treatment, by drug type. The years. 2010-2011

| Drug Type | The year 2010 | | The year 2011 | | Sources |
|-----------|------------------------|--------------------------------|------------------------|--------------------------------|--------------------------|
| | Subjects | Prevalence x 1,000 inhabitants | Subjects | Prevalence x 1,000 inhabitants | |
| Heroin | 200,400 | 5.0 | 193,000 | 4.8 | Ministry of Health |
| Cocaine | 120,000 ⁽¹⁾ | 3.0 | 136,750 ⁽²⁾ | 3.4 | Ministry of the Interior |
| Cannabis | 242,000 ⁽¹⁾ | 6.1 | 190,400 ⁽²⁾ | 4.8 | Ministry of the Interior |
| Total | 562,400 | 14.1 | 520,150 | 13.1 | |

Source: Department for Anti-drug Policies, based on data from the Ministry of Health and the Ministry of the Interior

(1) Ministry of the Interior information flow, the year 2008 (2) Ministry of the Interior information flow, the year 2009

Table 4.1 provides a summary of figures – obtained using the different methods described above according to different drug types – for groups of subjects in need of treatment, described in more detail in the following sections. Overall, we can see a decline in drug use within the population, reflected in the estimate of subjects in need of treatment. It should be noted, however, that estimates calculated on data from the Ministry of the Interior, following delays in notification, are not updated for the years 2010-2011, but for the years 2008-2009.

4.2. Prevalence and incidence estimates of PDU

4.2.1 Estimates of number of problem drug users requiring treatment for use of opiates

To estimate the size of the population of possible clients in need of treatment for the regular, long-term or injecting use of opiates, in view of the greater homogeneousness of this population of subjects in comparison with subjects who use other types of illegal drugs, the simple multiplier method listed in the EMCDDA guidelines was used.

The multiplier value for clients in need of treatment for opiate use was obtained by combining values at local levels, as estimated in 2011, for the Regions of Abruzzo, Sicily (the Local Health Authorities of Palermo and of Syracuse), Lombardy (the Local Health Authorities of Milan and Varese), Veneto (Local Health Authority of Verona), Friuli Venezia Giulia, Apulia, Trentino and the City of Bologna, ten available local estimates. These estimates were processed by the Monitoring Centre of the Department for Anti-drug Policies.

Summary of subjects in need of treatment

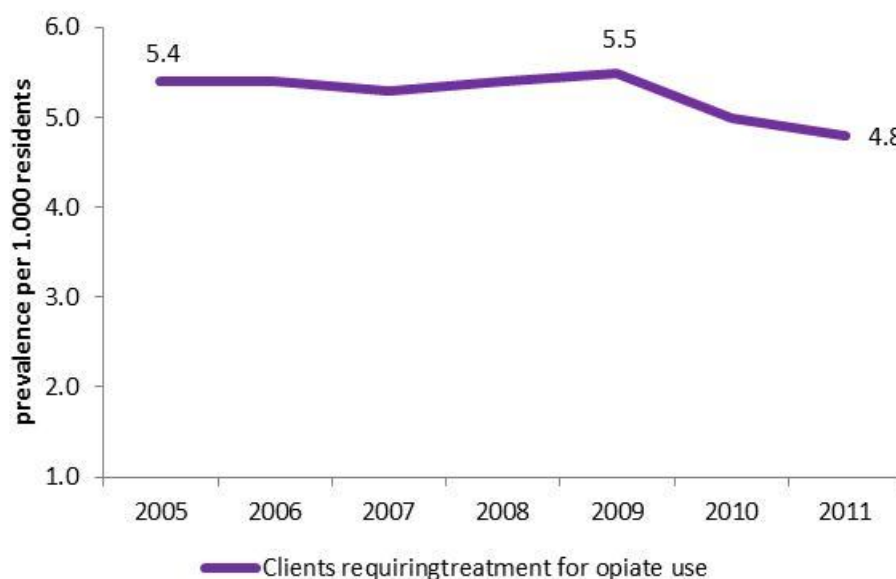
Methodological guidelines

In 2011 (ST 7 opiates), it is estimated that there were approximately 193,000 subjects in need of treatment for primary use of opiates in Italy, equal to a prevalence of 4.8 per thousand residents between 15 and 64 years of age.

193,000 opiate addicts in Italy, or rather, 4.8 per thousand residents (15-64 years of age)

The trend in prevalence estimates over time for the group of subjects eligible for treatment for opiate use remained largely stable between 2005 and 2009, falling over the last two-year period, a decline owed to the greater number of subjects in need of assistance intercepted by national health service facilities (indeed, there has been a reduction in the hidden population, directly linked to the multiplier indicator, in slight decline, falling from 1.68 in 2009 to 1.61 in 2011).

Figure 4.1: Prevalence estimates per thousand residents aged 15-64. The years 2005-2011



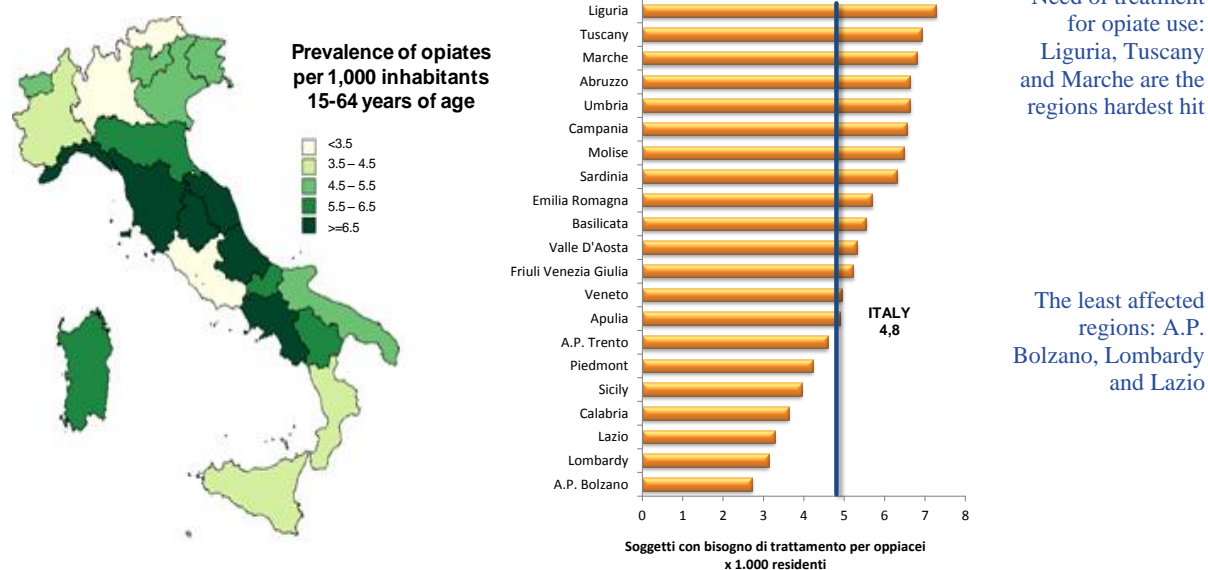
Source: Based on ministerial information flows

An analysis of regional estimates shows the highest prevalence levels in Liguria, Tuscany and Marche. The extreme north and south of Italy, on the other hand, are the regions with the lowest prevalence levels.

Regional prevalence estimates vary widely

Regarding estimates of problem drug users in need of treatment for opiate use divided according to gender, we can see that levels are markedly higher for men in comparison with women (5.2 vs. 0.8 subjects per 1,000 residents aged 15-64), while the regional prevalence distribution brings to light some differences between the two gender profiles.

Figure 4.2: Prevalence estimates (per thousand residents aged 15-64) of subjects requiring treatment for opiate use. The year 2011



Source: Based on ministerial information flows

Need of treatment for opiate use: Liguria, Tuscany and Marche are the regions hardest hit

The least affected regions: A.P. Bolzano, Lombardy and Lazio

4.3. Data on PDUs from non-treatment sources

4.3.1 Estimates of number of problem drug users requiring treatment for use of cocaine

As was mentioned earlier, multiple-source information capture-recapture methods, which have provided excellent results when estimating numbers of heroin and opiate users in need of treatment, are not reliable for estimating numbers of cocaine and stimulant users. It is for this reason that, on an international level, it is with increasing frequency that we observe the application of single-source capture-recapture methods, such as the truncated Poisson model.

Estimate of problem cocaine use

It is possible, however, to use this method to obtain population estimates which can be used as proxies for those in question.

The Department for Anti-drug Policies used this latter method to estimate populations of cocaine users. It also used Ministry of the Interior files on subjects reported under Art. 75 of DPR 309/90 for drug possession for personal use, specifically cocaine possession.

Methodological criteria for estimating PDU

Population estimates were obtained using the truncated Poisson model and by calculating Horvitz Thompson, Chao and Zelterman estimators and their relative confidence intervals.

Table 4.2: Zelterman estimates for cocaine user population sizes, for both New and Already Known users, and relative confidence intervals, by geographic area. The year 2009.

| Geographic area | Total reported | Cocaine users (Zelterman) | | |
|---|----------------|---------------------------|--------------|--------------|
| | | Estimate | Min (CI 95%) | Max (CI 95%) |
| New reported subjects | | | | |
| North-eastern Italy | 586 | 28,617 | 5,486 | 25,847 |
| North-western Italy | 1,289 | 39,441 | 22,300 | 56,582 |
| Central Italy | 1,017 | 73,734 | 18,628 | 128,839 |
| Southern Italy and the islands | 1,045 | 45,460 | 19,420 | 71,499 |
| Total | 3,935 | 187,251 | 65,834 | 308,669 |
| Estimate without geographic area division | 3,935 | 168,186 | 118,981 | 217,391 |
| Already reported in previous years | | | | |
| North-eastern Italy | 216 | 3,889 | 692 | 7,086 |
| North-western Italy | 591 | 12,477 | 5,789 | 19,165 |
| Central Italy | 234 | 6,845 | 24 | 13,667 |
| Southern Italy and the islands | 612 | 15,583 | 6,580 | 24,585 |
| Total | 1,653 | 38,793 | 13,085 | 64,502 |
| Estimate without geographic area division | 1,653 | 37,933 | 25,268 | 50,599 |

Source: Based on data from the Central Directorate for Documentation and Statistics (DCDS) – Ministry of the Interior

The population of reference is comprised of two subpopulations: subjects reported for the first time during the year in question, known as the “New” group, and those who had already been reported in previous years (recidivists), known as “Already Known”. In order to identify different aspects of each population, we can use estimates regarding the size of the phenomenon made based on reports filed to find distinctive characteristics of the two populations. Specifically, the population of subjects already reported can be enlisted to estimate the population of subjects in need of treatment, while the population of new reported subjects can be used, together with information on age at first use, to estimate incidence, although prevalence among younger age groups could already be considered an incidence estimate.

We must recall that the population being estimated is not the total population of users of a particular drug, but only those at risk of being reported under Art. 75 which, based on previous evaluations of locations where reports were filed⁴. These are estimated to be about 38% of the total population of cannabis users and 30% of the total population of cocaine users.

Furthermore, we must also add that the data suffers greatly from delays in notification. Reports filed during the period from 2010 to 2011 are incomplete, and we must therefore consider data regarding the year 2009 as the most reliable, assuming that, in that year, the total indicated must be increased by 5% to reach the actual number of reports filed. It thus

Parameters for correcting the estimate

⁴ The presentation can be viewed at: <http://www.urbandrugpolicy.com/en/catalogue/detail/6/175/->

follows that the final estimate will also have to be increased by 5%.

Using a multiplier which, being constructed thus (risk of being reported 30%, notification delay 5%) is certainly prudent, to correct the estimates for numbers of previously reported cocaine users, and calculating the average value of estimates obtained using the Horvitz-Thompson, Zelterman and Chao methods, we obtain an estimate of cocaine users in need of treatment of about 136,750 subjects between the ages of 15 and 64 (ST 7 cocaine), with variance from confidence intervals found to range from 45,700 to 228,000 subjects.

Estimate of cocaine users in need of treatment: 136,750 subjects between the ages of 15 and 64

Table 4.3: Horvitz-Thompson, Zelterman and Chao estimates for the size of the population of COCAINE users, both New and Already Known, and relative confidence intervals. The year 2009.

| | Reported | Estimate | Cocaine Users | | Corrected estimate |
|---|----------|----------|---------------|--------------|--------------------|
| | | | Min (CI 95%) | Max (CI 95%) | |
| New reported | | | | | |
| Horvitz-Thompson | 3,935 | 189,408 | 57,690 | 321,126 | 662,927 |
| Zelterman | 3,935 | 187,251 | 65,834 | 308,669 | 655,380 |
| Chao | 3,935 | 187,081 | 67,710 | 306,452 | 654,784 |
| Already reported in previous years | | | | | |
| Horvitz-Thompson | 1,653 | 39,645 | 13,905 | 65,386 | 138,759 |
| Zelterman | 1,653 | 38,793 | 13,085 | 64,502 | 135,777 |
| Chao | 1,653 | 38,781 | 13,903 | 63,659 | 135,733 |

Source: Based on data from the Central Directorate for Documentation and Statistics (DCDS) – Ministry of the Interior

The very low number of recaptures did not make it possible to obtain reliable estimates for the female population.

4.4. Intensive, frequent, long-term and other problematic forms of use

4.4.1 Estimates of number of problem drug users requiring treatment for use of cannabis

The same methodology employed to obtain estimates of cocaine users in need of treatment was used to obtain estimates of populations which could be taken as proxies for the population now in question, which is that of cannabis users in need of treatment.

Estimate of problem cannabis use

An application of the truncated Poisson model to data from Ministry of the Interior files regarding reports filed under Art. 75 of S.P.R. 309/90 for possession of drugs for personal use, specifically cannabis, and the use of Horvitz-Thompson, Chao and Zelterman estimators and their relative confidence intervals, produced the desired population estimates.

Methodological criteria for estimating PDU

As with the population of cocaine users, the introduction of the geographic area where the report was filed into the analyses produced a higher value for the estimate of the size of the population in question in comparison with the national estimate obtained without stratifying by geographic area.

Table 4.4: Horvitz-Thompson, Zelterman and Chao estimates for the size of the population of CANNABIS users, both New and Already Known, and relative confidence intervals. The year 2009.

| | Cannabis Users | | | | |
|---|----------------|----------|-----------------|-----------------|-----------------------|
| | Reported | Estimate | Min (CI 95%) | Max (CI 95%) | Corrected estimate |
| New reported | | | | | |
| Horvitz-Thompson | 21,360 | 493,735 | 397,449 | 590,021 | 1,364,268 |
| Zelterman | 21,360 | 482,323 | 387,922 | 576,724 | 1,332,735 |
| Chao | 21,360 | 481,802 | 390,527 | 573,077 | 1,331,295 |
| Already reported in previous years | | | | | |
| Horvitz-Thompson | 6,817 | 71,604 | 54,313 | 88,894 | 197,852 |
| Zelterman | 6,817 | 67,714 | 51,060 | 84,368 | 187,104 |
| Chao | 6,817 | 67,408 | 52,040 | 82,775 | 186,258 |

Source: Based on data from the Central Directorate for Documentation and Statistics (DCDS) – Ministry of the Interior

If we correct estimates of cannabis users using the information on the size of the population at risk of being reported (38%) and the information on notification delay (5%), we obtain an estimate of the total number of users already reported in previous years on a national level. Taking the average value of the results obtained when applying the three proposed methodologies, we find that this total amounts to approximately 190,400 subjects, with variability of estimates ranging from a minimum of 141,000 users to a maximum of 245,600 users. If we consider that these subjects are the same ones who have been reported multiple times over the years, we can consider this population to correspond to the population of cannabis users in need of treatment. We must recall that a fair number of these subjects also use other drugs in addition to cannabis.

Estimate of number
of cannabis users in
need of treatment:
190,400 subjects
between 15-64
years of age

5. DRUG-RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY

In accordance with the system of organisation as set forth under European standards, information about treatment demand on the part of drug users provides a profile which can be used to frame policies and strategies for the treatment of drug addicted subjects, as well as to determine organisation of the social and healthcare services throughout the country and provide useful information about the epidemiological characteristics of the population of Service network clients.

In Italy, this information comes from different information sources. Some of the information flows employed are created ad hoc, but most have been organised and put into use in accordance with regulations currently in force for monitoring the activities of the Services network.

Specifically, information useful for developing strategies and social and healthcare policies for the treatment of individuals who approach the Services for assistance, especially at a Regional level, is gathered through the use of the structured EMCDDA questionnaire (SQ 27 Part 1), while Part 2 of the same questionnaire is used to gather data about the monitoring of the quality of treatments provided. These questionnaires were distributed to all of the Regions and Autonomous Provinces for completion during the course of 2012, with the intention of gathering data regarding the situation in 2011.

Information on the organisation of the network of local services, the treatments provided by them and information regarding clients of those services comes from the information flow of the Ministry of Health, in accordance with D.P.R. 309/90.

Information flows
and information
sources

5.1 Strategy/policy

As described in the last edition of this report, nationwide strategy and action policies for the treatment of drug addicts are contained within the National Action Plan on Drugs for 2010 – 2013, where they are organised according to 5 principal action areas, one of which is devoted to the treatment and diagnosis of drug addictions (early outreach, reception centres, appropriate diagnoses and treatment and the concomitant prevention of drug-related diseases).

For each action area, the Action Plan includes goals which must be reached, as well as actions and assessment indicators for each of these.

With regard to the treatment of drug addictions, the Action Plan essentially aims to encourage an interdisciplinary treatment approach for individuals who use drugs, alcohol or tobacco, in full awareness of the fact that the addiction to narcotic drugs is a chronic disease, but one which can be treated and cured. To this end, it is necessary to make early contact with drug users (early outreach). It is then that, through a diagnostic assessment process, the user can be inserted into a suitable, personalised and integrated treatment programme inclusive of aspects regarding the prevention of drug-related diseases, which are complementary, but not alternative, to the treatment itself.

The National
Action Plan on
Drugs 2010 - 2013

The National
Action Plan's
approach to the
treatment of Drug
Addiction

A study was conducted between the end of 2011 and the beginning of 2012 to monitor regional best practices in the field of "addictions" under

Monitoring regional
best practices in the
field of addictions

the various action areas and evaluate them in relation to the National Action Plan on Drugs 2010-2013.

in relation to the
NAPD

The study was conducted using a form with columns containing the actions established in the NAPD and rows for the corresponding actions performed by the Regions. A criterion of “conformity” (presence-absence) was adopted for the purposes of the evaluation, using a scale of 1 to 4 where 1 was equivalent to no such action present and 4 meant that the action established in the NAPD had been adopted as a routine practice by the administration of the Region in question.

Stages of
monitoring

In the first phase, general information on the Regions’ organizational structures, regulations in the field of addictions and policy activities (plans and projects) were collected by consulting regional sites. In the second phase, the general information dossiers obtained during phase one were sent to Regional Management through the Regional Coordination Health Commission. In the third phase, Regional Management were interviewed in order to validate the information dossier and identify best practices. In the fourth phase, contacts for best practices were interviewed in order to gain more knowledge of Regional recommendations.

Under the action area of treatment, diagnosis and prevention of drug-related diseases, the survey showed that the NDAP objectives least implemented by the Regions and Autonomous Provinces are the following: reform of addiction services, early initiation of treatment, seeking to establish contact with occasional users, the adoption of standard diagnostic methods, the creation of separate treatment environments for minors and for women, the launching of gender-oriented programmes and the launching of services for new forms of addiction.

NDAP objectives
least implemented
by the Regions

At the same time, the objectives which Regions and Autonomous Provinces have implemented most are those which have to do with the reduction of acute drug-related mortality, the handling of patients with drug-related diseases, reducing the transmission of infectious diseases (HIV, HCV, etc.), reducing the risk of death by overdose and granting freedom in the choice of treatment facility. Other NDAP objectives which have been widely implemented at a regional level are the integration of public outpatient services with private non-profit services, the management of patients with poly-drug use issues, the quality and effectiveness of treatment, the reduction of social risks and family problems linked to drug use and the guaranteeing of appropriate treatment to prison inmates.

NDAP objectives
most implemented
by the Regions

5.2 Treatment systems

5.2.1 Organisation and quality assurance

On 31 December 2011, according to Ministry of Health and Interior Ministry Sources, a network of 1,630 active social-healthcare facilities were dedicated to the treatment and rehabilitation of individuals with treatment needs associated with the use of psychoactive drugs. Of these, 563 (34.5%) were public drug addiction service units (SerTs), and the remaining 1,067 were social-rehabilitative facilities, for the most part residential facilities (66.4%), followed by semi-residential facilities (17.9%) and outpatient facilities (15.7%). In comparison with 2010, there has been a 2.4% decrease (26 facilities) in the number of social-rehabilitation facilities, a decrease which has affected a greater number of semi-residential facilities (5.4%) and outpatient facilities (4.5%).

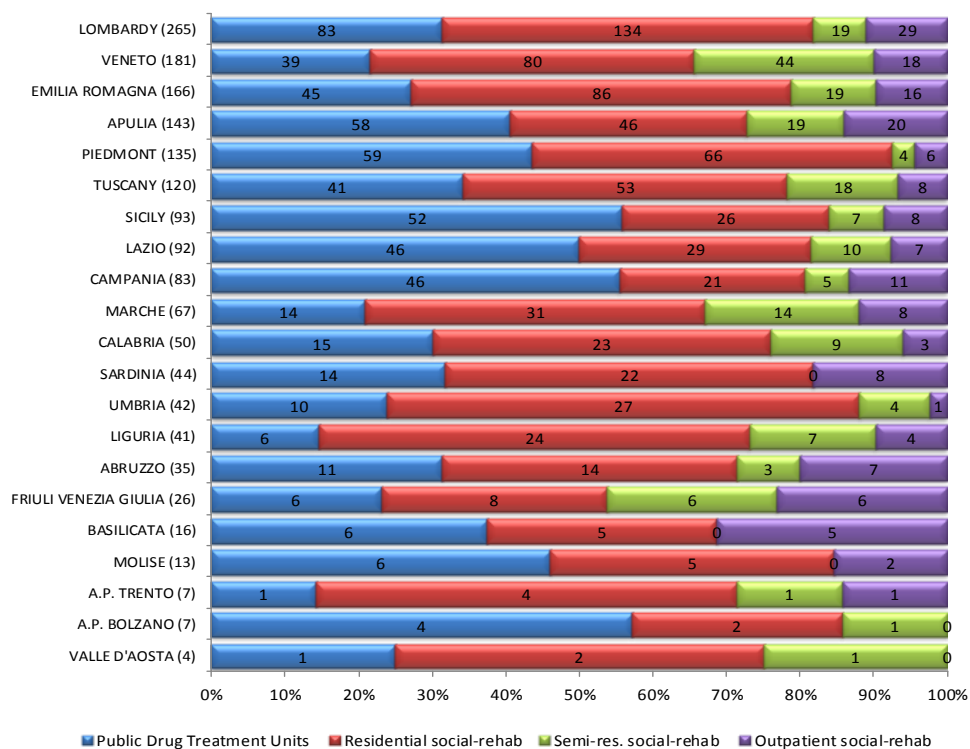
1,630 treatment
facilities, of which:

563 SerTs (Public
Drug Addiction
Service Units)

1,067 social-
rehabilitative
facilities, of which
66.4% residential
therapeutic
communities

As far as regards the distribution of public healthcare facilities and those belonging to private non-profit, as we had already seen in 2010, we find that there are greater percentage distributions of Public Drug Treatment Services (SerTs) in the Autonomous Province of Bolzano, in Sicily, in Campania and in Lazio (Figure 5.1).

Figure 5.1: Distribution of health and social services structures for drug addicts by type and by region – The year 2011



Source: Based on data from (1) The Ministry of Health; (2) The Interior Ministry – Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources

During the first six months of 2012, as in 2011, a survey was conducted by Regional Authorities regarding the recognition of private non-profit facilities (Auxiliary Entities which have received accreditation or authorisation pursuant to Articles 115 and 166 of DPR 309/90) and of public facilities. The facilities in question are those of a diagnostic – therapeutic – rehabilitative nature, as set forth in the State-Regional Accord Act of 5 August 1999. From information gathered from all the Regions and Autonomous Provinces (with the exception of Valle D'Aosta) on a specific online platform created by the Department for Anti-drug Policies, it was found that there were a total of 789 residential and semi-residential diagnostic – therapeutic – rehabilitative facilities of the type specified under the State-Regional Accord Act, 127 less than in the previous year. (Table 5.1). The number of crisis centres fell steeply (-57.1%), as did the number of dual diagnosis services (-28.6%), services for women and for children (-25.0%) and pedagogical rehabilitation services (-25.7%). The only types of services whose numbers showed an increase were those which fall under the category of “Reception” services in the Framework for the Accord Act (+6.7%).

The State-Regional Accord Act of 5 August 1999

The numbers of crisis centres, dual diagnosis services and pedagogical rehabilitation services have dropped, while the number of “Reception” services increased by 6.7%

Table 5.1: Diagnostic - therapeutic - rehabilitative facilities according to the Framework for State-Regional Accord Act of 5 August 1999, by type of facility and type of care provided. The years 2010 – 2011

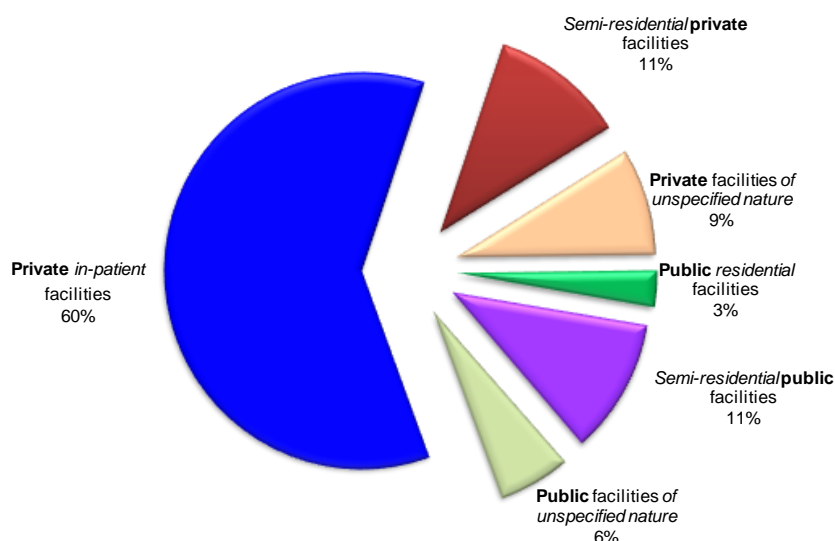
| | Private diagnostic – therapeutic – rehabilitative facilities | | |
|--|--|------------|--------------|
| | 2010 | 2011 | Δ % |
| <i>Collective pathological addictions (not included or not includable in the Framework for the Accord Act study)</i> | 67 | 52 | -22.4 |
| <i>Reception services Art.11</i> | 45 | 48 | 6.7 |
| <i>Therapeutic-rehabilitative services Art.12</i> | 430 | 387 | -10.0 |
| <i>Specialised treatment services Art.13</i> | 176 | 153 | -13.1 |
| 13 a) Double diagnosis | 56 | 40 | -28.6 |
| 13 b) Mother with child | 24 | 18 | -25.0 |
| 13 c) Alcoholics | 30 | 31 | 3.3 |
| 13 d) Cocaine addicts | 1 | 2 | 100.0 |
| 13 e) Pathological gamblers | 0 | 5 | n.c. |
| 13 f) Minors | 15 | 16 | 6.7 |
| 13 g) Couples | 1 | 1 | 0.0 |
| 13 h) Crisis centres | 14 | 6 | -57.1 |
| 13 i) AIDS assisted-living communities | 24 | 25 | 4.2 |
| 13 l) Other | 11 | 9 | -18.2 |
| <i>Pedagogical-rehabilitative services Art. 14</i> | 187 | 139 | -25.7 |
| <i>Integrated multi-disciplinary services Art. 15</i> | 11 | 10 | -9.1 |
| <i>Other accredited programmes</i> | 0 | 0 | n.c. |
| Total | 916 | 789 | -13.9 |

Decline in the number of crisis centres, dual-diagnosis services and services for women and for children

n. c.= figure not able to be calculated

Source: Based on information from the Regions and Autonomous Provinces

Figure 5.2: Percentage distribution of diagnostic therapeutic and rehabilitative public and private facilities according to the Framework for the State-Regional Accord Act of 5 August 1999. The year 2011



Source: Based on information from the Regions and Autonomous Provinces:

In addition to the private facilities, there were a total of 193 public residential, semi-residential or unspecified diagnostic-therapeutic rehabilitative facilities in the Regions participating in the survey. Principally, 43% are therapeutic-rehabilitative facilities, 32.6% are specialised treatment facilities and 18.7 % are reception facilities. Of the specialized treatment facilities, 38% provide treatment for alcoholics, 23.8% to minors and 12.7 to dual-diagnosis patients.

With regard to quality control and monitoring of treatments provided, during the first half of 2012, the Regions and Autonomous Provinces were asked to complete the SQ 27 Structured Questionnaire, Part 2, to which a new section had been added devoted to ensuring the quality of treatment. The objective was to collect information on the existence – on a regional / individual-service-provider level – of protocols / procedures / guidelines for the assessment of the quality of treatments provided by addiction services.

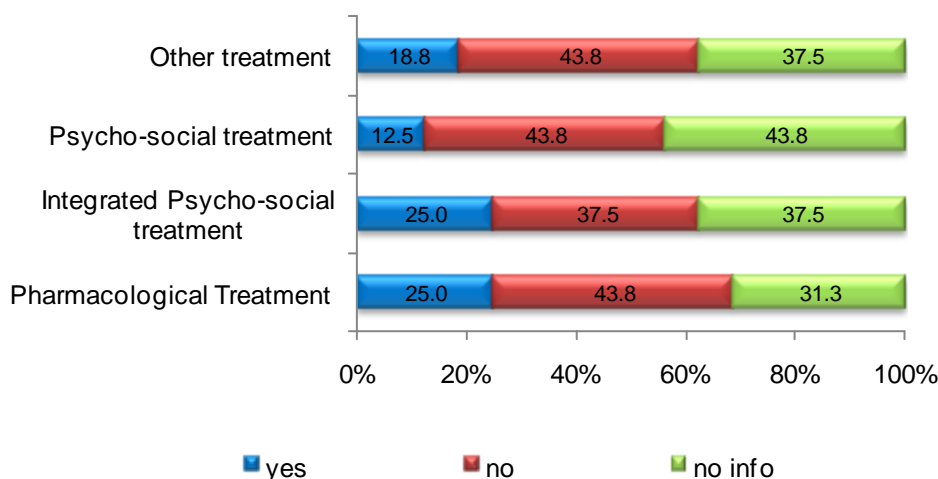
The survey was divided into three parts: Guidelines for evaluating the quality of treatment, Monitoring and assessment and, finally, the Development, sharing and implementation of “best practices”.

Guidelines for assessing treatment quality

Guidelines to use as a tool for assessing treatment quality are still not widely used among all of the Regions and Autonomous Provinces. Guidelines for pharmacological treatment and for integrated psycho-social treatment exist only in a quarter of Regions, while guidelines for psycho-social treatment and other types of treatment are rarer still. (Figure 5.3.). The lack of available data is also significant. In at least 30% of cases (with peak percentages of nearly 44%) there was insufficient data to formulate responses.

Guidelines not widely used

Figure 5.3: The existence of official documents for the assessment of treatment quality. The year 2011



Source: Based on data from EMCDDA questionnaires sent to the Regions

Despite the fact that the application of quality assessment guidelines is obligatory in order to provide treatments and as a prerequisite for obtaining funding for these services, only a very small number of Regions comply and sometimes, as in the case of funding for psycho-social treatment, none comply at all.

Very low compliance with obligatory application of guidelines

The Regions and Autonomous Provinces were asked to provide further information about guidelines, specifically concerning, “the inclusion of aspects / criteria of treatment protocols in guidelines”, “description of required documentation for the assessment of treatment quality including admission/discharge information, outcome, client and personnel satisfaction”, “the manner in which guidelines for assessing treatment quality were created” and whether or not “regulations of reference” existed. With regard to these topics, the amount of information available was always less than 50% and the availability of the data requested was almost always nil.

Very little information made available by the Regions and Autonomous Provinces

Monitoring and assessment

There are still very few assessments of various treatment types which have comparable outcomes, whether they be psycho-social, integrated psycho-social or pharmacological, and these are only conducted by a quarter of Regions, while 56.3% declare them inapplicable.

Assessments of treatment results not widely applicable

Development, sharing and implementation of “best practices”

Best practices are still in an embryonic stage. Continuing education courses are conducted for psychologists in only six regions, and this is the best case. Platforms (online portals) providing professional protocols (knowledge, insights and expertise) for professionals are even less widespread. The most encouraging figure concerns nurses, who are able to make use of specially-created protocols in three different regions.

Very little sharing of “best practices”

5.2.2 Availability and diversification of treatment

In Italy, treatment for individuals who use narcotic or psychotropic drugs is provided by the Addiction Departments of the Local Health Authorities. Addiction Departments can be divided into simple operative units or complex drug treatment units which are equipped to provide out-patient treatments (SerTs *t.n. Public Drug Treatment Units*) or residential treatment facilities (Social-Rehabilitative Structures), as well as healthcare for prison inmates. The Public Drug Treatment Units (SerTs) handle all those individuals whose social-healthcare treatment needs are linked to the use of narcotic or psychotropic drugs. Facilities that differentiate between the drug types for which social-healthcare treatment is being requested do not generally exist, although treatment programmes are designed based on a diagnostic assessment carried out by a multidisciplinary team within drug addiction services and tailored to each client’s social-healthcare needs according to international treatment protocols and in accordance with the laws in force (Art. 122 D.P.R. 309/90).

Preface on the types of treatment provided

The European Monitoring Centre for Drugs proposes that treatment programmes be broken down into three categories, each further subdivided based on its context of application. Specifically, treatments are divided as follows: non-specific non-substitution anti-withdrawal treatments, “pharmacologically assisted” treatments employing specific therapies, “drug-free” treatments and “abstinence-oriented” treatments.

Treatments broken down according to EMCDDA categories: anti-withdrawal, pharmacologically assisted, drug free

Pharmacological treatment is further subdivided into to subcategories: treatments with substitution drugs (methadone and buprenorphine) and treatment with antagonists.

According to the EMCDDA, each of the above-mentioned types of treatment can be carried out in out-patient facilities, in-patient or residential facilities or as ambulatory treatment under a general practitioner.

Generally speaking, these classifications of treatment exist in Italy as well, although the places where they are provided differ. Pharmacological treatments are rarely provided by general practitioners and in-patient facilities generally assist clients in the event of acute episodes.

55% of Regions and Autonomous Provinces report having regional strategies aimed to promote social and healthcare activities to benefit persons in need of treatment for drug use. Of these, 91% declared that a document attesting to this was present and accessible on the internet (SQ 27 Part 1).

75% of Regions participating in the survey had launched treatment programmes targeting subjects whose primary drug of use was cocaine and 70% had launched programs targeting children and adolescents. However, specific treatment programs targeting ethnic groups in need of treatment were launched in only 20% of regions, while only 10% had launched programs for other groups of people with problem drug use.

An assessment of the availability of services offered returned very positive results overall, with ratings of at least “good” in 100% of regions with reference to “problem drug users with a dual diagnosis”, “other groups of people with problem drug use” and “subjects who abuse benzodiazepine”. Accessibility also received a positive rating from at least 75% of Regions and Autonomous Provinces, with low scores reported in only four out of ten cases, of which two returned percentages of under 10% and therefore not of any great relevance.

At least 65% of Regions and Autonomous Provinces use treatment data collected from Public Drug Treatment Units/Departments to plan, adjust or modify anti-drug policies and practices within their own Regions, planning and reorganizing local services and planning and implementing actions to be taken involving projects and prevention, both primary and secondary.

2012 saw the activation of the new SIND (National Information System on Addictions) information flow on clients in treatment with out-patient drug-addiction services (2011 data), meaning that there was a loss of continuity with respect to information gathering carried out in previous years. Indeed, some regions (6 out of 21) only sent data according to the new layout, and it was therefore impossible to reconstruct all the information in such a way as to be in line with the method previously employed (see paragraph 5.3). In order to still be able to obtain an overall national profile, an estimate was used, calculating the percentage difference between the year 2011 and the year 2010 for the regions for which aggregate data were available and applying this correction factor to 2010 data for the regions for which 2011 data were unavailable.

An initial analysis of estimated distribution of subjects in care divided by treatment type shows that most of these (66.6%) were receiving pharmacological treatment, of whom most (75.1%) received methadone, while 30.5% of subjects receiving treatment in 2011 were undergoing psycho-social and/or rehabilitation treatment. It is, however, important to remember that the total number of subjects receiving treatment during the course of the year could appear higher than it actually was, due to the fact that the same subject could be counted more than once if undergoing

A large number of activities designed to assist subjects who use cocaine, subjects with dual-diagnoses and minors were launched

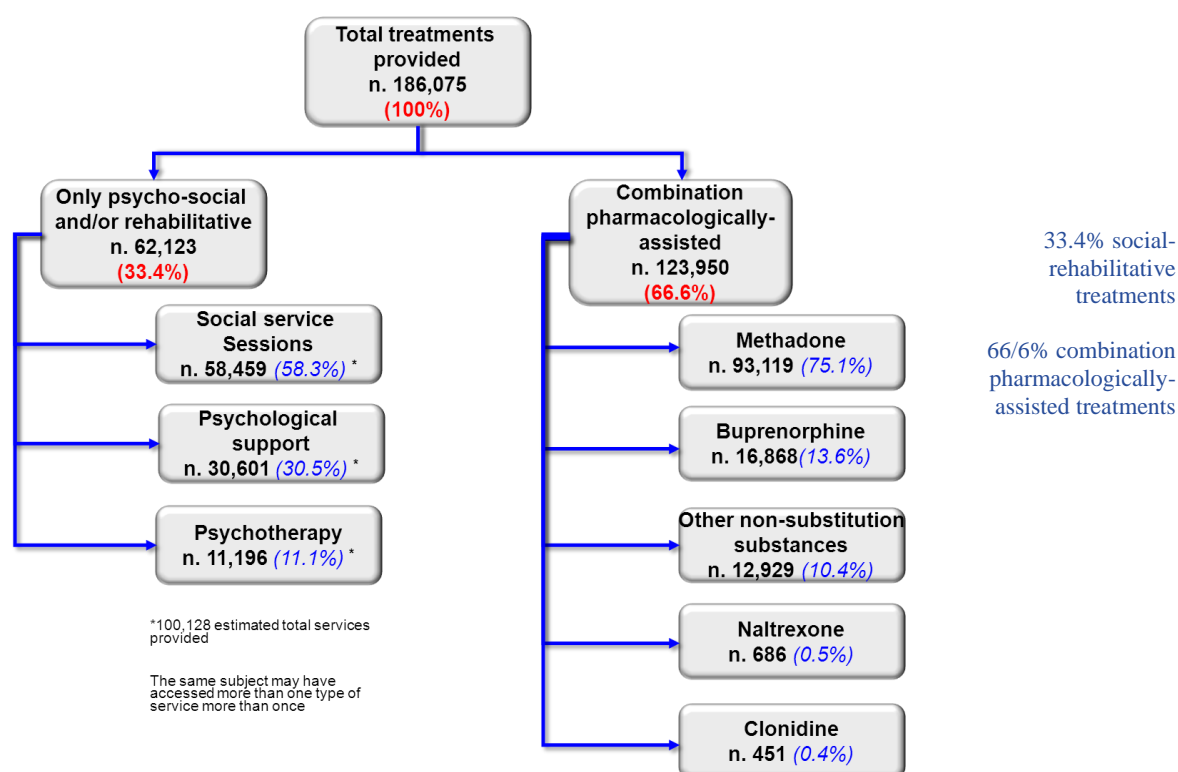
Positive results regarding the accessibility of treatment services

Activation of the new SIND information flow and loss of continuity with data from previous years

186,073 treatments provided by Public Drug Treatment Units (SerTs)

more than one type of treatment during the time period of reference. It should be pointed out that, as established by the Decree of the Ministry of Health of 20 September 1997, pharmacological treatments must be in “combination”, meaning that they must include psycho-social and/or rehabilitative treatment. This is the reason for the use of the classifications “pharmacological” and “only psycho-social and/or rehabilitative” in identifying the number of combination treatments which are pharmacologically assisted (Figure 5.4).

Figure 5.4: Outline of the organisation of the flow of treatment data – The year 2011



Source: Based on data from the Ministry of Health

5.3 Characteristics of treated clients

The National Information System on Addictions (SIND)

On 11 June 2010 the “Institution of the National Information System on Addictions”, was approved by decree of the Ministry of Health. This new information flow contains individual data on subjects receiving care from the addiction services of the Regions and Autonomous Provinces.

The National Information System on Addictions (SIND) decree

This new information flow substitutes the previous flow, which was based on aggregate data (Ministerial Decree 20 September 1997), and provides for the collection of data consisting of facility census information, information on personnel working in drug addiction services, information on activities conducted by services in order to assist drug addicts and, finally, anonymous HIV-monitoring data.

Specifically, the service activities database is comprised of six archives containing the following information:

- SUBJECTS' PERSONAL INFORMATION – This contains personal information, living situation, drug of use, age at first use and age at first

The SIND archives

treatment information for the individual clients who are the objects of the SIND study.

- TESTS UNDERGONE – This contains information concerning tests the individual clients who are the objects of the SIND study underwent and which have been reported. By ‘reported’, what is meant is the existence of a report on the test in question prepared by a testing laboratory or the transcription of a report seen by a member of personnel.
- CONCOMITANT DISEASES – This contains information on diseases with which the individual clients who are the objects of the SIND study were diagnosed with or reported to have which were active during the period in question and concomitant with the principal diagnosis.
- DATES OF CONTACT – This contains the dates of contact when individual clients who are the objects of the SIND study were first taken into care of services and provided with a series of services grouped homogeneously
- DRUGS OF USE – This contains information on the drugs of use or behaviours which caused the individual clients who are the objects of the SIND study to be taken into a treatment programme.
- HOMOGENEOUS SERVICES GROUP – This contains data on groups of homogeneous services offered by each service provider (Public Drug Treatment Units, prisons, communities) for the open contact.

Table 5.2: Transmission of data on addiction services activities according to the Ministerial Decree 11 June 2010 and Ministerial Decree 20 September 1997 information flows. The year 2012

| | SIND flow M.D. 11 June 2010 (obligatory) | ANN and SER flows M.D. 20 September 1997 (optional) |
|-----------------------|--|---|
| Abruzzo | Complete transmission | Complete transmission |
| Basilicata | Data not received | Complete transmission |
| Calabria | Data not received | Complete transmission |
| Campania | Complete transmission | Complete transmission |
| Emilia Romagna | Complete transmission | Data not received |
| Friuli Venezia Giulia | Complete transmission | Complete transmission |
| Lazio | Partial transmission | Partial transmission |
| Liguria | Data not received | Data not received |
| Lombardy | Complete transmission | Data not received |
| Marche | Data not received | Complete transmission |
| Molise | Data not received | Complete transmission |
| PA Bolzano | Complete transmission | Complete transmission |
| PA Trento | Complete transmission | Complete transmission |
| Piedmont | Partial transmission | Data not received |
| Puglia | Complete transmission | Complete transmission |
| Sardinia | Data not received | Complete transmission |
| Sicily | Complete transmission | Complete transmission |
| Tuscany | Data not received | Complete transmission |
| Umbria | Complete transmission | Data not received |
| Valle d'Aosta | Complete transmission | Complete transmission |
| Veneto | Complete transmission | Complete transmission |

Source: the Ministry of Health

By the end of the first half of 2012, not all Regions had adopted the new information flow. The previous aggregated data flow thus remained partially active and was used by a number of Regions and Autonomous Provinces in addition to the already-adopted SIND flow in order to be able

Data transmission
by the Regions and
Autonomous
Provinces

to compare the data from the two information flows and evaluate their consistency. Table 5.2 summarises the transmission of information (2011 data) from the SIND flow and/or the ANN and SER forms (Ministerial Decree 20 September 1997) on the part of the Regions and Autonomous Provinces.

The analysis of clients receiving treatment in 2011 was based upon information provided by the Ministry of Health, collected from the Regions and Autonomous Provinces, which used the M.D. 20 September 1997 and M.D. 11 June 2010 information flows.

The following data flows were used in order to create a reconstruction of the population of subjects receiving treatment from drug addiction services in 2011 consistent with data from previous years:

- Regions and Autonomous Provinces which provided both information flows: (Abruzzo, Campania, Friuli Venezia Giulia, A.P. Bolzano, A.P. Trento, Sicily, Valle d'Aosta and Veneto) – use of the SER and ANN aggregate-data forms provided by the Ministry of Health
- Regions which only submitted the SIND flow (Emilia Romagna, Lombardy and Umbria) – use of aggregate data reconstructed by the Ministry of Health
- Regions which did not submit the SIND flow or submitted it only in part (Liguria and Piedmont) – use of aggregate-data forms collected in 2010
- Regions which only submitted the SER and ANN flows (Basilicata, Calabria, Marche, Molise, Sardinia and Tuscany) – use of SER and ANN aggregate-data forms provided by the Ministry of Health.

It should also be pointed out that the data from previous information flows refer to the entire population of clients receiving out-patient addiction care, including new subjects receiving care for the first time in 2011, subjects already known to services who began new treatments in 2011 and subjects already undergoing treatment with services at the beginning of 2011.

This data is therefore not consistent with data published in the TDI, which refers only to a sample of clients, as indicated in paragraph “*Multicentric study on a sample group of drug addiction service providers*”.

Based on information collected using the methods outlined above and provided by the Ministry of Health, we can estimate that 172,211 individuals received assistance for drug addiction in 2011, a decline of 1.1% over the previous year's figures. Of this population, approximately 20% were beginning their first-ever treatment with drug addiction services of any kind, while 80% were already known to services (and had begun a new treatment in 2011 or had been in on-going treatment since a prior period).

Table 5.3: Drug use among Drug Addiction Services clients, according to primary drug type. The years 2010 - 2011

| Primary drug of use | 2010 | | 2011 | | Δ % | Diff% |
|---------------------|---------|------|---------|------|------|-------|
| | No. | % | No. | % | | |
| Heroin | 118,651 | 69.8 | 114,644 | 69.3 | -3.4 | -0.5 |
| Cocaine | 25,717 | 15.1 | 25,262 | 15.3 | -1.8 | 0.2 |
| Cannabis | 15,415 | 9.1 | 15,157 | 9.2 | -1.7 | 0.1 |
| Other stimulants | 1,429 | 0.8 | 1,470 | 0.9 | 2.9 | 0.1 |
| Other drugs | 8,756 | 5.2 | 8,946 | 5.4 | 2.2 | 0.2 |

Source: Based on data from the Ministry of Health

Data from Ministry of Health differ from TDI data

172,211 drug addicts receiving care from services in Italy

Of all the people undergoing treatment with Drug Addiction Services in 2011 who specified a primary drug of use, 69.3% reported that drug to be heroin, followed by cocaine (15.3% of the total number of clients undergoing treatment) and then by cannabis (9.2% of the total number of clients undergoing treatment) (Table 5.3). In comparison with the European profile, more clients reported using opiates, while levels for cocaine use were similar, but levels for cannabis and other drugs, predominantly of the synthetic type, were much lower.

Cannabis and cocaine, while continuing to grow in appeal as primary drugs among service clients, are also the preferred secondary drugs of clients who use more than one type of drug.

Indeed, in 2011, as in 2010, cocaine and cannabis were almost equal in the classification of secondary drugs of choice, coming in at approximately 30% apiece (Table 5.4).

Most commonly used primary drugs:
69.3% heroin,
15.3% cocaine,
9.2% cannabis

Table 5.4: Drug use among Drug Addiction Services clients, according to secondary drug type. The years 2010 - 2011

| Secondary drug of use | 2010 | | 2011 | | Δ % | Diff% |
|-----------------------|--------|------|--------|------|-------|-------|
| | No. | % | No. | % | | |
| Heroin | 6,348 | 5.3 | 7,010 | 5.8 | 10.4 | 0.5 |
| Cocaine | 36,089 | 30.1 | 36,404 | 30.1 | 0.9 | 0.0 |
| Cannabis | 36,314 | 30.3 | 37,288 | 30.9 | 2.7 | 0.6 |
| Psychotropic drugs | 8,483 | 7.1 | 8,632 | 7.1 | 1.8 | 0.0 |
| Alcohol | 18,007 | 15.0 | 15,885 | 13.2 | -11.8 | -1.8 |
| Other drugs | 14,566 | 12.2 | 15,567 | 12.9 | 6.9 | 0.7 |

Source: Based on data from the Ministry of Health

Injecting drug use, and in particular the injecting use of opiates, showed a slight increase during the last year (58.9% in 2010 vs. 61.0% in 2011), although still remaining below the 1997 level (approximately 68%).

Table 5.5: Injecting drug use by clients undergoing treatment with Drug Addiction Services. The years 2010 - 2011

| Injecting drug use | 2010 | | 2011 | | Δ % | Diff% |
|--------------------|--------|------|--------|------|------|-------|
| | No. | % | No. | % | | |
| Heroin | 69,851 | 58.9 | 69,973 | 61.0 | 0.2 | 2.1 |
| Cocaine | 3,396 | 12.7 | 3,300 | 13.1 | -2.7 | 0.4 |
| Benzodiazepine | 133 | 13.6 | 200 | 20.3 | 50.4 | 6.7 |
| Other opiates | 99 | 15.1 | 125 | 19.0 | 26.3 | 3.9 |

Source: Based on data from the Ministry of Health

Multicentric study on a sample group of drug addiction service providers

The TDI tables were compiled in accordance with the new TDI 3.0 protocol, using data gathered directly from the Regions and Autonomous Provinces via the new SIND information flow.

As has already been mentioned, since the new information flow was not implemented by all of the Regions, the data received and processed represents a partial profile of the overall national situation.

In 2011, the multicentric study conducted by the Department for Anti-drug Policies on a sample group of drug addiction services which make use of information systems with data on individual clients was extended to

The DPA's multicentric study

services located in the Regions of Friuli Venezia Giulia and Lazio, two more than in 2010. The Regions participating in the study in 2011 were Abruzzo, Friuli Venezia Giulia, Lazio, Liguria, Lombardy, Sicily, Umbria and Veneto.

The group participating in the study was comprised of 78,267 clients from 91 drug addiction service facilities located in the regions listed above. A careful analysis of the quality of socio-demographic data and of drug-use data (completeness of information collected for the TDI), along with an examination of the geographic distribution of the sample group, reduced the size to a sample of 22,871 clients. This sample, while not representative of the entire population of subjects receiving treatment with Public Drug Treatment Units, nonetheless presents characteristics which are not statistically different (gender distribution, client age, new clients and clients already known to services, distribution according to primary and secondary drugs of use). The sample group was comprised of: 4,064 new subjects and 18,807 subjects already known to services. Of this latter group, 3,247 subjects began a treatment during the course of 2011 and 15,560, on the other hand, were continuing a treatment that had begun prior to 2011. The sample group taken into consideration thus consisted of a total of 7,311 subjects eligible to be considered for the TDI, 87.3% of which were male and 55.6% of which were entering the care of Public Drug Treatment Units for the first time.

7,311 subjects
analysed for the
TDI

The average age of new female clients thus found was discovered to be younger than the figures which emerged from an analysis of the aggregate data provided by the Ministry of Health. For women in the sample group, the average age was 30.0 vs. the 31.1 which emerged from the aggregate data, and 31.8 vs. 31.6 years of age for the men, respectively. We find the same situation when examining the clients who underwent treatment in periods prior to the period of reference who returned in 2011: 34.1 years of age for women in the sample group vs. the 34.7 years of age which emerged from the aggregate data, and 35.9 vs. 35.9 years of age for men, respectively. Generally speaking, the data from the sample group provides a greater average age for clients already receiving treatment, regardless of gender.

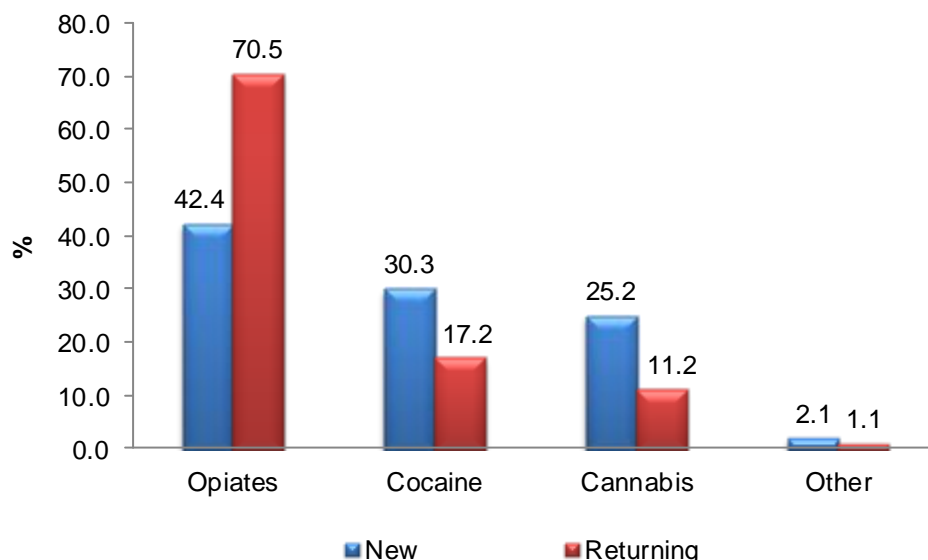
As had already emerged from an examination of the aggregate data (Ministry of Health), the majority of clients undergoing treatment with Public Drug Treatment Units were being treated for the problem use of opiates. Indeed, 56.1% of clients for whom drug-of-use information is available used opiates as their “primary” drug. The second most commonly used “primary” drug was cocaine, accounting for 23.9% of cases, and thirdly cannabis, the “primary” drug of 18.4% of clients. Another 1.6% of clients reported other illegal drugs as their primary drugs of use. If we compare these results with the information reported in the previous section (Table 5.3) we see that the figures and percentages differ greatly. This is explained by the fact that the Ministry of Health data includes those clients who, in 2011, were continuing a treatment begun in a period prior to 2011, unlike the sample group of 7,311, which included only so-called ‘returning’ clients.

Primary drug of use:
56.1% heroin,
23.9% cocaine,
18.4% cannabis

The use profile which emerged from a study of primary drug of use according to client type was particularly interesting. 70.5% of subjects who had received assistance from Public Drug Treatment Units in the past and

returned in 2011 were receiving treatment for opiate abuse, while the numbers of users of cocaine (17.2%) and cannabis (11.2%) among this group were much lower. The number of problem opiate users is quite high among new service clients as well (42.4%) but with a markedly lower percentage than that found for clients who had already received assistance in the past. The numbers of new clients undergoing treatment for cocaine and cannabis use are higher than among clients who had already been undergoing treatment, at 13.1% and 14% respectively.

Figure 5.5: Percentage distribution of the sample of clients undergoing treatment with Drug Addiction Services according to type of client and primary drug of use. The year 2011



Source: Based on data from the DPA 2011 Multicentric Study, compiled using data from Public Drug Treatment Units

Figures concerning methods of use of primary drugs, and especially regarding injecting drug use, also differ between new and returning clients: we can see that primary drug use via injection is more common among clients who had already undergone treatment in the past (42.3%), with percentages of injecting users standing at 97% for opiate users and at 3% for cocaine addicts in this group. Among new clients beginning treatment, on the other hand, only 21.3% of the total use the injection method, specifically, 94.4% of opiate users and 5.6% of cocaine users.

As a direct consequence of these different behaviours concerning injection of the primary drug of use, we also find differences in the figures for other methods of drug use: 46.3% of new clients smoke their primary drug or inhale it once vaporized, while 23.8% sniff their primary drug. The percentages for these methods are lower among clients who had already been treated in the past, of whom 34.1% use by smoking or inhaling and 14% by sniffing.

As revealed by studies conducted in previous years, average age at first use changes in relation to the type of drug in question: heroin and cocaine users began at average ages of 21 and 22 respectively, while cannabis users began at 18.

As far as age at first treatment is concerned, on the other hand, the following figures emerged in 2011: age 26 for heroin users, 33 for cocaine users and, finally, 23 for subjects who reported using cannabis as their primary drug.

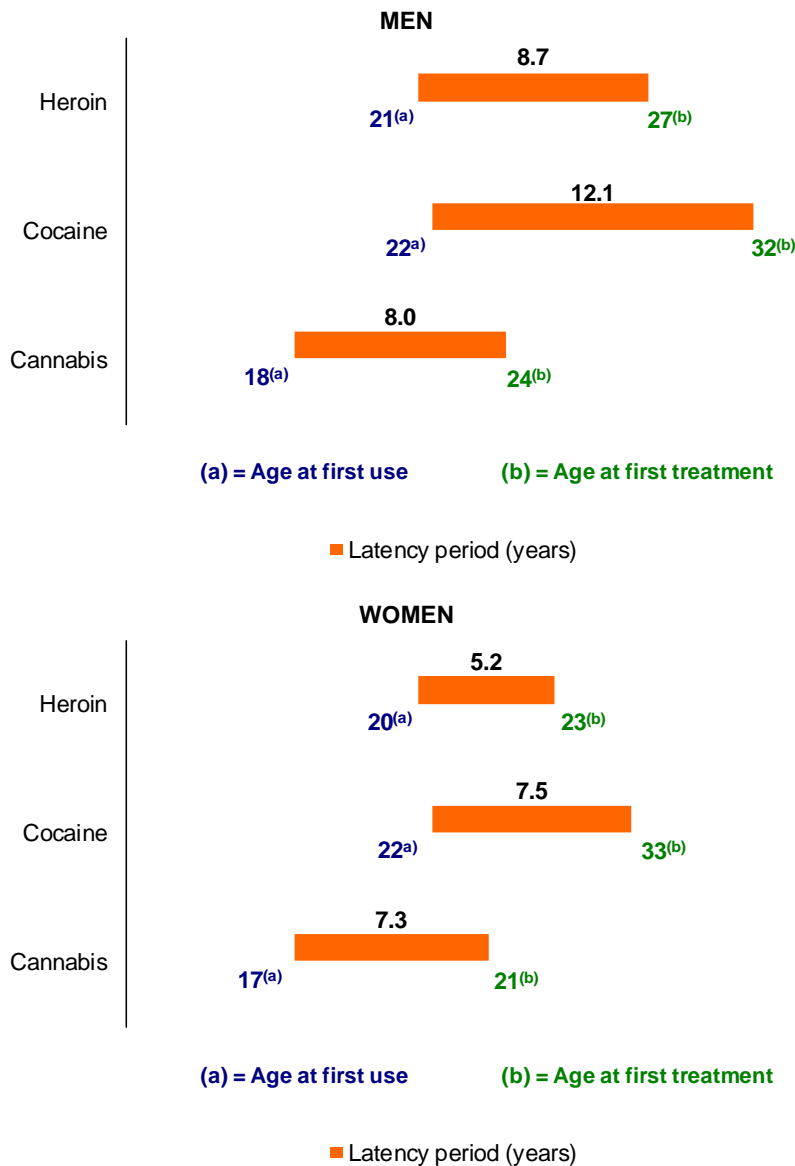
Age at first use:
ages differ based on
drug type:
heroin: age 21
cocaine: age 22
cannabis: age 18

Age at first treatment:
younger for
heroin (26) than for
cocaine (33); 23
years of age for
cannabis

Unlike the average age at the time of first treatment, the latency period is a direct consequence of the variation in ages at first drug use. Latency period, defined as the period of time that passes between first drug use and first request for drug treatment assistance (as a result of problems deriving from the use of the particular drug in question), stands at 9.3 years in the sample group overall (9.9 years for men and 5.9 years for women). An analysis based on primary drug type reveals longer latency periods for cocaine users. Specifically, we find that latency periods are 8 years for opiate users, 11.7 years for cocaine users and 7.8 years for cannabis users. These figures vary greatly when findings are analysed according to gender. Latency periods for female users of all three drugs in question are shorter than men’s latency periods. This finds confirmation in the fact that the age at first treatment is significantly younger for female heroin and cannabis users than for their male counterparts, although their age at first use is only slightly younger than that of the men.

Latency periods between first use and first contact with services:
 heroin: 8 years
 cocaine 11.7 years
 cannabis 7.8 years

Figure 5.6: Age at first use, age at first treatment and latency period, by gender. The year 2011



Source: Based on data from the DPA 2011 Multicentric Study, compiled using data from Public Drug Treatment Units

The manner in which clients enter into the care of drug addiction services differs according to drug type. While most heroin and cocaine users seek treatment voluntarily or are brought into contact with services by friends or family members (59.5% of heroin users and 48% of cocaine users), 29% of cannabis users, on the other hand, are sent to Public Drug Treatment Units by order of the Prefectures (under Articles 121 and 75) and 28.6% enter into treatment voluntarily. The low number of referrals for most drug types on the part of a number of important potential sources, such as social services, schools and local health boards, should be noted.

Heroin and cocaine:
most clients seek
treatment
voluntarily

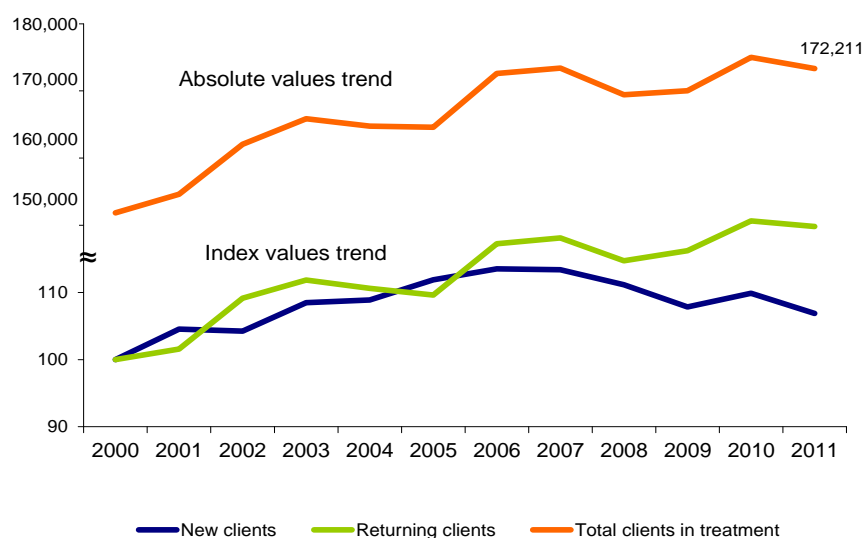
Cannabis:
most clients sent to
treatment by the
Prefectures

If we compare the manner in which clients enter into the care of drug addiction services according to type of client, we find that the percentage that were sent to Public Drug Treatment Units by the Prefectures is significantly higher among new subjects than among those already in treatment, a difference which is most marked among cannabis users (35% vs. 14.7%) and cocaine users (15.5% vs. 5.7%). This is the opposite of the situation among clients already in treatment, of whom 58.8% sought treatment voluntarily (in comparison with 43.2% of new clients). For heroin users, on the other hand, the number of clients referred by other services is much higher among new clients than among returning clients (18.7% vs. 8.3%), unlike the percentages for those seeking treatment voluntarily (52.1% vs. 64.2%).

5.4 Trends of clients in treatment

Data presented in this section refer to all clients receiving care from out-patient drug-addiction services, including new subjects treated in 2011 and those already known to services (both those who began a new treatment in 2011 and those who were already undergoing treatment when 2011 began). It must also be recalled that the issues previously described impacted the estimate of the number of subjects receiving care in 2011.

Figure 5.7: Clients undergoing treatment with Drug Addiction Services by type of contact – Absolute values and index values (Base year 2000 = 100) – The years 2000 - 2011



Source: Based on data from the Ministry of Health (figures for the Liguria and Piedmont Regions date from 2010)

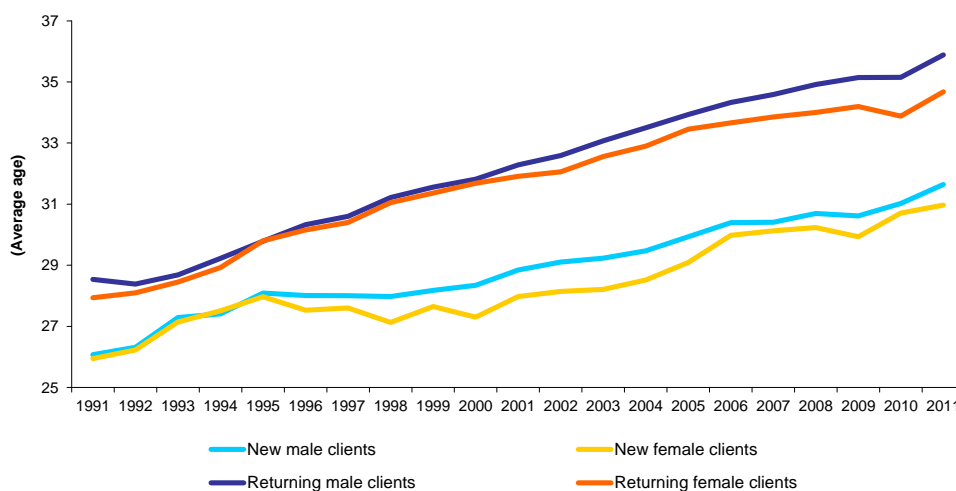
Between 2000 and 2006, there was a steady increase in the number of drug addicts requesting first-time treatment from the network of public services provided by the National Health System (new clients), rising from 31,510 in 2000 to 35,766 in 2006; in the following three-year period (2007-2009) there was a phase of decline (35,731 in 2007 to 35,020 in 2008 and finally to 33,983 in 2009), followed by an increase in 2010, which brought the figure up to 34,625, matching levels seen in 2004 (Figure 5.7). Over the last year, according to the estimates calculated for 2011, a decrease of 2.7% was observed in the number of new clients in the care of services, which fell from 34,625 clients in 2010 to 33,679 in 2011. This downturn, which can be observed among clients already known to services as well, might be explained by the criteria used when calculating the estimate, by the different information flows employed or by the lower level of information-flow coverage in the previous two-year period, which reveals a steady trend in new clients during the period spanning 2006 to 2011.

Number of new clients decreased over the last year

Between 1991 and 2009, the average age of new clients increased, rising from 26 for both genders to 31.0 for women and 31.6 for men. Among clients already known to services, the average age continues to rise, although differently for each gender, with a more pronounced age increase for men than for women: men rose from 35.2 years of age in 2010 to 35.9 in 2011, while the average age for women already known to services rose from 33.9 in 2010 to 34.7 in 2011.

Increase in average age at the time of first request for care from services: from 26 in 1991 to 31.6 for men and 31.0 for women in 2011

Figure 5.8: Average age of clients undergoing treatment with Drug Addiction Services by type of contact and by gender. The years 1991 - 2011



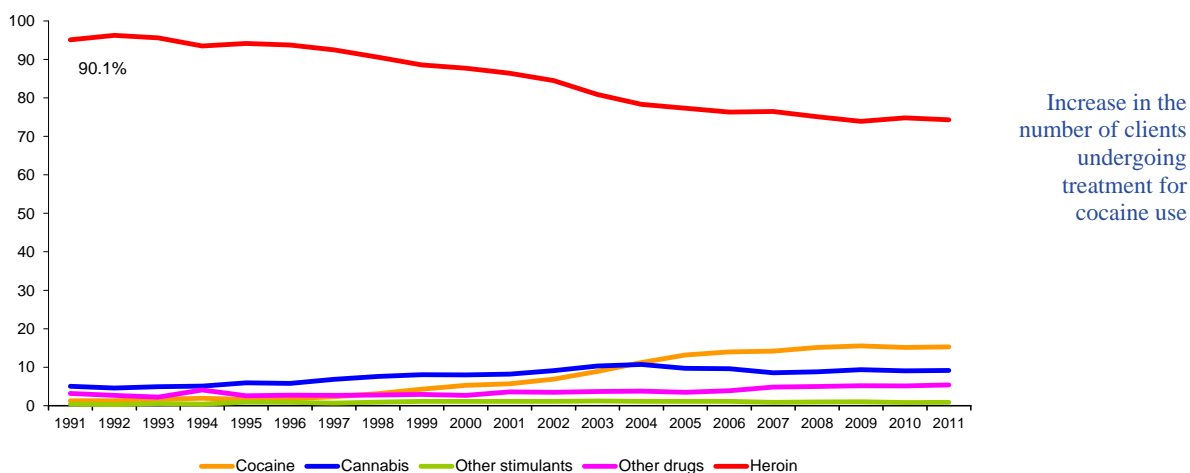
Source: Based on data from the Ministry of Health

Although it remains high, the percentage of clients undergoing treatment for the use of heroin as their primary drug of use showed a progressive decrease between 1991 to 2005 (falling from approximately 90% to 68.9%). During the last four-year period, however, the phenomenon seems to have levelled off at around 70%.

Clients undergoing treatment for heroin use: trend levelled off during the last four years

While the number of clients who use heroin as their primary drug has decreased, the number who use cocaine has increased (from 1.3% to 15.3%) and, since 2005, has been greater than the number of clients undergoing treatment for cannabis use (which climbed from 5% to 9.2%) The percentage of clients who use cocaine as their primary drug has levelled off at around 15%.

Figure 5.9: Percentage distribution of clients undergoing treatment with Drug Addiction Services, by primary drug. The years 1991 – 2011



Source: Based on data from the Ministry of Health

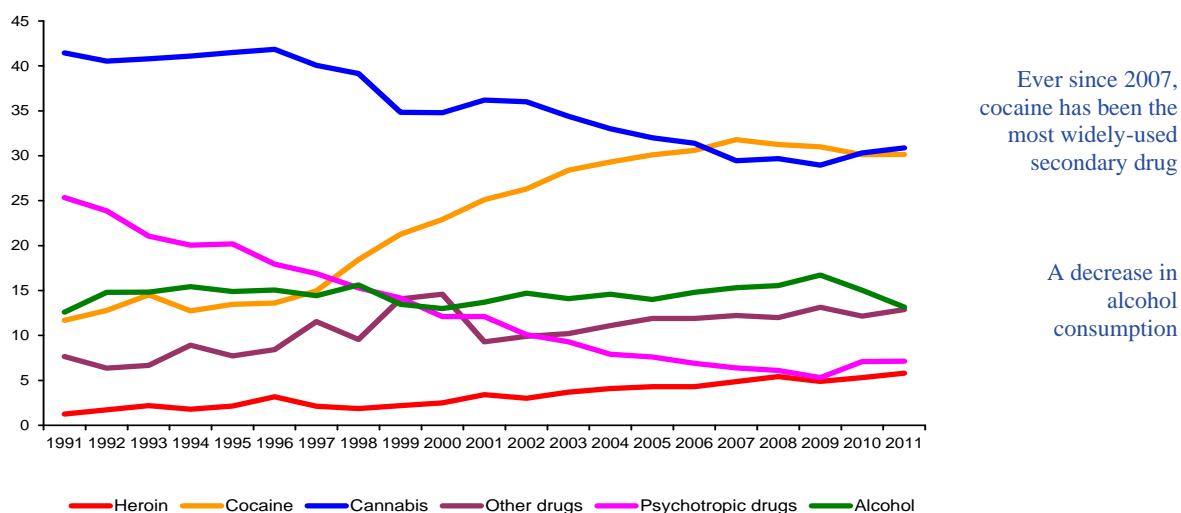
Ever since 1997, there has been a visible increase in the use of cocaine as a secondary drug, which rose from 15% to 32% in 2007 and then remained stable until 2009, only to fall slightly to 30.1% over the last two years. The last two years have also seen an 11.8% drop in the combination use of alcohol, which fell from 15% in 2010 to 13.2% in 2011. The use of heroin as a secondary drug fluctuated slightly. Although remaining at very low levels, it rose over the last five-year period under consideration, from 3% in 2002 to approximately 5.4% in 2008, but falling to 4.9% in 2009 only to rise again slightly over the last two years (increasing from 5.3% in 2010 to 5.8% in 2011).

Increase in the number of clients undergoing treatment for cocaine use

Trend in cannabis and psychotropic medications as secondary drugs on the rise among clients undergoing treatment

Decrease in the use of alcohol in combination with the primary drug of use

Figure 5.10: Percentage distribution of clients undergoing treatment with Drug Addiction Services, by secondary substance. The years 1991 - 2011



Source: Based on data from the Ministry of Health

6. HEALTH CORRELATES AND CONSEQUENCES

The principal consequence directly correlated with the use of psychoactive drugs, and in particular with their methods of use, not to mention the type of lifestyle the average individual who uses drugs leads, is, among other things, the high risk of contracting infectious diseases, a topic to which a large part of this chapter is devoted.

One specific section will be devoted to traffic checks carried out by Law Enforcement Agencies for drivers under the influence of psychoactive drugs.

The final part of the chapter will deal with acute drug-related mortality, the subject of a study by the Central Directorate for Anti-drug Services of the Ministry of the Interior, and with mortality among users of psychoactive drugs following hospital admission.

Infectious diseases
among drug
addiction services
clients

Drug- and alcohol-
related traffic
checks

Deaths caused by
acute effects

6.1. Drug related infectious diseases

One of the key indicators established by the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA) in Lisbon for monitoring the phenomenon of drug use is the prevalence of diseases related to the use of illegal psychoactive drugs.

At a European level, special attention is devoted to injecting drug users (IDUs), as a consequence of their high risk of contracting infectious diseases, HIV and viral hepatitis.

In Italy, testing is carried out both among drug addiction services users as well as among patients admitted to hospitals for drug-related issues (although the majority of tests are performed on clients receiving care from outpatient services).

With the introduction of the new National Information System for Addictions (a.k.a. SIND) into drug addiction services, as described in-depth in the previous chapter, information on testing for infectious diseases is another category of information which is only partial for the year 2011.

In fact, due to transmission issues, to only partial transmission of the information flow or to a failure to submit data, it was impossible to conduct an analysis of the situation concerning the infectious diseases HIV, HBV and HCV for four of the Regions.

In order to maintain continuity with data from previous years for those Regions for which information was available, data was processed based upon the aggregate data flow collected by the Ministry of Health through the annual survey conducted using the forms denominated ANN.04, ANN.05 and ANN.06. However, aggregate data does not allow for a detailed analysis of the prevalence of infectious diseases among those clients who inject psychoactive drugs.

Drug-related
infectious diseases:
in the form of HIV,
HBV, HCV, TBC,
STDs

Information flows
on infectious
diseases remain
partial

6.1.1. HIV and viral hepatitis

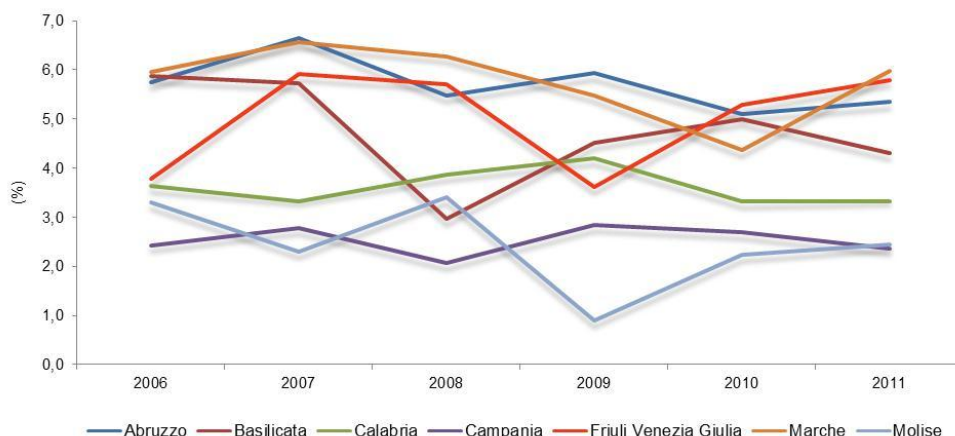
In the 14 Regions which submitted data flows using the ANN forms (M.D. 20 September 1997), we find that in 2011, as in previous years, there is a tendency not to perform tests on subjects. The Regions with the highest percentage of subjects not being tested were found to be Tuscany (86.6% not tested), Abruzzo (83.4%), Sicily (81.1%) and Sardinia (81.0%).

No Testing in:
Tuscany, Abruzzo,
Sicily and Sardinia

Data reported in the Standard Tables 09, Part 2, for each individual Region and Autonomous Province, served as verification of the significance of trends in the prevalence of HIV-positive test results found using a chi-square test to calculate trends from 2006 to 2011. Results show trends in considerable decline in the Regions of Apulia, Sardinia, Sicily and Tuscany, while the chi-square test did not reveal any significant variations in any other Regions or Autonomous Provinces.

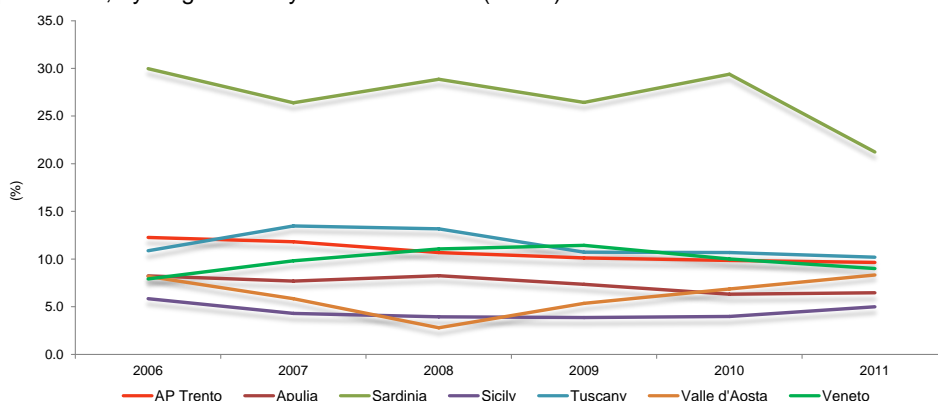
Trends in
prevalence of HIV-
positive test results
during the period
from 2006 to 2011

Figure 6.1: Prevalence of HIV-positive service clients among clients on whom tests were performed, by Region. The years 2006 -2011 (Part 1)



Source: Based on Ministry of Health data submitted by the Regions and Autonomous Provinces.

Figure 6.2: Prevalence of HIV-positive service clients among clients on whom tests were performed, by Region. The years 2006 -2011 (Part 2)



Prevalence of HIV-
positive test results
falling in the
Regions of Apulia,
Sardinia, Sicily and
Tuscany (ST 09 –
Part 2)

Source: Based on Ministry of Health data submitted by the Regions and Autonomous Provinces

If we draw a distinction between new clients and clients who were already known to services because they had received treatments prior to the year under consideration (ST 09, Part 2), different trends emerge in the various Regions. We find a growing prevalence among new clients in the period from 2006 to 2011 in the Marche and Valle d'Aosta Regions, while the number of HIV-positive results fell in Molise, Apulia and Veneto.

Among clients already known to services, we can see an increase in prevalence in Veneto (the trend among new clients is the opposite), while there is a significant downturn in the Regions of Apulia, Sardinia and Marche (the trend among new clients is the opposite).

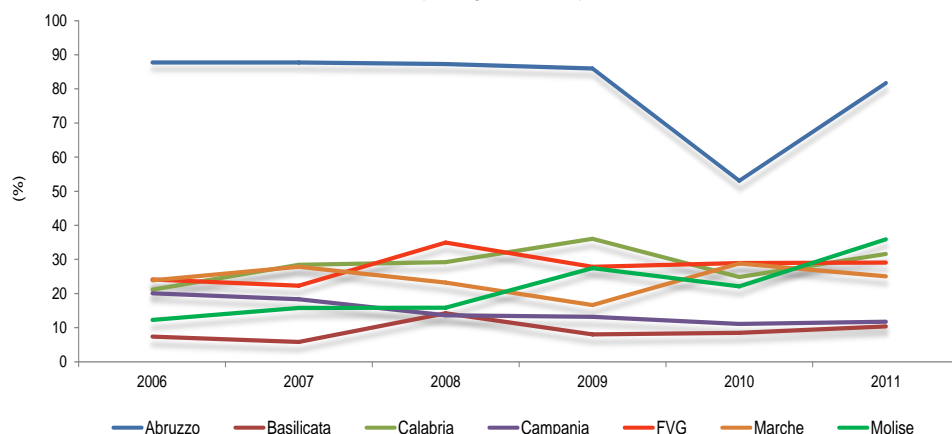
The distributions of prevalence of HIV-positive subjects by Region in 2010 and 2011 showed a marked decrease of 8.2 percentage points in the Region of Sardinia (29.4% in 2010 vs. 21.2% in 2011) and other more limited decreases in the Regions of Tuscany (10.7% in 2010 vs. 10.2% in 2011), The Autonomous Province of Trento (9.9% in 2010 vs. 9.7% in 2011), Veneto (10.0% in 2010 vs. 9.0% in 2011) and Campania (2.7% in 2010 vs. 2.4% in 2011).

There has been an on-going tendency not to test patients for viral hepatitis B over recent years as well. Of the 14 Regions which submitted data in accordance with the M.D. 20 September 1997 (ANN forms) information flow, the national percentage distribution of 'No Testing' shows the highest numbers of clients not being subjected to testing in Abruzzo (92.6%), Tuscany (92.1%) and Sicily (86.5%). On the other end of the spectrum, the Regions with the lowest percentage of clients not being subjected to testing are Campania (60.1%) and the Autonomous Province of Trento (69.0%).

Using a chi-square test to calculate trends from 2006 to 2011, we see that there was a decrease in the number of subjects testing positive for HBV in the Regions of Abruzzo, Campania, the Autonomous Province of Trento, Apulia, Sardinia and Veneto. On the contrary, an analysis of the trends shows a significant increase in the prevalence of clients in treatment testing positive for HBV in Calabria, Friuli Venezia Giulia, Molise, Sicily and Valle d'Aosta.

Differences in trends of prevalence of HIV-positive test results during the period from 2006 to 2011 for new clients and clients already known to services

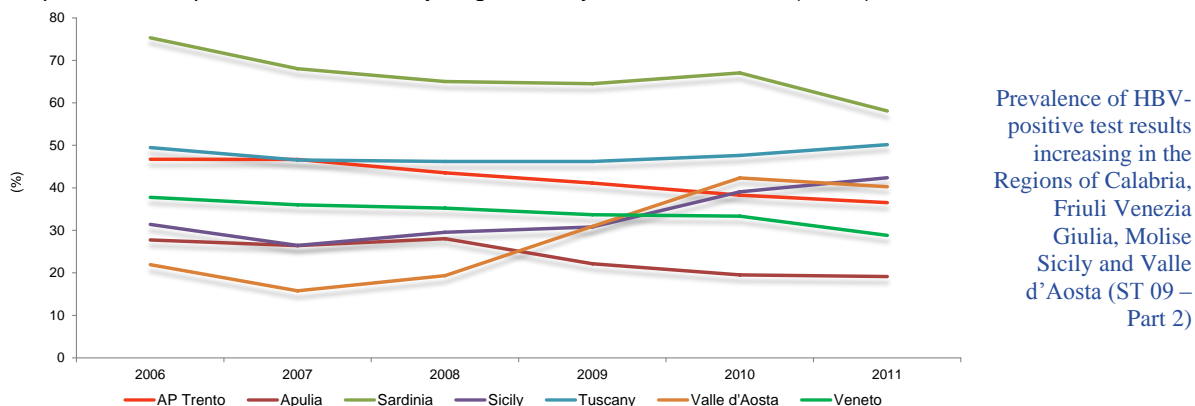
Figure 6.3: Percentage of subjects eligible for testing who were actually tested for HBV and prevalence of positive test results, by Region. The years 2006 to 2011 (Part 1)



Prevalence of HBV-positive test results decreasing in the Regions of Abruzzo, Campania, Apulia, Sardinia, Veneto and the Autonomous Province of Trento (ST 09 – Part 2)

Source: Based on Ministry of Health data submitted by the Regions and Autonomous Provinces

Figure 6.4: Percentage of subjects eligible for testing who were actually tested for HBV and prevalence of positive test results, by Region. The years 2006 to 2011 (Part 2)



Source: Based on Ministry of Health data submitted by the Regions and Autonomous Provinces

An in-depth analysis of the two groups of patients, new and already known to services (ST 09, Part 2) confirms significant variation in trends, either rising or falling, for both groups and for the majority of Regions which submitted data (10 out of 14).

Among new clients subjected to HBV testing, the prevalence of positive results was found to be falling in five Regions (Campania, Apulia, Sardinia, Tuscany and Veneto) but rising in the Regions of Calabria, Friuli Venezia Giulia and Molise, while the remaining six Regions displayed no significant variations in the trend of HBV-positive test results.

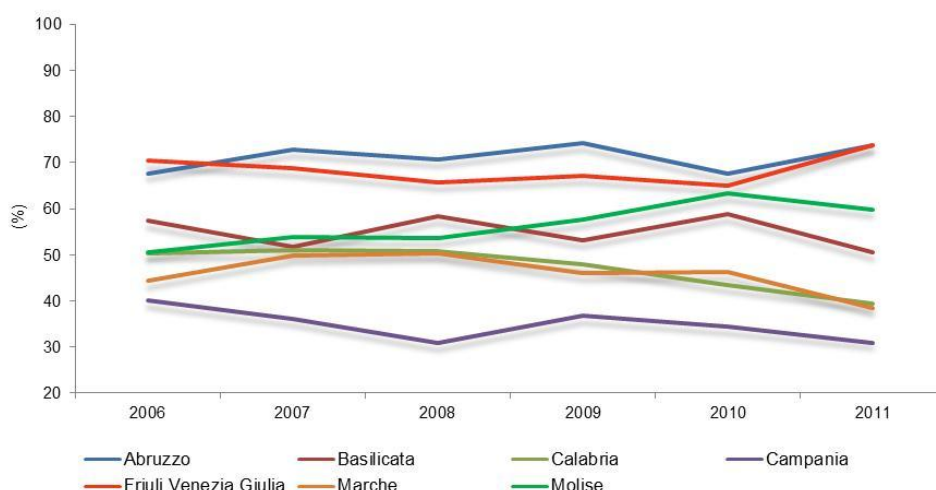
There was found to be greater variability among clients already known to services in comparison with new clients; indeed, it is only in four Regions that trends in HBV-positive test results showed no variation between 2006 and 2011. In the majority of the Regions (Abruzzo, Campania, Apulia, Sardinia, Veneto and the Autonomous Province of Trento) the percentage of HBV-positive clients already known to services decreased, in contrast with the rising trends in the Regions of Calabria, Molise, Sicily (Regions in which there was also found to be a rise in prevalence of HBV-positive results among new clients) and Valle d'Aosta.

If we focus on the two-year period spanning 2010-2011, we find that the distribution of prevalence of HBV-positive test results by Region shows a decline of 8.9 percentage points for the Region of Sardinia (67% in 2010 vs. 58.1% in 2011), in contrast with a considerable increase of 28.7 percentage points in the Region of Abruzzo (53.1% in 2010 vs. 81.8% in 2011).

We can see that the same alarming situation which for HIV and HBV also exists for HCV, with a wide spread of the virus and a low number of tests being performed. Of the 14 Regions which submitted information from the M.D. 20 September 1997 data flows, 'No Testing' percentages show that the Regions which perform the least testing are Tuscany (90.2%), Abruzzo (90.2%) and Valle d'Aosta (89.9%).

An analysis of trends in the prevalence of subjects testing positive for HCV in the period from 2006 to 2011 reveals a decrease in the Regions of Calabria, Campania, Marche, the Autonomous Province of Trento, Apulia, Sardinia and Sicily. The Regions where, on the other hand, the prevalence trend was shown to be rising between 2006 and 2011 were Tuscany and Veneto.

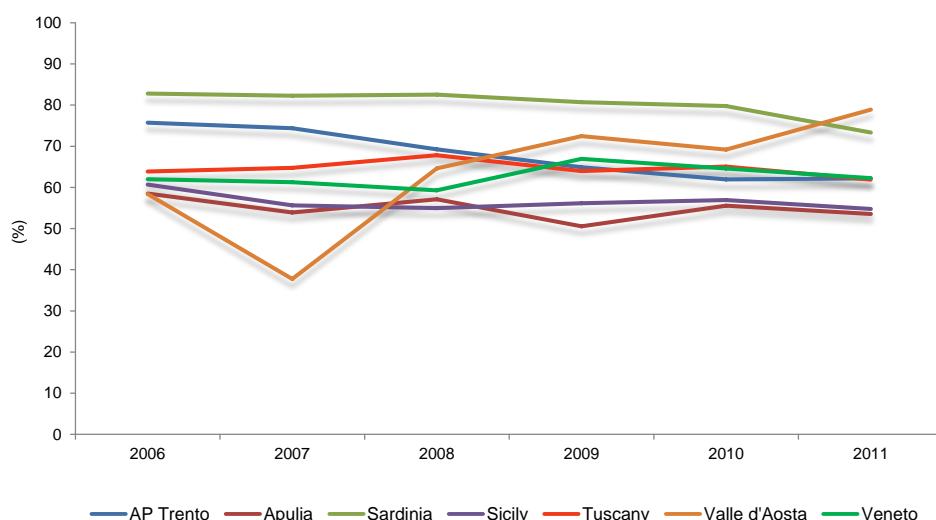
Figure 6.5: Prevalence of HCV-positive clients, by Region The years 2006 to 2011 (Part 1)



Prevalence of HCV-positive test results decreasing in the Regions of Calabria, Campania, Marche, Apulia, Sardinia, Sicily and the Autonomous Province of Trento (ST 09 – Part 2)

Source: Based on Ministry of Health data submitted by the Regions and Autonomous Provinces

Figure 6.6: Prevalence of HCV-positive clients, by Region. The years 2006 to 2011 (Part 2)



Prevalence of HCV-positive test results increasing in Tuscany and in Veneto (ST 09 – Part 2)

Source: Based on Ministry of Health data submitted by the Regions and Autonomous Provinces

In approximately half of the Regions, the trend in HCV-positive test results appears to be either significantly increasing or decreasing, both among new clients and clients already known to services.

Among new clients in the six Regions of Campania, Apulia, Sardinia, Sicily, Tuscany and the Autonomous Province of Trento, the prevalence of HCV-positive test results was found to have fallen in the period from 2006 to 2011, while it was shown to have risen only in the Region of Molise. Among clients already known to services, the number of positive serological test results fell in most of the Regions as well (Calabria, Campania, Marche, Apulia, Sardinia, Sicily and the Autonomous Province of Trento), while the only rise in numbers was found in the Marche Region. A comparison of 2010-2011 data for the prevalence of HCV-positive clients by Region reveals a decline of 8.4 percentage points in the Basilicata Region (58.9% in 2010 vs. 50.4% in 2011) and, on the other hand, a considerable increase of 9.8 percentage points in the Region of Valle d'Aosta (69.1% in 2010 vs. 78.9% in 2011).

6.2 Other drug-related health correlates and consequences

The following analysis draws upon accident statistics collected by the National Institute of Statistics (ISTAT) by means of a comprehensive monthly collection of data on traffic accidents where persons were harmed (killed or injured), carried out nationwide over the course of one calendar-year. Accidents where the only damage was to property were not included in the calculation.

The European Union's White Paper of 13 September 2001 set the goal that mortality caused by traffic accidents would have fallen by 50% by 2010.

The number of traffic accidents in Italy where persons were harmed fell from 263,100 to 211,404 between 2001 and 2010, a 19.6% decrease. In the same time period, the number of deaths shrank from 7,096 to 4,090 (-42.4%) and the number of injuries from 373,286 to 302,735 (-18.9%).

If we consider that, during the same span of time (2001-2010) the vehicle fleet grew by approximately 17%, the Italy's performance should be deemed satisfactory, even if the goal (a 50% reduction) was not attained. A comparison shows that the Italian figure is in line with the figure for the EU-27 (-42.4% vs. -42.8%) .

In 2010, in comparison with 2009, there were decreases in the numbers accidents (-1.9%) and injuries (-1.5%) and an even greater decrease in the number of deaths (-3.5%).

A comparison of data from 2009 and 2010 shows largely stable numbers for accidents and injuries caused by both alcohol and drugs, while the situation regarding deaths is more variable, with deaths caused by alcohol falling from 4.25% to 3.33% while those caused by drugs rose from 0.83% to 1.47% .

Table 6.1: Accidents and their causes, absolute values and percentages, the years 2009-2010

| | 2009 | | | 2010 | | |
|--------------------|----------------|--------------|----------------|----------------|--------------|----------------|
| | Accidents | Deaths | Injuries | Accidents | Deaths | Injuries |
| Alcohol | 5,597 | 180 | 8,638 | 5,400 | 136 | 8,276 |
| Drugs | 848 | 35 | 1,489 | 916 | 60 | 1,471 |
| Total | 6,445 | 215 | 10,127 | 6,316 | 166 | 9,717 |
| No substance | 208,960 | 4,022 | 297,131 | 205,088 | 3,924 | 293,018 |
| Grand Total | 215,405 | 4,237 | 307,258 | 211,404 | 4,090 | 302,735 |
| Alcohol | 2.60% | 4.25% | 2.81% | 2.55% | 3.33% | 2.73% |
| Drugs | 0.39% | 0.83% | 0.48% | 0.43% | 1.47% | 0.49% |
| Total | 2.99% | 5.08% | 3.29% | 2.98% | 4.80% | 3.22% |

Source: Department for Anti-drug Policies, based on data from the National Institute of Statistics

Italy 2001-2010

19.6% decrease in traffic accidents;
42.4% decrease in deaths;
18.9% decrease in number of people injured

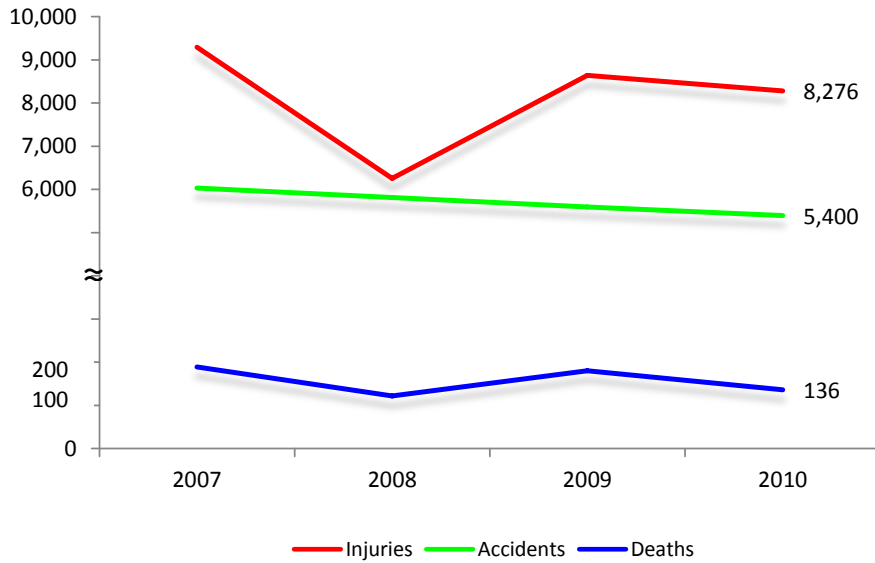
Growth of vehicle fleet:
+17%

Situation overview

Deaths caused by drugs rose to 1.47% from 2009 to 2010, while deaths caused by alcohol fell to 3.33%

Nearly 5% of deaths were officially caused by alcohol or drugs in 2010

Figure 6.7: Trends in alcohol-related traffic accidents, deaths and injuries in Italy, the years 2007-2010 – absolute values

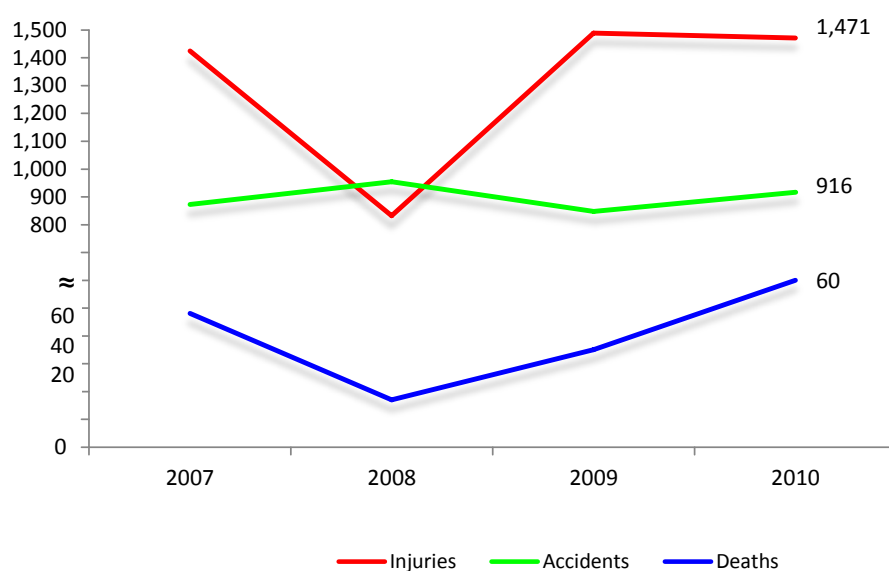


Alcohol-related accidents cause far more deaths than accidents on average

Source: Based on data from the National Institute of Statistics

In Figure 6.7, a very stable trend is shown for alcohol-related accidents, while it is important to note the increase in absolute values for deaths and injuries in the years 2009 and 2010. The same phenomenon, on a greater scale, can be observed for drug-related deaths, as shown in the following Figure 6.8.

Figure 6.8: Trends in drug-related traffic accidents, deaths and injuries in Italy, the years 2007-2010 – absolute values



Drug-related accidents also cause far more deaths than accidents on average

Source: Based on data from the National Institute of Statistics

Table 6.2: Confirmed violations of Articles 186 and 187 of the Traffic Code and percentages of the total for each of these – Italy – the years 2009-2011

| | 2009 | 2010 | 2011 | %09 | %10 | %11 |
|---|-----------|-----------|-----------|-------|-------|-------|
| Driving under the influence of alcohol (Art. 186) | 26,785 | 24,744 | 25,956 | +1.09 | +1.04 | +1,07 |
| Driving under the influence of drugs (Art. 187) | 2,211 | 2,083 | 2,003 | +0.09 | +0.09 | +0,08 |
| Total violations of Articles 186 and 187 | 28,996 | 26,827 | 27,959 | +1.18 | +1.13 | +1,15 |
| Total Traffic Code Violations | 2,448,641 | 2,369,540 | 2,426,956 | | | |

Source: Based on data from the Ministry of the Interior – Traffic Police

Confirmed alcohol-related violations account for more than 1%

An examination of Table 6.2 reveals that the number of violations confirmed by the Traffic Police under Art. 186 of the Traffic Code have been increasing, just as the total number of overall violations has risen. However, violations under Art. 187 of the Traffic Code show a further decline. The ratio of alcohol- and drug-related violations to the overall total number of violations shows us a rising trend for violations of Art. 186 and a decrease, on the other hand, of violations under Art. 187 of the Traffic Code.

More checks, less violations

6.3 Drug related deaths and mortality of drug users

6.3.1. Drug-induced deaths (overdoses)

As per the instruction of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon, the following section on the mortality of drug users will be divided into deaths by acute intoxication, or overdose, and deaths among drug addicts due to other causes. This section will address the former, while the following section will examine the deaths of patients hospitalised for drug-related diseases.

In Italy, incidences of overdose are recorded in the Special Death Register of the Central Directorate for Anti-Drug Services of the Ministry of the Interior, where incidents in which the Police Forces have been involved are recorded on an evidential basis (i.e. unmistakable signs of drug-induced intoxication).

Data provided by the Central Directorate for Anti-drug Services shows that, after 1999, a year in which 1,002 deaths by overdose were recorded, there was a decline in the phenomenon which lasted until 2003, when the number of deaths was 517. Numbers remained largely stable from 2004 to 2007, albeit with some limited variability, at between 551 and 653 deaths. The following years saw a new decline, with numbers reaching their lowest point in 2011, with 362 deaths (Figure 6.9). The direction of the trend has been largely similar for men and women, although the ratio of male to female deaths is approximately 9 men per every one woman (9.3); this ratio varies between a minimum of 6.5 in 2011 (when 13.3% of the deaths were among women) and a maximum of 11.8 in 2004-2005 (when women accounted for 7.8% of these deaths) (Table 6.3).

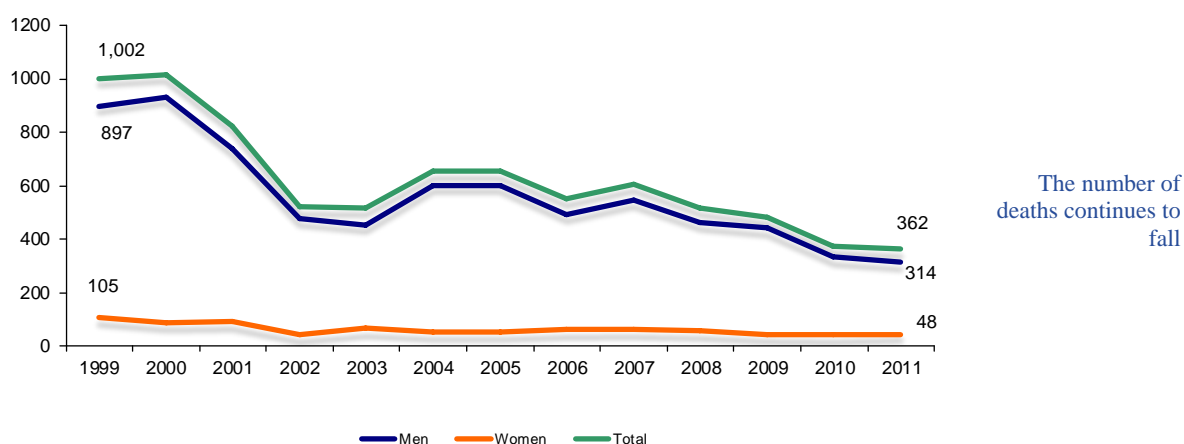
Sharp decrease in the number of drug-related deaths: from 1,002 deaths in 1999 to 362 in 2011

Table 6.3: Trend in deaths by overdose, by gender and year of death. The years 1999 – 2011

| | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|------|-------------|-------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| M | 897 | 931 | 737 | 478 | 454 | 602 | 602 | 492 | 546 | 462 | 440 | 332 | 314 |
| F | 105 | 85 | 88 | 42 | 63 | 51 | 51 | 59 | 60 | 55 | 44 | 42 | 48 |
| Tot. | 1002 | 1016 | 825 | 520 | 517 | 653 | 653 | 551 | 606 | 517 | 484 | 374 | 362 |
| M/F | 8.5 | 11.0 | 8.4 | 11.4 | 7.2 | 11.8 | 11.8 | 8.3 | 9.1 | 8.4 | 10.0 | 7.9 | 6.5 |

Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services

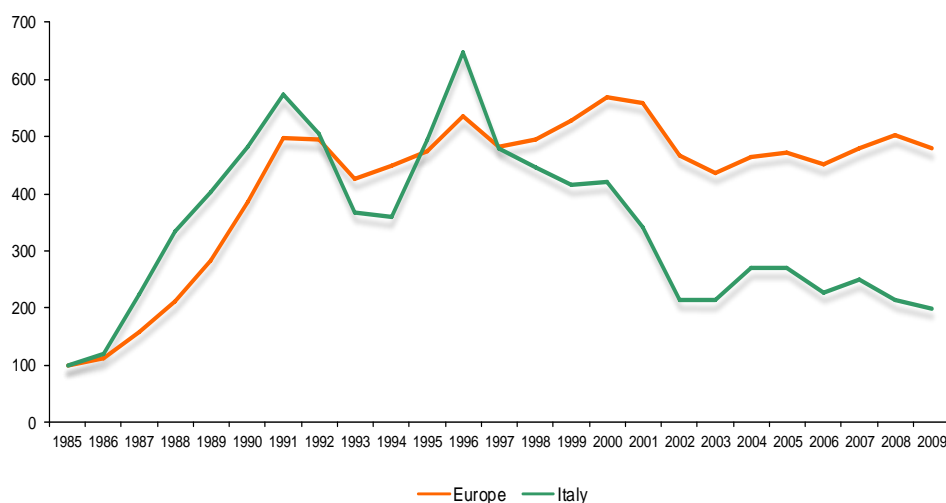
Figure 6.9: Trend in deaths by overdose, by gender and year of death. The years 1999-2011



Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services (CDAS)

The number of deaths by acute narcotic drug-induced intoxication in Europe and Italy shot up during the Nineteen-Eighties and early Nineteen-Nineties. In Italy, these deaths were mostly linked to heroin use and injecting drug use. Beginning in 1997, this mortality rate in Italy began a progressive decline which continued until 2002, probably due to the increase during those years in the number of facilities offering treatment services and to diversification in choice of drug type on the part of users. During the following period, spanning the years from 2003 to 2009, the trend levelled off with slightly greater figures, unlike the European average trend, which also levelled off, but with higher numbers. (Figure 6.10).

Figure 6.10: Trends in index values for deaths by acute narcotic drug-induced intoxication in Europe and in Italy. The years 1985 – 2009 (Base year 1985 = 100)



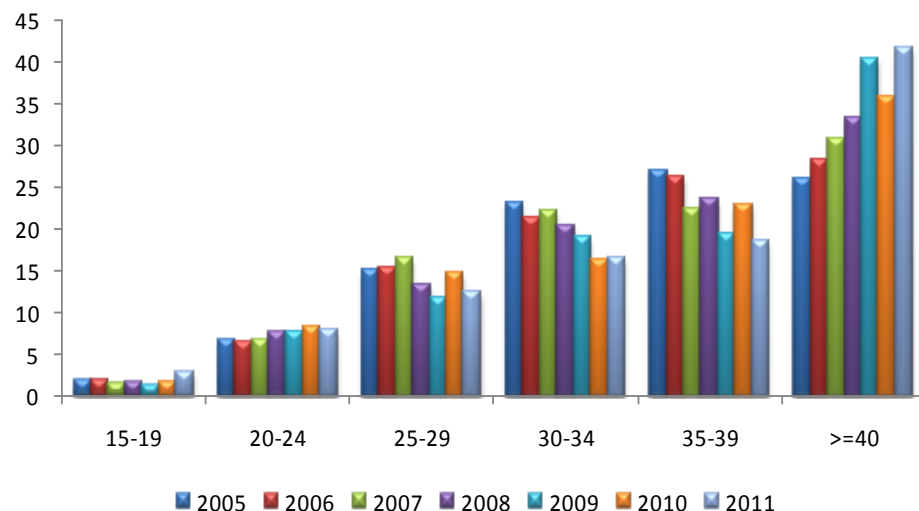
Greater decrease in deaths in Italy than in Europe overall

Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services and the European Monitoring Centre for Drugs and Drug Addictions – 2011 Statistical Bulletin

Over the most recent ten-year period, the average age of death increased progressively, rising from approximately 32 years of age in 1999 to 37 in 2011. If, at the beginning of the time period of reference, approximately 31% of deaths were of people over 35 years of age, in 2011 that figure rose to approximately 60%, the highest value yet, together with the figure recorded in 2009. If we analyse the trend by drawing a distinction between the genders, we find largely similar characteristics, although there is a greater variability where women are concerned during the time period being considered. For both genders, mortality has been increasing for the over-40 age group. If we examine the year 2011, we see a reduction in deaths in the 25- to 29-year-old age group and in the 35- to 39-year-old age group, both for men and for women. For women alone, there was also a decrease in deaths in the 20- to 24-year-old age group.

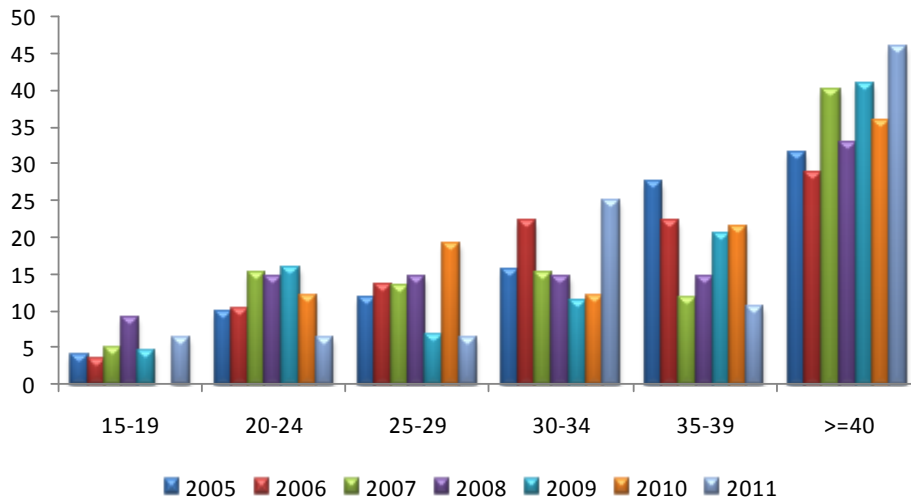
Increase in the average age of death: from 32 in 1999 to 37 in 2011

Figure 6.11: Percentage distribution of deaths by overdose in the male population, by age group. The years 2005 – 2011



Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services

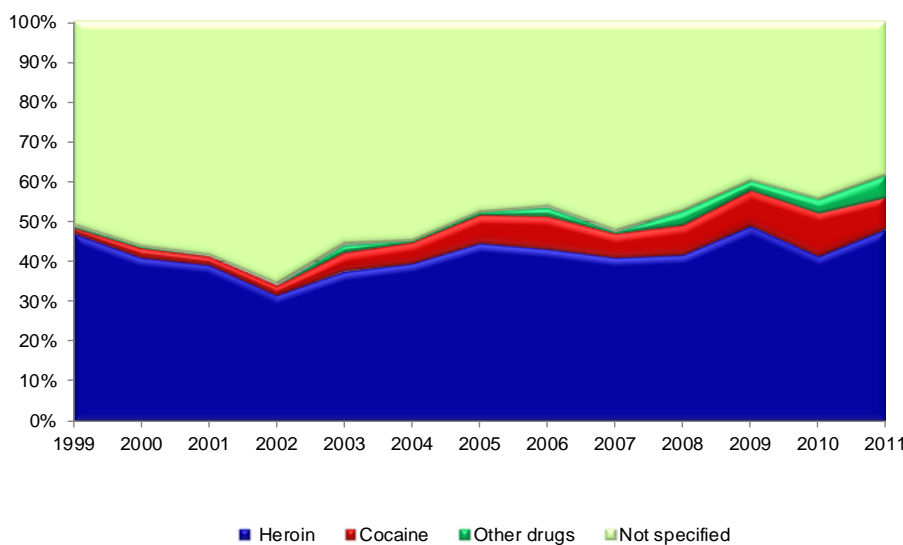
Figure 6.12: Percentage distribution of deaths by overdose in the female population, by age group. The years 2005 – 2011



Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services

Gender differences emerge in the young adult age group (20-24 years of age) and among the very young (15-19 years of age), where percentages of deaths are higher for girls and women. In the youngest age group, we can observe a decrease over time in the percentage of deaths among boys which lasted until 2009, followed by a slight increase over the last two years. Among the youngest, however, girls always account for a greater percentage of deaths than boys, with the highest figure reached in 2008 (9.1%). No deaths were recorded among the youngest girls 2010, while in 2011 the figure stood at 6.3% (Figure 6.12).

Figure 6.13: Percentage of deaths attributed to overdose, by drug type. The years 1999 – 2011



Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services

In approximately 38% of deaths recorded in 2011, it was not possible to detect the substance which had presumably caused the death (we remind the reader that findings were not based on toxicological analyses but on

purely circumstantial elements). In 48% of cases, the cause of death could, with reasonable certainty, be traced back to heroin, while in 8% of cases it could be traced back to cocaine, to methadone in 4% of cases and to other substances in the other 1% (these include one death caused by MDMA, one by methamphetamine, one by crack, one by hashish and two by barbiturates). Heroin therefore reaffirms its place as the narcotic which causes the greatest number of deaths and drug addictions. As in 2010, the average age for deaths caused by both heroin and cocaine was 37.

Of all drugs, heroin is the number one cause of death

After 1999, when 470 deaths were recorded as being attributable to heroin, there was a decline in the phenomenon which lasted until 2002, when the number of deaths fell to 165. Between 2004 and 2009, with the exception of a peak in 2005, numbers remained largely stable at between 200 and 250 cases per year. 2010 saw another sharp drop in numbers (154 deaths, equal to -34.7%). In 2011, however, the number of deaths caused by heroin rose to 174 (+13%). As far as regards deaths attributable to cocaine overdose, this figure rose slowly but steadily until 2010, then dropped in 2011, falling from 41 to 29 deaths (-29.3%) (Figure 6.13).

Decline in the number of cocaine overdoses, increase for heroin

6.3.2. Mortality and causes of deaths among drug users

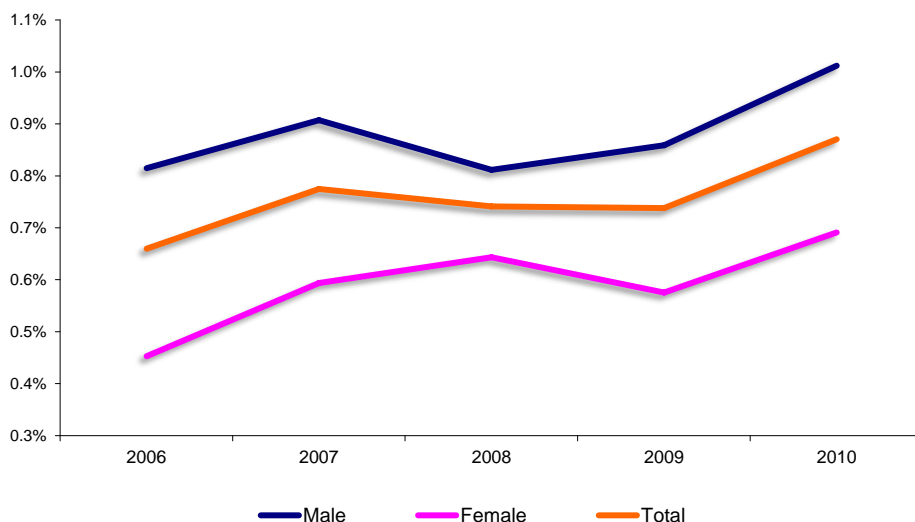
Acute intoxication from one or more psychoactive drugs is the most common cause of death among drug users, but the phenomenon of mortality extends to other causes as well, some less immediately "attributable" to the direct effect of the same drug (death from heart problems or liver disease) or deaths indirectly related to the use of drugs (e.g. accidents, medical conditions or diseases directly linked to, but different from, acute intoxication).

It is still difficult to reconstruct the various causes of drug-related deaths

Attribution of cause of death is based upon the first diagnosis of cause of death made by the doctor certifying death or by the doctor conducting the post-mortem examination, and not upon specific clinical documentation. There is therefore an issue of proper and complete clinical verification of the "initial cause" or, in other words, "the disease, or cause, which set off the chain of events which resulted in death".

Premature death, which may affect very young people as well as people who are not necessarily addicted or in chronic situations, can be caused both by natural causes (above all infections and cardiovascular problems/complications) and by non-natural causes (overdose, suicide, homicide, traffic and workplace accidents). These elements, however, are rarely recorded as being linked to the action of psychoactive drugs. Additional information regarding drug-related deaths, although only partial compared to the above, may be deduced from analysis of hospital discharge forms from cases of drug-related hospital admissions.

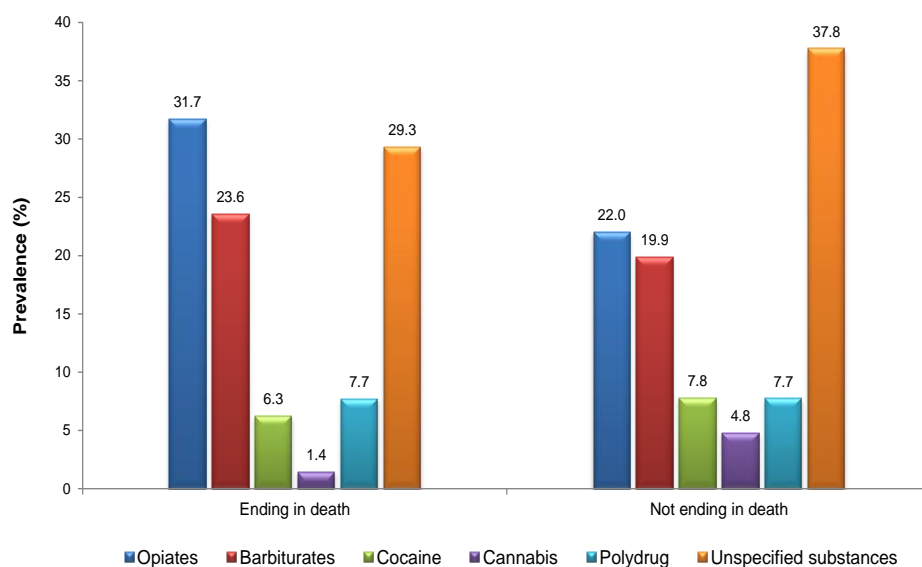
Figure 6.14: Rate of drug-related hospital admissions ending in death (hospitalisations per 100,000 residents), by gender. The years 2006 – 2010



Source: Based on information contained in Hospital Discharge Records – Ministry of Health

Once again in 2010, the most recent year for which data is available, Hospital admissions ending in death account for less than 1% of total drug-related hospital admissions (208). A comparison of rates of hospital admissions ending in death over the last five years shows a decline during the period from 2007 to 2009 (206 in 2007, 192 in 2008 and 177 in 2009) followed by an increase in deaths for the most recent year (17.5%). If we consider the numbers by gender, we find an increase in deaths for both genders in 2010 with respect to 2009; among male patients there was an increase in deaths to 1.0% of all male patients admitted (0.81% in 2008 and 0.7% in 2010) and, among female patients, an increase to approximately 0.7% (0.65% in 2008 and 0.58% in 2009).

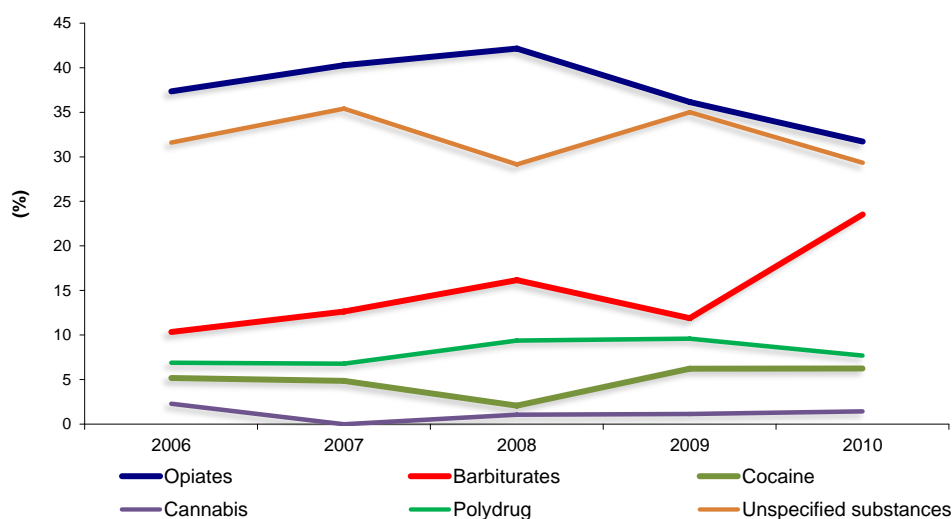
Figure 6.15: Percentage of drug-related hospital admissions ending in death and not ending in death, by drug type. The year 2010



Source: Based on information contained in Hospital Discharge Records – Ministry of Health

Between 2006 and 2010, the drugs which caused the greatest numbers of deaths were opiates; deaths caused by opiates increased until 2008 (37.4% in 2006, 40.3 % in 2007 and 42.2% in 2008) to then decrease over the following two-year period (36.2% in 2009 and 32.7% in 2010). Deaths caused by unspecified substances fell over the most recent two-year period (from 11.8% in 2009 to 23.6% in 2010). Among those drugs which caused lower percentages of deaths, the number of deaths caused by barbiturates rose by 11.7 percentage points, from 21 deaths in 2009 to 49 deaths in 2010, with subjects over 65 years of age emerging as those especially affected by this trend.

Figure 6.16: Percentage of drug-related hospital admissions ending in death, by drug type. The years 2006 - 2010



Source: Based on information contained in Hospital Discharge Records – Ministry of Health

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

Italy had its first experiences in preventing drug-related diseases in the early 1990s. These involved mostly the need to deal with the emergency of the spread of HIV among drug addicts. These initial experiences were extremely important, from both epidemiological and epistemological viewpoints. In other words, while they proved effective at combating the spread of HIV, they also made a marked contribution to consolidating a pragmatic approach to drug addiction. This was the start of the trend to contact and “take into care” those not being treated at drug treatment services because at that time in their lives they did not wish to stop using drugs.

After over fifteen years of working to prevent the spread of drug-related diseases and to reduce the risk and the harm caused by drugs in Italy, the range of services and initiatives continues to be heterogeneous and diversified, while the anti-drug strategy of the Council of Europe still highlights the importance of reducing harm in social and health spheres.

7.1. Prevention of drug-related emergencies and reduction of drug-related deaths

The 2010 – 2013 National Action Plan on Drugs devotes a large section to the treatment and prevention of drug-related diseases, with a specific action area covering the following goals:

1. To further integrate drug-related disease prevention as a part of treatment programmes.
2. To establish new national operational guidelines for the launch, maintenance and/or refocusing of drug-related disease prevention activities throughout the country.
3. To prevent and reduce the risk of death by overdose.
4. To prevent and reduce the risk of acquiring and transmitting drug-related infectious diseases including HIV, the viral hepatides, TBC and sexually transmitted diseases.
5. To launch gender-oriented programmes.
6. To prevent and reduce the social risks linked to drug use: marginalisation; discrimination; stigmatisation; involvement in criminal networks; incarceration; loss of positive social networks; prostitution; leaving school and loss of learning capacity; loss of employment and loss of production capacity.

As described in Chapter 5, a study was conducted between the end of 2011 and the beginning of 2012 to monitor regional best practices in the field of “addictions” under the various action areas and evaluate them in relation to the National Action Plan on Drugs 2010-2013.

A criterion of “conformity” (presence-absence) was adopted for the purposes of the evaluation, using a scale of 1 to 4, where 1 was equivalent to no such action present and 4 meant that the action established in the NAPD had been adopted as a routine practice by the administration of the Region in question.

First approaches to
harm reduction in
Italy

Goals of the
National Action
Plan on Drugs

Monitoring
Regional best
practices in the
addictions field in
relation to the
NAPD

With reference to the six NAPD goals dedicated to the prevention of drug-related diseases, the survey showed that, of these, the NAPD goals least implemented by the Regions and Autonomous Provinces were those having to do with the launch of gender-oriented programmes.

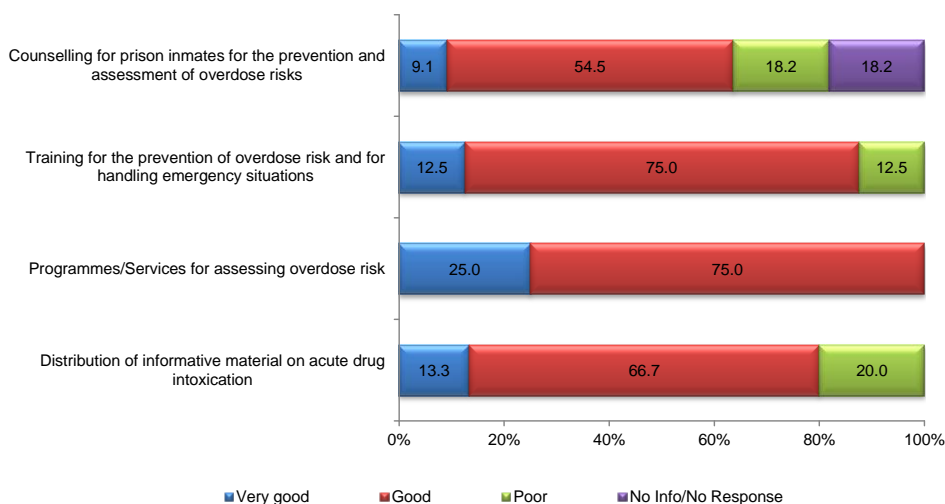
NAPD goals least implemented by the Regions

The goals in this action area which Regions and Autonomous Provinces have implemented most, on the other hand, are those which have to do with the reduction of acute drug-related mortality, the management of patients with drug-related diseases, reducing the transmission of infectious diseases (HIV, HCV, etc.) and reducing the risk of death by overdose. Other NAPD objectives which have been widely implemented at a regional level are the reduction of social risks and family problems linked to drug use and the guaranteeing of appropriate treatment to prison inmates.

NAPD objectives most implemented by the Regions

The information collected from the Regional Administrations by means of Structured Questionnaire (SQ), 23 regarding the “Prevention and reduction of drug-related diseases and of acute drug intoxication mortality”, and specifically the reduction of drug-related deaths, shows a smaller number of death by acute drug intoxication priority prevention programmes being in effect in 2011. Informative material had been distributed in 75% of Regions, but programmes/services to assess overdose risk and emergency overdose risk prevention training were only in effect in 40% of Regions. Assessment of availability (Figure 7.1) was generally good and stood at over 60% across the board.

Figure 7.1: Assessments of availability of death by acute drug intoxication priority prevention programmes. The year 2011



Source: Based on data from the survey conducted by means of EMCDDA questionnaires sent to the Regions

There were positive findings regarding prevention programmes in recreational venues (discotheques and other places) such as, for instance, prevention information regarding the use of psychotropic drugs being distributed in 80% of discotheques and in 75% of other recreational venues. Findings regarding the placement of bins and containers for the deposit of illicit drugs, on the other hand, were negative, with none being present in the discotheques or other recreational venues of the Regions. Other types of programmes which existed in 2010 had disappeared from the discotheques and other recreational venues of 20% of Regions and

Autonomous Provinces in 2011.

The availability of prevention programmes for discotheques and other recreational venues (distribution of information for the prevention and reduction of harm associated with the use of psychotropic drugs, personnel trained in emergency medical response) was generally good, including the availability of "Chill-out rooms", which existed in less than 50% of Regions in 2010.

The assessment of the presence of personnel trained in emergency medical response in discotheques and other recreational venues was also positive across the board.

In comparison with 2010, the amount of funds set aside for the prevention of acute mortality shrank by nearly two-million Euros (-21.8%). This was largely caused by the total cut in funds invested in this area on the part of the Regions of Piedmont and Apulia and the dramatic slash in such funding by the Region of Tuscany.

2 million Euros less
than in 2010

The Regions launched targeted, structured services in support of policies and strategies encouraging the prevention of drug-related diseases and risk limitation.

In 2011, there were 123 structured services in existence in the Regions and Autonomous Provinces (33.2% fewer than in 2010) serving over one-hundred thousand individual clients. The only type of service which increased its numbers in 2011 was that of street units dealing with problems associated with prostitution.

60 street units for
the prevention of
drug-associated
health risks.

Specifically, there were 60 street units for the prevention of drug-related health risks, 17 street units (LRD) dealing with alcohol and other risks associated with nightlife, 14 street units handling problems associated with prostitution, 21 daytime drop-in services, 3 24-hour low-threshold reception centres, 3 dormitories specialized in pathological addictions and 5 services providing for basic needs.

7.2. Prevention and treatment of drug-related infectious diseases

As described in previous chapters, the introduction of the National Information System on Addictions (SIND) in 2012, with its content of data on individual clients receiving treatment from addiction services in 2011, made it impossible to make a complete collection of data in all of the regions, and it was therefore not possible to paint a picture of the overall national profile regarding a number of indicators, including the DRID indicator.

Scale of the
phenomenon in
Italy

Nonetheless, from an analysis of the regional data received, it can be seen that the tendency not to test clients is on the rise (a trend found in 10 out of 14 regions which sent information using the previous information flow), with percentages of subjects not tested standing at higher than 80% in four regions.

These conditions make it impossible to truly describe the phenomenon of the evolution of infectious diseases among drug addicts. However, it is possible to draw a few conclusions with reference to the subjects tested in the 14 regions from which data was received.

Analyses conducted on trends in HIV prevalence from the 14 regions from which information was available (data published in each regional ST09) for the period from 2006 to 2011 reveal that most regions (10 out of 14) have not shown significant variation, while the remaining four (Apulia, Sardinia, Tuscany and Sicily) show a trend in decline.

These results are different, however, if we draw a distinction between new

clients and those already known to services. Indeed, the prevalence of HIV-positive test results among new clients increased in 2 out of 14 regions, while the prevalence among clients already known to services fell in 3 out of 14 regions.

The trend in prevalence of HBV-positive subjects between 2006 and 2011 was more variable. Of 14 Regions and Autonomous Provinces which provided data in 2011, 6 showed a falling trend in HBV-positive results, 5 displayed an increase and the phenomenon stayed stable in the remaining three.

Lastly, the trend in prevalence of HCV-positive subjects seems to have been on the decline (in 4 regions and autonomous provinces out of 14) or stable (5 regions out of 14) since 2006. Only in the Regions of Veneto and Tuscany could we find numbers found to have been rising.

From an examination of Hospital Discharge Records from the three-year period from 2008 to 2010, we can see that the number of drug-related hospital admissions fell by 7.8% during that time, with a rate of 2 per thousand total hospital admissions. Medical emergencies accounted for most of these admissions, and there is still a high percentage of voluntary discharges (9.7%), although this figure has shrunk, albeit only slightly, since 2009, when it stood at 10.5%. A comparison with the numbers from 2006 reveals that drug-related hospital admissions mostly involve diagnoses of a psychiatric nature, traumas and poisoning. It is interesting to note that the number of drug-related hospital admissions with a principal or secondary diagnosis related to infectious diseases is in decline.

There has been an on-going, long-term decline in the number of drug-related deaths, a decline which has been sharper in Italy than in Europe as a whole. In 1999, there were 1,002 drug-related deaths, while in 2011 there were 362. There has also been an increase in the average age of death, which rose from an average of approximately 32 in 1999 to 37 in 2011.

Figures regarding death by acute intoxication in Italy over the last ten years show that the highest numbers of these deaths occur in the central-southern area of the country, despite some small variation over the time period in consideration. In 2011, we can see an increase in the number of these deaths occurring in the northeast of the country, accompanied by declines in Central and Southern Italy.

Of all drugs, heroin is the primary cause of death by overdose, responsible for 48% of deaths, an increase over last year's figure (41%). It is followed by cocaine, which is responsible for 8%, a decrease over the 2010 figure (11%).

In the face of the significant decline over recent years in HIV and Hepatitis B and C testing being offered by drug addiction services, a decrease which could lead to substantial delays in the early diagnosis of said diseases and a consequent reduction of access to antiretroviral therapies, the Department for Anti-drug Policies, following the publication of the "Screening and early diagnosis of the principal drug-related infectious diseases" guidelines, has strongly supported the re-launch of the offering of testing for these important infectious diseases among the drug-addicted population.

In order to encourage the adoption and application of these guidelines, in 2011 the DPA launched a targeted project, Early Diagnosis and Treatment of Drug-related Diseases (known as DTPI), which has been entrusted to the AIDS Operative Centre of the Higher Institute of Health.

These guidelines are a follow-up to the document entitled "Measures and

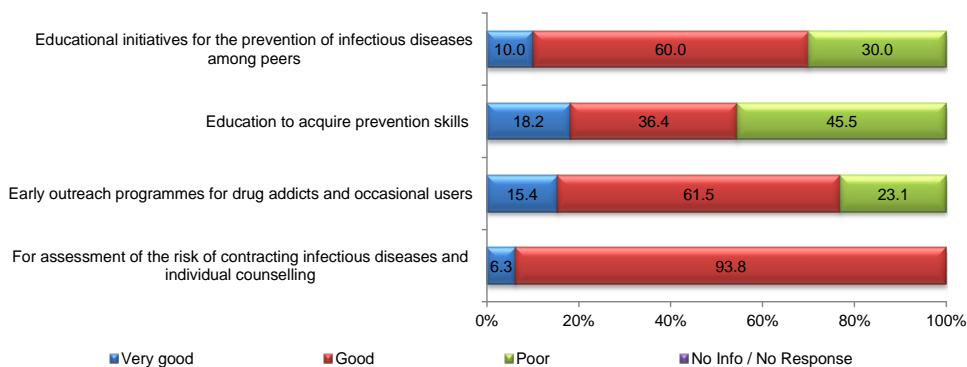
Launch of the Early
Diagnosis and
Treatment of Drug-
related Diseases
(DTPI) Project

Concrete Actions for the Prevention of Drug-related Diseases”, published and distributed in 2009.

Information regarding drug-related infectious disease prevention initiatives in prisons and in social-rehabilitation facilities was collected from Regional Administrations through the use of the EMCDDA structured questionnaire. It was found that the most common prevention initiatives were, specifically, those concerning infectious disease risk assessment and individual counselling, with 75% of Regions reporting that such actions had been carried out both in therapeutic communities (80% of Regions) and in prisons (70% of Regions); in the other Regions these types of initiatives were more commonly conducted in communities than in prisons.

Drug-related infectious disease prevention initiatives in therapeutic communities and in prisons, by Region

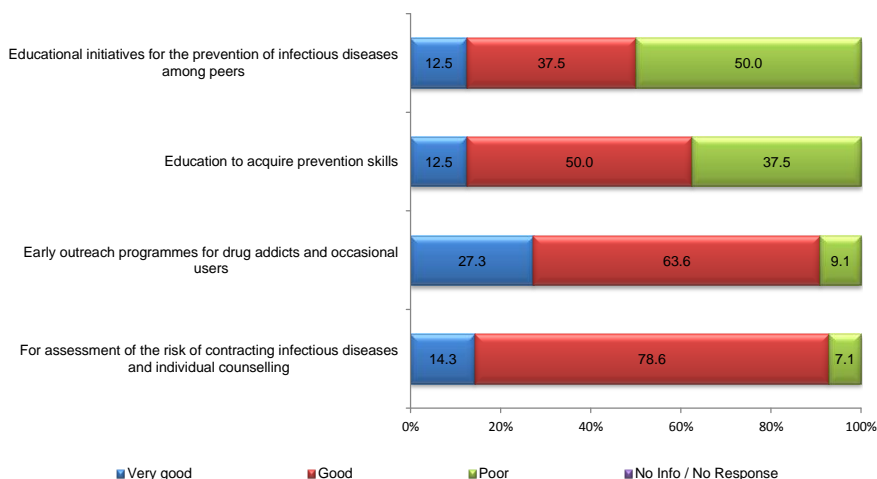
Figure 7.2: Assessment of availability of drug-related infectious disease prevention services in therapeutic communities – the year 2011



Source: Based on data gathered through EMCDDA structured questionnaires provided to the Regions

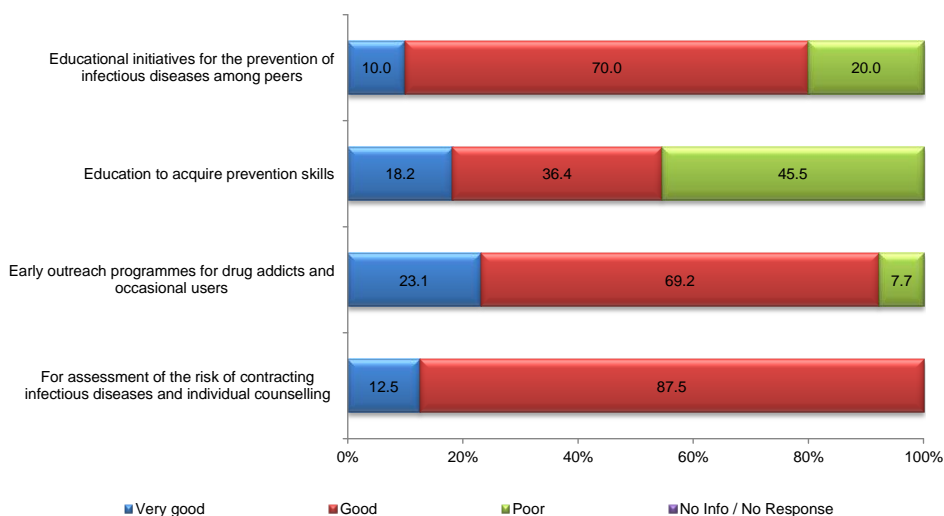
Assessments of the availability of infectious disease prevention services in therapeutic communities (Figure 7.2) and in prisons (Figure 7.3) gave overall positive findings, with services for assessing the risk of contracting infectious diseases and individual counselling services receiving especially high marks. The assessment of educational initiatives for the prevention of infectious diseases among peers improved with respect to 2010.

Figure 7.3: Assessment of availability of drug-related infectious disease prevention services in prisons – the year 2011



Source: Based on data gathered through EMCDDA structured questionnaires provided to the Regions

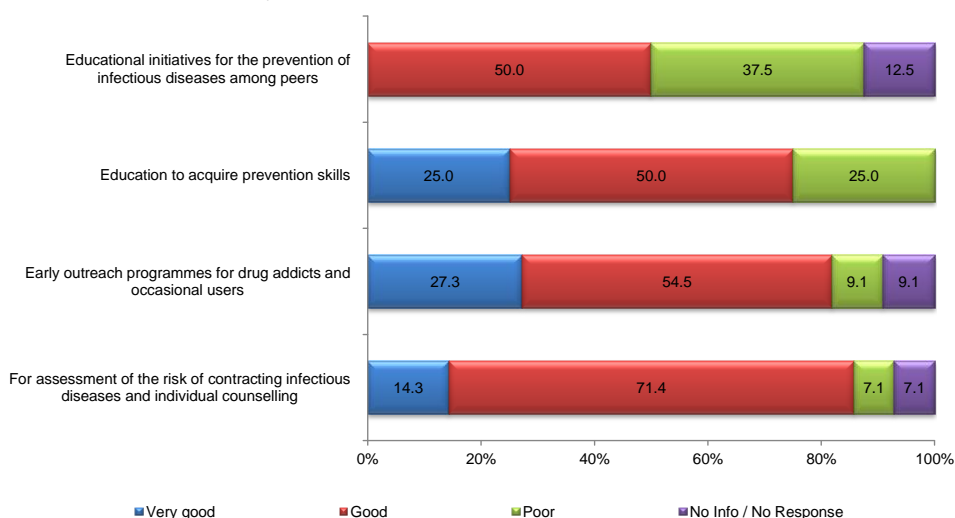
Figure 7.4: Assessment of accessibility of drug-related infectious disease prevention services in therapeutic communities – the year 2011



Source: Based on data gathered through EMCDDA structured questionnaires provided to the Regions

Accessibility of these services (Figures 7.4 and 7.5) was given a medium-to-positive evaluation. Complete information is available to subjects in therapeutic communities, while in prisons the only programmes for which results of “no information/no response” were returned were educational initiatives to acquire prevention skills.

Figure 7.5: Assessment of accessibility of drug-related infectious disease prevention services in prisons – the year 2011



Source: Based on data gathered through EMCDDA structured questionnaires provided to the Regions

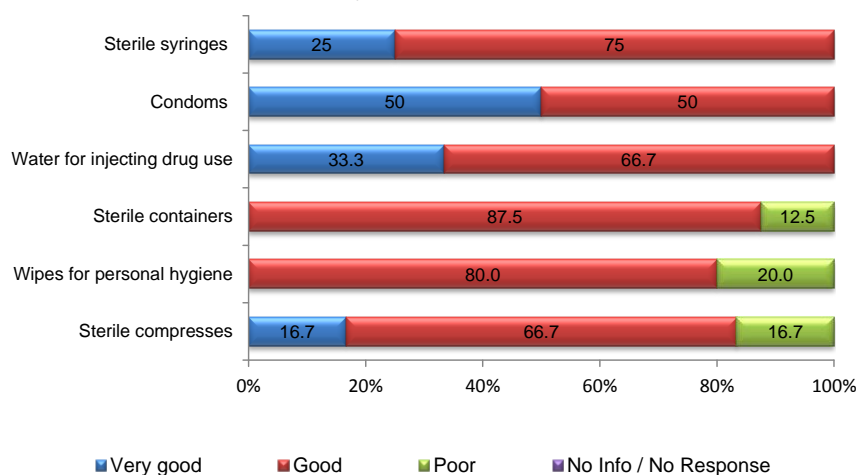
Very few regions and autonomous provinces have launched educational initiatives to acquire prevention skills which target specific groups. To be precise, only 45% have launched such initiatives for professionals in the drug addiction services field (55% for those who work in prisons), and only 10% for other groups, while not a single such initiative was launched targeting pharmacists.

However, where they do exist, educational initiatives were found to have a very good level of availability, in over 90% of cases across the board (Figure 7.6) and their level of accessibility also received an overall positive assessment.

In no more than 40% of cases was training paraphernalia distributed in the context of educational programmes to acquire prevention skills. Specifically, unlike in the previous year, tin foil was no longer employed for inhaling drugs.

Availability is good, however, everywhere paraphernalia is distributed, especially as far as regards condoms (Figure 7.6).

Figure 7.6: Assessment of availability of paraphernalia (where present) employed in education to acquire prevention skills. The year 2011



Source: Based on data gathered through EMCDDA structured questionnaires provided to the Regions

8. SOCIAL IMPLICATIONS AND SOCIAL REINTEGRATION

This chapter is devoted to the social consequences for particularly vulnerable subjects who regularly use illicit drugs. Specifically, the profiles of marginalised subjects were analysed using the information collected by means of a multicentric study conducted on 7,311 subjects undergoing treatment with drug addiction services in 2011, carried out by the Department for Anti-drug Policies (for the details of the study, see chapter 5).

The information flows employed as part of the Treatment Demand key indicator, which exist thanks to the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA), involve the gathering of data concerning subjects' living situations, in particular regarding the nuclear family within which the drug addict lives on a day-to-day basis and the type of accommodation it is. This information is collected by Drug Addiction Services and forms part of the core data that makes up the individual information flow for each client undergoing treatment (the National Information System on Addictions [SIND] information flow).

Further information was recorded by providing the Regional Administrations responsible for issues concerning drug addiction with EMCDDA Structured Questionnaire SQ 28 to complete.

Foreword

Sources of information

TDI data

SQ 28 data

8.1 Social exclusion

8.1.1 Social exclusion among drug users

An analysis of the characteristics of the individuals comprising the sample group for the Department for Anti-drug Policies' (DPA) Multicentric Study on Public Drug Treatment Units (SerTs) makes it possible to sketch a profile of the employment situation of subjects undergoing treatment with drug addiction services for the use of psychotropic drugs.

In the sample group in question, it was found that 33.7% of all clients were unemployed, while 52.3% were employed in some capacity and in various ways (occasionally or continuously).

The employment situation appears to be more critical among female clients and among clients already known to Services, of whom respectively 41.1% and 36.2% are unemployed, compared to 32.5% of male clients and 31.4% of new clients.

52.3% of Public Drug Treatment Unit (SerT) clients are employed in some capacity; 33.7% are unemployed

Table 8.1: Percentage distribution of drug addiction services clients according to type of employment, gender and type of client (new or returning). The year 2011

| Type of employment | New clients | | | Returning clients | | | Total | | |
|------------------------------------|-------------|------|------|-------------------|------|------|-------|------|------|
| | M | F | Tot | M | F | Tot | M | F | Tot |
| occasionally employed | 7.7 | 9.0 | 7.9 | 8.0 | 6.6 | 7.8 | 7.8 | 8.0 | 7.9 |
| stable employment | 48.9 | 29.2 | 45.9 | 45.0 | 26.9 | 42.8 | 47.0 | 28.2 | 44.4 |
| student | 6.4 | 14.2 | 7.5 | 3.4 | 10.2 | 4.2 | 4.9 | 12.5 | 5.9 |
| unemployed | 30.1 | 38.7 | 31.4 | 35.1 | 44.3 | 36.2 | 32.5 | 41.1 | 33.7 |
| retired/house spouse/disabled/etc. | 3.7 | 7.2 | 4.2 | 5.0 | 9.9 | 5.6 | 4.3 | 8.3 | 4.9 |
| other | 3.3 | 1.8 | 3.1 | 3.5 | 2.1 | 3.4 | 3.4 | 1.9 | 3.2 |

Higher level of unemployment among women and among clients already known to services (41.1% and 36.2%)

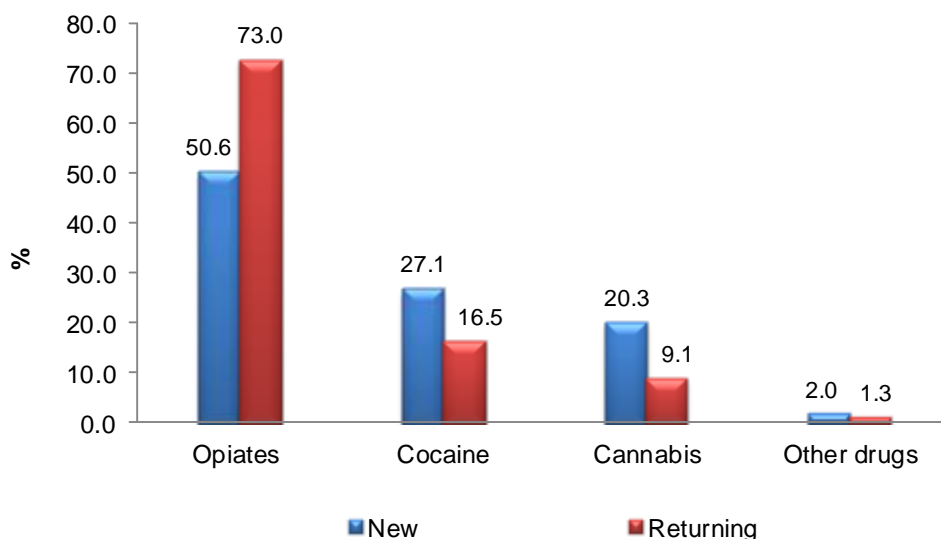
Based on information from the Department for Anti-drug Policies' 2010 Multicentric Study compiled from Public Drug Treatment Unit (SerT) data.

Comparing these two groups based on employment rate, we find a higher percentage among new clients (53.8% vs. 50.6%), a situation which is reflected among those clients who are still students, with 7.5% of new clients currently studying, but only 4.2% of clients already in the care of Public Drug Treatment Units.

As far as “primary” substance of abuse is concerned, if we consider the percentage of opiate users among the unemployed in comparison with the percentage of these in the overall client community, we can see that there is a slightly higher percentage of opiate users among unemployed subjects than among the total sample group (62.7% of the unemployed vs. 56.1% of the total sample). On the other hand, there is a lower percentage of cocaine users among the unemployed than in the sample group as a whole (21.4% vs. 23.9%), a situation which is reflected among cannabis users (14.3% vs. 18.4%).

Among unemployed drug addiction services clients, we can see that there are substantially different amounts of unemployed opiate users approaching services for the first time (new) in comparison with clients who are already known to the services for their use of these types of drugs (50.6% vs. 73.0%). On the contrary, the percentage of unemployed cocaine and cannabis users who are already known to services is considerably lower than the percentage of unemployed new clients who use those drugs (-10.6% and -11.2% respectively) (Figure 8.1).

Figure 8.1: Percentage distribution of unemployed drug addiction services clients according to drug type and type of client (new or returning) – The year 2011



Source: Based on information from the Department for Anti-drug Policies’ 2011 Multicentric Study compiled from Public Drug Treatment Unit (SerT) data.

The group in question appears to be characterised by a more critical drug addiction profile in comparison with the community of drug addiction services clients as a whole. As a matter of fact, among the unemployed we find higher numbers of injecting drug users (40.4% in comparison with 33.8% of the client community as a whole), of subjects who use cocaine as a secondary drug (24.5% in comparison with 15.6% of the client community as a whole) and who use alcohol as a secondary substance (11.6% in comparison with 10.7% of the client community as a whole). As far as treatment is concerned, it was found that 60.2% of unemployed

subjects had never received any pharmacologically-assisted treatment, but solely psychological support (53.1%) or solely psychological and social support (26.8%).

Homelessness

Based on the Multicentric Study conducted by the Department for Anti-drug Policies in 2012 (using 2011 data from Public Drug Treatment Services) it is possible to identify specific characteristics of subjects undergoing treatment with drug addiction services which concern their housing situations (whether they have a permanent residence, live in some type of facility or are homeless).

Of the sample group under consideration, 88.7% reported having a permanent residence, while 4.3%, on the other hand, were homeless. Data from the study shows that, among service clients who are homeless, there are a higher percentage of men than of women (89% vs. 11%), and a higher number of returning clients than new ones (51.1% vs. 48.9%).

An in-depth analysis based on gender and type of client (new or returning) shows that 87.5% of new clients and 90% of returning Public Drug Treatment Unit (SerT) clients have a permanent residence, with more women having a permanent residence than men, regardless of whether they are new or returning clients. The percentage of subjects who reported living in various types of facilities was, on the other hand, higher among new clients than among returning ones (8.5% vs. 5.4%), while, on the contrary, the number of homeless was higher among returning clients (4%) than among new ones (4,6%) (Table 8.2).

A small percentage of Public Drug Treatment Unit clients are homeless (4.3%)

Table 8.2: Percentage distribution of drug addiction service clients according to housing situation, by gender and type of client (new or returning). The year 2011

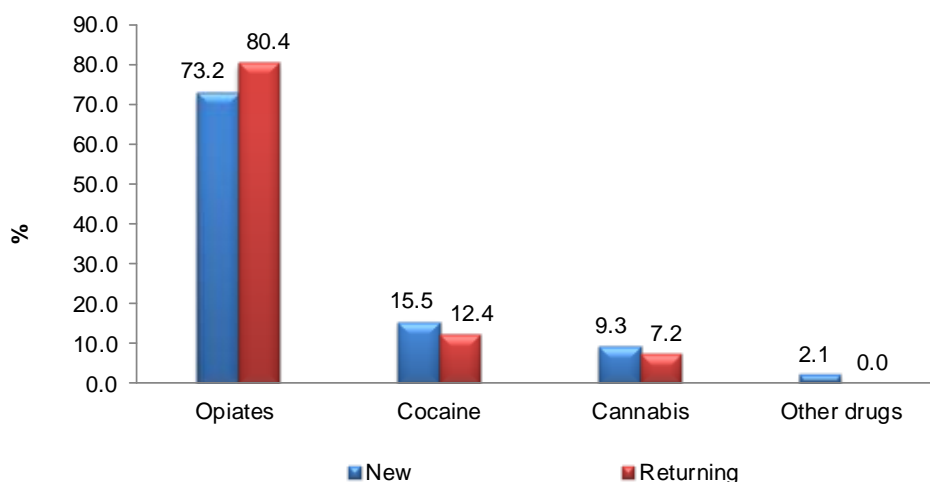
| Housing situation | New clients | | | Returning clients | | |
|---------------------|-------------|------|-------|-------------------|------|-------|
| | M | F | Total | M | F | Total |
| Permanent residence | 87.0 | 90.5 | 87.5 | 89.5 | 93.3 | 90.0 |
| In a facility | 8.9 | 6.7 | 8.5 | 5.8 | 2.7 | 5.4 |
| Homeless | 4.2 | 2.8 | 4.0 | 4.7 | 4.0 | 4.6 |

Source: Based on information from the Department for Anti-drug Policies' 2011 Multicentric Study compiled from Public Drug Treatment Unit (SerT) data.

In comparison with the community of drug addiction service clients as a whole, among homeless clients there is a higher percentage of opiate users (76.8% vs. 56.1%) and a lower percentage of cocaine users (13.9% vs. 23.9%) and cannabis users (8.2% vs. 18.4%).

Higher percentage of opiate users among the homeless

Figure 8.2: Percentage distribution of homeless drug addiction services clients according to type of drug and type of client (new or returning). The year 2011



Source: Based on information from the Department for Anti-drug Policies' 2010 Multicentric Study compiled from Public Drug Treatment Unit (SerT) data

Disaggregating this information according to the type of user, we can see that the percentage of homeless opiate users requesting assistance from Public Drug Treatment Units is lower among new clients than among returning ones (73.2% vs. 80.4%), while the opposite is true for cocaine users (15.5% vs. 12.4%) (Figure 8.2).

Moving on to the method of drug use, we find that, as with unemployed clients, there is a higher percentage of injecting drug users among homeless clients than in the sample as a whole (38% vs. 33.8%). This percentage is slightly higher among returning clients (38.3% of returning clients vs. 37.6% of new clients), while there is a lower percentage of clients who smoke or inhale drugs among returning clients in comparison with new (38.3% of returning clients vs. 38.7% of new).

As far as the treatment of homeless subjects is concerned, 53.9% of these clients receive pharmacological treatment, while 41.6% of the remainder of the group in question receive solely psychological support and 35.6% of the remainder receive a combination of psychological and social support.

8.2 Social reintegration projects

The 2010-2013 National Action Plan on Drugs includes, among its five principal action areas, one specifically devoted to the social and work reintegration of drug addicts. Rehabilitation and reintegration are a central and integral part of the action plan, as these two aims reinforce the belief that it is not only possible but of fundamental importance to always and completely rehabilitate drug addicted individuals and fully reintegrate them into society. To this end, the National Action Plan puts forward a number of concrete solutions which involve the establishment of drug treatment units devoted solely to the goal of reintegration.

National Action Plan goals focusing on this area, which were flanked within the document by specific actions which should be undertaken in order to achieve them and indicators for monitoring their results, are listed below:

The 2010-2013
National Action
Plan on Drugs

2010-2013 National
Action Plan Goals

1. Reduce criminal and illegal activities as well as prostitution among drug addicts through the promotion of targeted social and work reintegration programmes
2. Standardise, on a national level, the principles and principal methods of rehabilitation and reintegration
3. Promote concrete actions and targeted projects to increase the number of rehabilitation activities involving both the social and interpersonal spheres of drug addicts undergoing treatment with drug addiction services and in therapeutic communities
4. Improve the education and professional skills of drug addicts undergoing treatment
5. Promote the development within Addiction Departments of operative units specialised in reintegration activities
6. Integrate and coordinate reintegration activities among the various local agencies (Public Drug Treatment Units [SerTs], therapeutic communities, local and provincial administrations, local health authorities and associations of business owners)
7. Directly involve public companies and administrations (local governments, provincial governments, Local Health Authorities) in social and work reintegration activities for drug addicts through the allocation of contracts to social cooperatives operating in this sector.
8. Encourage the reintegration of drug addicts into the employment structure of ordinary businesses.
9. Orient organisations which deal with social and work reintegration towards developing corporate social responsibility programmes in order to encourage the creation of organisations for reintegration which are capable of generating income and thus self-financing their own activities
10. Promote a nationwide targeted project for social and work rehabilitation and reintegration, in order to support the process of innovation in this field throughout the country.

As discussed in previous chapters, a study was conducted between the end of 2011 and the beginning of 2012 to monitor regional best practices in the field of “addictions” according to fields of action and evaluate them in relation to the National Action Plan on Drugs 2010-2013.

In order to conduct this comparison, A criterion of “conformity” (presence-absence) was adopted which used a scale of 1 to 4, where 1 was equivalent to no such action present and 4 meant that the action established in the NAPD had been adopted as a routine practice by the administration of the Region in question.

According to the study, the extent to which the Regions and Autonomous Provinces were found to have complied with the first nine of the aforementioned NAPD objectives addressing rehabilitation and reintegration was found to be decidedly lower than the level of compliance found for objectives that addressed treatment.

The majority of Regions claim only that the goals set forth in the NAPD exist in the form of regulations, with the exception of a small number of Regions who have already adopted the activities set forth in the NAPD as part of their routine practices. The existence of a mediocre rate of conformity was found when evaluating the actual situation in the Regions with respect to the goals set. This is true in the case of some goals which fall largely under the competence of national authorities (the creation of a nationwide standard for principles and principal methods of rehabilitation and reintegration), as well as for a number which are of strictly local

Monitoring regional best practices in the field of addictions in comparison with the NAPD

competence (reintegration into the employment structure of ordinary businesses, or the development of operative units for reintegration into departments).

With regard to the last goal listed above, the Department for Anti-drug Policies, as part of the implementation of the 2010-2011 DPA Projects Plan, funded with a budget of approximately 26 million Euros, dedicated a full 34% of that budget to a project devoted to the social reintegration and rehabilitation of drug addicts (the RELI Project).

The aim of the Integrated Work Reintegration Project (RELI) is to promote and create a new integrated public-private rehabilitation and social and work reintegration model for drug addicts coming from Therapeutic Communities and Public Drug Treatment Units through the launch of a national network of productive organizations and countrywide coordination. In October 2010, the launch of a competition for the presentation of project proposals for the nationwide RELI Project was approved by decision of the Region of Sardinia, to which it had been entrusted. The competition, advertised on the websites www.politicheantidroga.it, www.droganews.it, www.dronet.org and www.regione.sardegna.it, invited Therapeutic Communities, Addiction Departments, Type A and Type B Social Cooperatives, Foundations and Associations to submit local reintegration projects by 30 November 2010.

127 projects for therapeutic communities and public services were launched throughout the country in 2011 as part of the RELI project, for a total of €8,200,000.00 of available budgeted funding (greater European funding in this area).

The RELI project

The RELI project:
127 local projects
launched

Table 8.3: Total amount dedicated by Regions and Autonomous Provinces to finance social reintegration projects over the course of 2011

| Regions | Amount | % |
|-----------------------|---------------------------------|--------------|
| Abruzzo | 0.00 | - |
| Basilicata | 0.00 | - |
| Bolzano | 1,476,994.00 | 15.7 |
| Calabria | 886,221.00 | 9.4 |
| Campania | 1,254,798.00 | 13.3 |
| Emilia - Romagna | 610,000.00 | 6.5 |
| Friuli Venezia Giulia | 791,808.56 | 8.4 |
| Lazio | Data requested but not provided | - |
| Liguria | 0.00 | - |
| Lombardy | 1,108,071.00 | 11.8 |
| Marche | 210,133.60 | 2.2 |
| Molise | 0.00 | - |
| Piedmont | 0.00 | - |
| Puglia | 682,970.00 | 7.3 |
| Sardinia | 0.00 | - |
| Sicily | 1,278,556.00 | 13.6 |
| Tuscany | 400,264.00 | 4.3 |
| Trento | 0.00 | - |
| Umbria | 704,666.00 | 7.5 |
| Valle d'Aosta | Data requested but not provided | - |
| Veneto | 0.00 | - |
| Total | 9,404,482.16 | 100.0 |

Over 9 million
Euros for social
reintegration
projects

Source: Based on data collected by means of the EMCDDA questionnaires sent to the Regions

On the questionnaires provided by the European Monitoring Centre in 2011, 75% of Regions and Autonomous Provinces reported having targeted and established strategies for the social reintegration of current and former problem drug users; most of these (80%) had made the relevant official document available online.

The goal most often referred to was social and work reintegration.

Table 8.3 shows all of the Regions and Autonomous Provinces which, on the EMCDDA questionnaire, reported having social reintegration projects funded from Regional Social Funds and/or through other special public funding channels for the year 2011.

In comparison with 2010, there has been a sharp drop in funding (-21.4%), largely attributable to the fact that funding in Campania was halved and in Piedmont was cut altogether. The Autonomous Province of Bolzano alone accounts for 15.7% of the national total.

8.2.1 Housing

In 2011, an average of 50% of Regions and Autonomous Provinces had created housing programmes specifically created for individuals undergoing social and healthcare treatment for the use of psychotropic drugs

In most cases, these subjects are able to take advantage of temporary housing (shelters) or reception centres providing temporary lodging, created in order to provide assistance to socially excluded groups (70%). 55% of Regions and Autonomous Provinces (10% less than in 2010), in the interests of more effective social reintegration, provide residential facilities for persons undergoing treatment for the use of psychotropic drugs which are devoted specifically to the reintegration of current and former drug users.

Long-term housing initiatives continue to improve (Figure 8.3), with 50% of Regions reporting the existence of these types of programmes, a number which rises to 55% if we include similar projects which target other socially disadvantaged groups as well.

The availability of these different types of services was judged to be, on average, at least 'good' by 57% of Regional representatives (in comparison with 53% in 2010), and was even higher (82%) with regard to the availability of residential facilities for social reintegration.

75% of Regions and Autonomous Provinces reported that they had targeted reintegration strategies

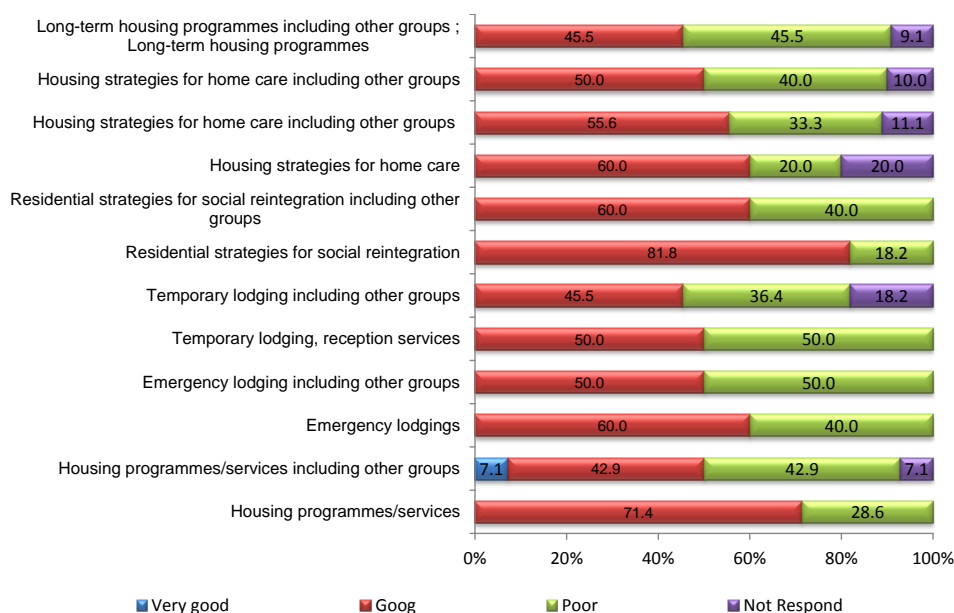
21.4% less funding for social reintegration programmes: €2.5 million less than in 2010

50% of Regions reported having launched housing programmes for drug addicts.

55% of Regions and APs report that they provide residential facilities for the social reintegration of drug addicts

Availability of housing services is improving

Figure 8.3: Assessment of the availability of housing services specifically targeting current and former drug users. The year 2011



Source: Based on data from the survey conducted by means of EMCDDA questionnaires sent to the Regions

The Regions and Autonomous Provinces judged the level of accessibility to these kinds of services to be quite good. The ability to access housing services devoted specifically to current and former drug users was judged to be, on the average, ‘good’ across the board. Assessments of residential facilities for social reintegration and emergency lodgings stand out for the positive marks these two categories received from all respondents.

Accessibility of housing services was reported as being good

8.2.2 Employment

In 2011, workplace reintegration was reported as being a high priority goal by the Regions and the Autonomous Provinces.

Few professional training programmes have been put into effect

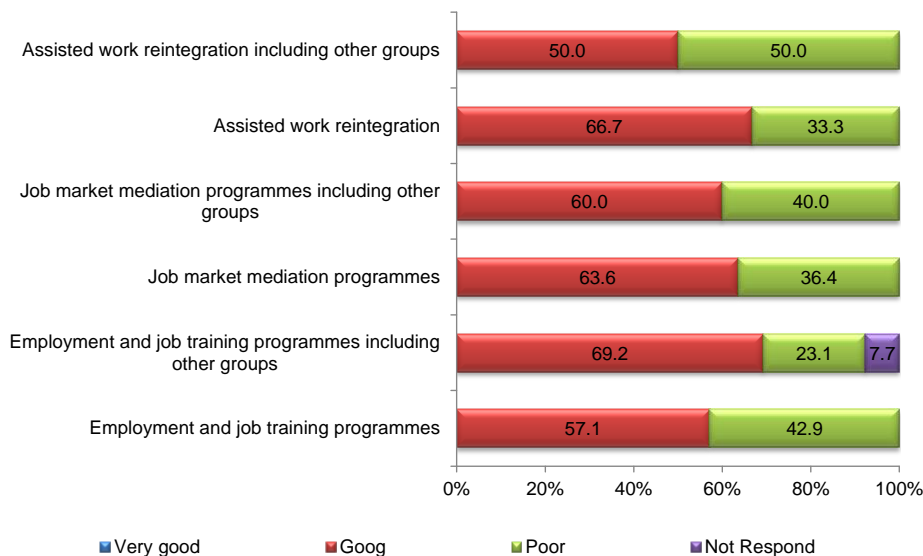
Employment and job training programmes created exclusively for current and former drug users were put into effect in only 35% of the Regions and Autonomous Provinces. If we include in this figure programmes which are open to other socially disadvantaged groups as well, the percentage rises to 65%.

Most regional representatives reported the launch of assisted work reintegration programmes.

Good availability of employment services reported

The level of availability of employment services designed exclusively for current and former drug users was given, on the average, a positive evaluation (more than 60% positive assessments). Employment and job training programmes open to other groups as well were given especially positive assessments.

Figure 8.4: Assessment of the availability of employment services specifically targeting current and former drug users. The year 2011



Source: Based on data from the survey conducted by means of EMCDDA questionnaires sent to the Regions

Even higher evaluations were given regarding the accessibility of employment services: there were consistently more positive evaluations than negative ones with one exception, that of work reintegration initiatives targeting other groups besides current and former drug users, in which positive and negative evaluations were equal in number.

High accessibility of employment services reported

8.2.3 Completion of education

By “education”, what is meant is the attainment of a secondary level of education or a specialization, but not of special training for a specific type of job. In 2011, 50% of Regions and Autonomous Provinces created educational programmes/services targeting more than one type of socially disadvantaged group and programmes aiming to help individuals complete their basic education which were intended exclusively for current and former drug users. A smaller number (30%) launched programmes for the completion of secondary education and 10% for completion of university studies or doctoral degrees. Availability and accessibility of these initiatives were given an overall positive evaluation.

Programmes to assist in the completion of education exist in less than 50% of Regions and Autonomous Provinces

8.2.4 Other social reintegration programmes

Once again in 2011, among the social reintegration activities of note planned for current and former drug users, we find psychological assistance focusing on social and family relationships in effect in 75% of Regions and Autonomous Provinces. The number of financial aid and legal consulting programmes, which in 2010 existed in 55% of Regions and APs, only existed in 45% of these in 2011.

A high number of psychological assistance programmes

It should be pointed out that very positive evaluations were given for the availability and accessibility of psychological assistance programmes, while the availability of programmes designed to limit social exclusion and the availability of financial assistance programmes were found to be poor.

9. DRUG-RELATED CRIME, PREVENTION OF DRUG-RELATED CRIME, AND PRISON

Information regarding offences for illicit drug possession for personal use (Art. 75 and Art. 121 of DPR 309/90) is collected by the Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources of the Ministry of the Interior (ST 11 – IT 1), while the Central Directorate for Anti-drug Services (DCSA) of the Ministry of the Interior is responsible for information regarding operations to fight the production and illegal trafficking of drugs (Art. 73 and Art. 74 of DPR 309/90) (ST 11 – IT 2).

Information sources

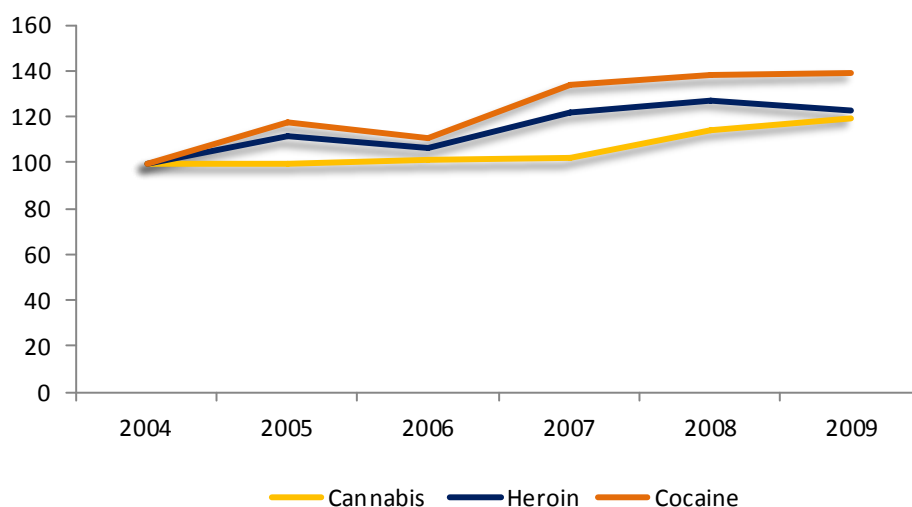
As far as drug law offences are concerned, the archives at the Department of Judicial Affairs, Office 1 (Legislative and International Affairs and Pardons), and Office 3 (Criminal Records) provide information on pending and completed cases with a definitive sentence. The movement of adults and minors through the correctional system is the responsibility, respectively, of the Department of Prison Administration (DAP) for adults (ST 12), and of the Department of Juvenile Justice for minors.

9.1. Drug-related crime

9.1.1. Drug law offences

Overall trends in persons reported for illicit conduct in violation of drug law (criminal and non) in Europe in the period from 2004 – 2009 show a progressive increase in activities to combat the spread of drugs, resulting in an increase in illicit conduct related to cocaine and cannabis (in most European countries, cannabis-related offences represent a percentage varying between 50% and 70% of drug offences reported in 2009).

Figure 9.1: Trends in index values (*) for offences (criminal and non) in violation of drug law within EU Member States, by drug type. The years 2004 - 2009



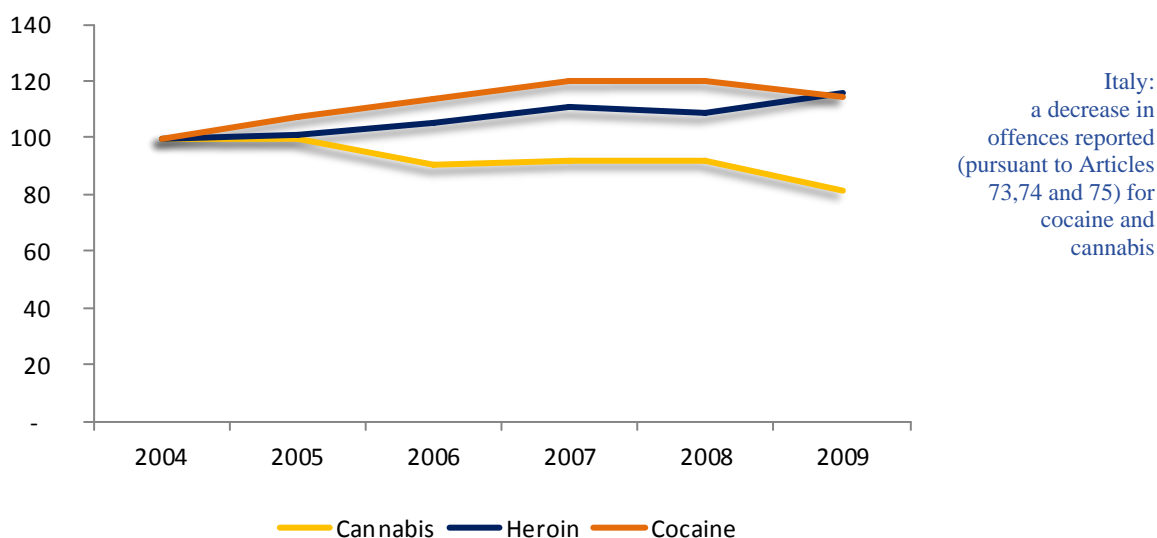
Europe:
Rising trend in
offences linked to
cocaine and
cannabis
Offences reported in
Europe – the years
2004-2009

(*) Index values: percentage variation in comparison with base-year (= 2004) value

Source: European Monitoring Centre for Drugs and Drug Addictions – 2011 Annual Report (Table DLO -3 of the 2011 Statistical Bulletin)

In Italy, in 2009, there was an increase in persons reported for offences related to heroin; offences related to cocaine rose slowly but steadily until 2008, then fell during the year under consideration. Offences linked to cannabis, on the other hand, declined until 2006, then levelled off in 2007 and 2008, only to decrease slightly in 2009. (Figure 9.2).

Figure 9.2: Trends in index values (*) for illicit conduct in violation of drug law (Art. 74, Art. 74 and Art. 75) reported in Italy. The years 2004 - 2009



(*) Index values: percentage variation in comparison with base-year (= 2004) value

Source: Based on Data from the Ministry of the Interior - Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources and the Central Directorate for Anti-drug Services

According to the information collected by the Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources of the Ministry of the Interior (formerly the Central Directorate for Documentation and Statistics) Law Enforcement Agencies reported 29,190 persons for drug possession for personal use (Art. 75, 309/90, ST 11 – IT 2) in 2011, of whom 27,275 were male (equal to 93.4%) and 1,915 were female (equal to 6.6 %).

If we consider the figure from the same time period in the previous year (31,550 individuals) we can see that there is a decrease in the number of persons reported to the Prefectures, although the data for the most recent three-year period should still be considered provisional¹.

Over 29,000 persons reported by Law Enforcement Agencies for drug possession for personal use (Art. 75 of DPR 309/90)

¹ Based on data for the year 2010, collected by 31 March 2011, 31,550 persons were reported that year pursuant to Art. 75. Data are continuously being updated by the personnel of the personnel of the Drug Addiction Operating Units (NOTs) of the Prefecture-UTGs (Territorial Government Offices) and are consolidated after approximately two years or more.

Table 9.1: Characteristics of persons reported to the Prefectures by Law Enforcement Agencies pursuant to Art. 75. The years 2010 - 2011

| Characteristics | 2010 | | 2011 | | Δ% |
|---------------------------------------|---------------|--------------|---------------|--------------|-------------|
| | No. | %c | No. | %c | |
| Persons reported | | | | | |
| Reported for the first time | 23,139 | 73.3 | 21,125 | 72.4 | -8.7 |
| Already reported in previous years | 8,411 | 26.7 | 8,065 | 27.6 | -4.1 |
| Total | 31,550 | 100.0 | 29,190 | 100.0 | -7.5 |
| Frequency | | | | | |
| Once during the year | 30,277 | 96.0 | 27,937 | 95.7 | -7.7 |
| At least twice during the year | 1,273 | 4.0 | 1,253 | 4.3 | -1.6 |
| Men | 29,408 | 93.2 | 27,275 | 93.4 | -7.3 |
| Women | 2,142 | 6.8 | 1,915 | 6.6 | -10.6 |
| Average Age | | | | | |
| Men | | 26.4 | | 26.5 | |
| Women | | 26.6 | | 26.8 | |
| Reports filed, by drug type | | | | | |
| Opiates (heroin, methadone, morphine) | 3,549 | 11.2 | 3,036 | 10.4 | -14.5 |
| Cocaine/Crack | 4,258 | 13.5 | 3,908 | 13.4 | -8.2 |
| Cannabinoids | 23,415 | 74.2 | 21,956 | 75.2 | -6.2 |
| Stimulants | 152 | 0.5 | 140 | 0.5 | -7.9 |
| Other drugs | 176 | 0.6 | 150 | 0.5 | -14.8 |
| Total | 31,550 | 100.0 | 29,190 | 100.0 | -7.5 |

Source: Based on Data from the Ministry of the Interior - Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources

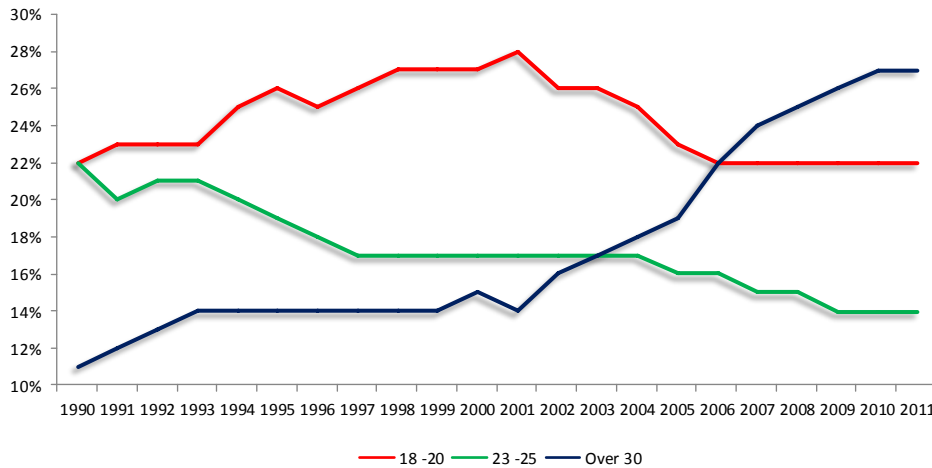
The average age of persons reported was approximately 27, with the highest prevalence among the age groups 18-22 (34%) and over 30 (27%). Trends among the different age groups between 1990 and 2011 show that, over the course of the years, most of the persons reported pursuant to Art. 75 were between 18 and 25 years of age, and the percentage of persons reported who are over the age of 30 began to rise more substantially starting in 2002 (Figure 9.3).

As far as types of drugs are concerned, most of the persons reported in the year 2011, meaning 75% of subjects (reported for the first time and recidivists), were found to be in possession of cannabinoids, followed by cocaine (13%) and then by those in possession of heroin, who accounted for nearly 10% of the total of persons reported for the year of reference. If we add to those reported for heroin use the numbers for those reported for methadone, morphine and other opiates, we obtain a percentage slightly higher than 10%.

Rising trend in the number of persons over the age of 30

Reports filed by drug type: 75% of reports filed were for cannabis

Figure 9.3: Percentage distribution of persons reported pursuant to Art. 75, by major age groups. The years 1990 – 2011



Since 2002, the number of persons reported who are over 30 years of age has increased, while the number under 25 years of age has decreased

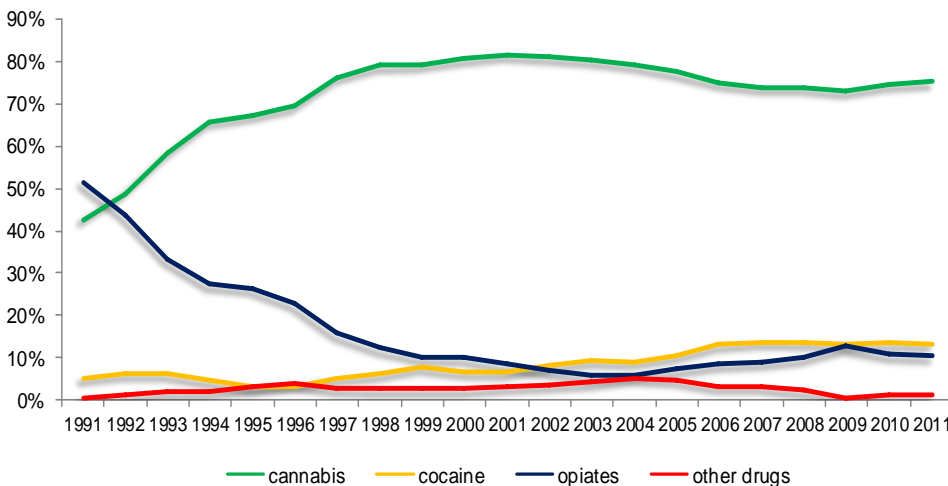
Source: Based on Data from the Ministry of the Interior - Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources

In comparison with the past, there has been a slight decrease over the last four years in the number persons found in possession of heroin for personal use, while the number of cannabinoid users, which had declined progressively until 2009 (from 81% in 2002 to 73% in 2009), began rising slightly again in 2010 (75%), remaining stable in 2011. Users of hashish or marijuana clearly account for the largest percentage of persons reported for possession for personal use pursuant to Art. 75 (Figure 9.4).

Decrease in the number of heroin users reported

Increase in the number of cannabinoid users reported

Figure 9.4: Percentage distribution of persons reported pursuant to Art. 75, by drug type. The years 1991 – 2011



Trends for cannabis and cocaine remained largely stable between 2006-2011

Source: Based on Data from the Ministry of the Interior - Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources

The number of persons in possession of cocaine for personal use (which rose from 10% in 2005 to 13% in 2006 and 14% in 2007 and 2008) fell slightly in 2009 (to 13%) and numbers remained stable until 2011. Cocaine nonetheless remains the second-most commonly-reported drug,

Trend in cocaine users reported remained stable

a figure which is particularly alarming when we consider that a large portion of the subjects reported are between 18 and 25 years of age.

Trends in drug use among the population of persons reported to the Prefectures are in line with figures and estimates gathered on international and European levels, and demand particular attention due to the fact that most subjects reported consider themselves to be “occasional users” and thus represent an important source of information for estimates of use among the general population.

According to information gathered by the Central Directorate for Anti-drug Services of the Ministry of the Interior, Law Enforcement Agencies conducted 23,103 anti-drug operations in Italy in 2011, resulting in 36,796 charges brought for crimes related to the production, trafficking and sale of illegal substances, conspiracy with intent to traffic and other crimes and offences in violation of Presidential Decree DPR 309/90 (Articles 73, 74 and other Articles of DPR 309/90, ST 11 – IT 1), registering a 5.8% decrease in comparison with 2010.

Over 23,000 anti-drug operations in 2011.
Over 36,000 charges brought (a decrease over 2010)

Table 9.2: Characteristics of charges brought before the Judicial Authorities by Law Enforcement Agencies for violations of Articles 73 and 74 of DPR 309/90. The year 2011

| Characteristics | 2010 | | 2011 | | Δ% |
|---------------------------------|---------------|--------------|---------------|--------------|-------------|
| | N | % | No. | %c | |
| Gender | | | | | |
| Men | 35,703 | 91.4 | 33,673 | 91.5 | -5.7 |
| Women | 3,350 | 8.6 | 3,123 | 8.5 | -6.8 |
| Total | 39,053 | 100.0 | 36,796 | 100.0 | -5.8 |
| Nationality | | | | | |
| Italians | 27,047 | 69.3 | 24,148 | 65.6 | -10.7 |
| Foreigners | 12,006 | 30.7 | 12,648 | 34.4 | 5.3 |
| Offences | | | | | |
| Art. 73 – Italians | ,032 | 69.2 | 24,109 | 65.5 | -10.8 |
| Art. 73 – foreigners | 12,006 | 30.8 | 12,647 | 34.4 | 5.3 |
| under Art. 74 – Italians | 2,795 | 68.7 | 2,164 | 70.5 | -22.6 |
| under Art. 74 – foreigners | 1,273 | 31.3 | 906 | 29.5 | -28.8 |
| Average age | | | | | |
| Italians for Art. 73 offences | 31.7 | | 31.9 | | |
| Foreigners for Art. 73 offences | 29.8 | | 30.0 | | |
| Italians for Art. 74 offences | 36.0 | | 37.5 | | |
| Foreigners for Art. 74 offences | 33.3 | | 34.5 | | |
| Measures taken | | | | | |
| Arrested | 29,076 | 74.5 | 28,552 | 77.6 | -1.8 |
| At liberty | 9,577 | 24.5 | 7,936 | 21.6 | -17.1 |
| Untraceable | 400 | 1.0 | 308 | 0.8 | -23.0 |

Decrease in the number of charges brought in 2011 (-5.8%)

Source: based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services

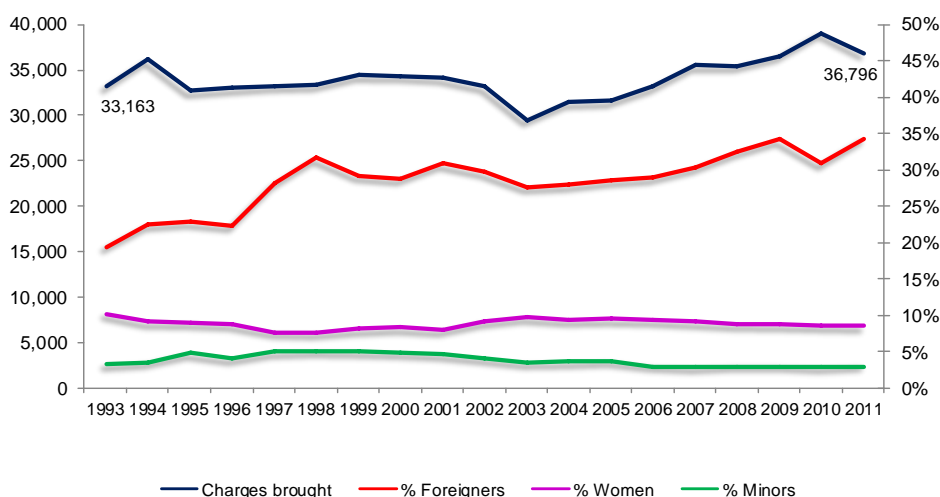
65.6% of persons reported to the Judicial Authorities in 2011 were Italians and 8.5% were women. The average age of persons reported was approximately thirty-one, with some variation based on nationality (32 years of age for Italians and 30 years of age for foreigners), and even greater variation based on the type of offence committed (31 years of age for Art. 73 and 37 years of age for Art. 74).

Characteristics of subjects reported:
66% Italians
34% foreigners
Low number of women (approximately 9%)

Following 2003, the year in which the fewest subjects were charged (approximately 29,500), the number of reports filed with the Judicial Authorities increased progressively until 2010, when the highest value in seventeen years was recorded; numbers decreased in 2011 (Figure 9.5).

Cases submitted to the courts increased from 2003 to 2010, then decreased in 2011

Figure 9.5: Persons charged with crimes during the course of anti-drug operations conducted by Law Enforcement Agencies, percentages of foreigners, women and minors charged. The years 1993 – 2011



Data on charges against foreigners and minors from 2007 – 2011 updated

Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services

If, on the one hand, the number of reports filed with the Judicial Authorities for drug-related offences has decreased, on the other hand, the percentage of foreigners apprehended and brought before the courts increased in 2011 (34.4% of the total number of persons charged during the course of anti-drug operations), a number greater than the previous maximum value of 34.2%, registered in 2009. 3,123 women were reported to the Judicial Authorities in 2011, a 6.8% decrease over the previous year. In terms of absolute values over the past 11 years, the number of charges brought against women peaked in 2010, but if we consider the percentage of women reported in relation to the total number of charges brought, the maximum value was recorded in 2003 (9.7%) and the lowest in 2001 (approximately 8%). Regarding charges brought against minors, there were a total of 1,175 in 2011 (3.2% of the total of persons reported on a national level), a decrease of approximately 3.2% over 2010.

Increase in the % of foreigners charged

6.8% decrease in the number of women reported

3.2% increase in the number of minors reported

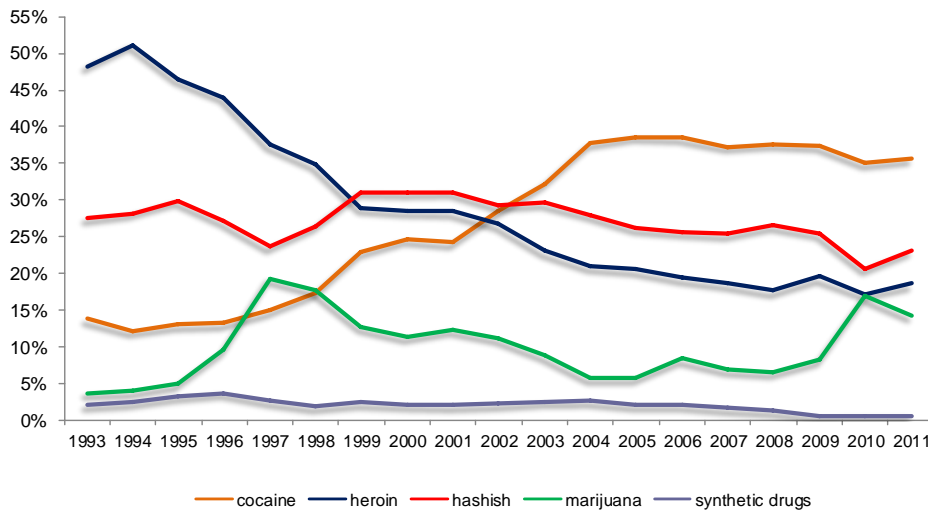
37.3% of reports filed with the Judicial Authorities for violations of drug laws had to do with the trafficking of cannabis, followed by cocaine (35.5%) and, on a smaller scale, heroin (18.5%). 90% of Italians against whom charges were brought were male, with the exception of charges for heroin trafficking, for which the percentage falls to 83%. There are higher percentages recorded for the foreign male population, on the other hand, especially with regard to heroin and cannabis (96%).

Principal reports filed by drug type:
37.3% cannabis
35.5% cocaine
18.5% heroin

Persons charged with the trafficking of synthetic drugs were generally found to be younger (27 years of age) with respect to those whose cases were submitted to the courts for other drugs, and the average age for women was found to be higher than for men (33 and 32 years of age, respectively, in the Italian population and 32 and 30 years of age among the foreign population).

Persons charged for the trafficking of synthetic drugs are younger

Figure 9.6: Persons charged with crimes during the course of anti-drug operations conducted by Law Enforcement Agencies, by type of illegal substance seized. The years 1993 – 2011



Since 2009 there has been a significant increase in the number of charges related to marijuana

Trends for cocaine and synthetic drugs remained stable from 2004 to 2011

Source: Based on data from the Interior Ministry – Central Directorate for Anti-drug Services

Over the last seventeen years, the profile of illicit drug trafficking has evolved considerably. The percentage of charges for the sale of heroin fell from 48% in 1993 to 18.5% in 2011, in contrast with a dramatic increase, until 2004, in the percentage of reports filled for cocaine dealing, which has levelled off in recent years. Over the last two years of reference, we can see a significant increase in the percentage of charges brought for the sale of marijuana (from 8% in 2009 to 16.8% in 2010 and 14.1% in 2011) and a rise in hashish sales (approximately 21% in 2010 vs. 23% in 2011) (Figure 9.6). In terms of absolute values, in 2011 there was a 2.7% drop in the number of reports filed for the sale of synthetic drugs in comparison with 2010.

Trends in charges brought, by drug type: larger % of charges for hashish and heroin

9.2. Prevention of drug-related crime

In addition to the preventative action taken from a legislative point of view by reducing the legal limits for concentrations of psychotropic substances in the body and the imposition of stricter sanctions against transgressors, checks and monitoring of the psychological and physiological state of drivers continued in 2011.

Drugs, alcohol and driving

Considering the positive results achieved in the “Drugs on Street” (D.O.S.) pilot project during the two-year period spanning 2009-2010, the project was extended to 29 Italian municipalities, which were provided with funds to launch local working projects tailored to local needs, in accordance with the goals set forth in the National Network for Drug- and Alcohol-related Accidents (NNIDAC) Project Framework – D.O.S. Protocol.

The “Drugs on Street” Project

The checks, performed thanks to the synergetic collaboration between different branches of Law Enforcement (the Traffic Police, Carabinieri, Guardia di Finanza [Revenue and Excise Police], Municipal Police, Provincial Police) and a team of doctors and nurses, covered a very large portion of the country, equal to 5,256.06 square kilometres, or 1.74% of the entire surface area of Italy, and a potential population (aged 15-64

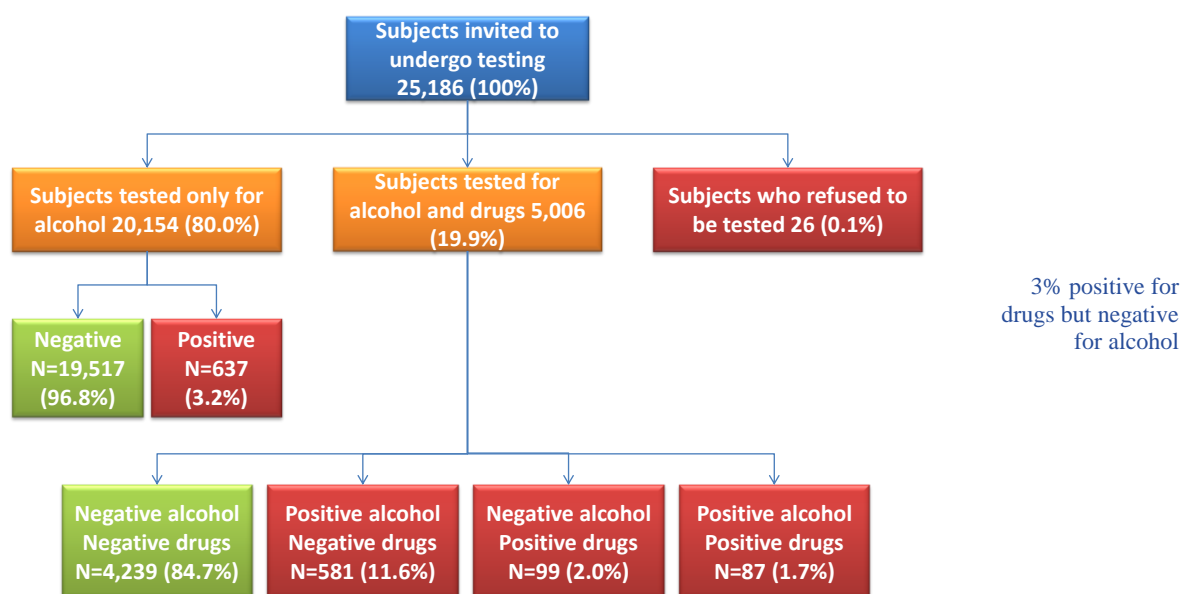
years) of 4,635,728 inhabitants, equal to 11.69% of the total population belonging to that age group.

During the course of the checks, nearly 44,300 vehicles were stopped and over 25,000 drivers between the ages of 15 and 64 were subjected to clinical and toxicological testing.

44,000 vehicles checked

5.6% of the entire sample of drivers who underwent testing tested positive for alcohol, drugs or alcohol and drugs together. Of the drivers who tested positive with the breathalyser (1,218; 637 + 581), the majority (81.4%) had a blood alcohol level of between 0.5 and 1.5 g/l (up to three times the legal limit of 0.5 g/l), 9.9% had blood alcohol levels between 0.0 and 0.5 g/l (the limit for drivers under the age of 21, new license holders and professional drivers responsible for the transport of people or goods) and the remaining 8.7% had blood alcohol levels higher than 1.5 g/l, which results in seizure of the vehicle.

Figure 9.7: Results of checks carried out on the sample of drivers tested for alcohol and drugs.



Source: Based on information from the Department for Anti-drug Policies - National Network for Drug- and Alcohol-related Accidents (NNIDAC) Project Framework – D.O.S. Protocol

Among drivers who tested positive for drugs, cannabis was the drug which had most often been used (51% of cases). This drug plays an important role as a cause of traffic accidents, both because of the frequency with which it is used among the general population and as a result of the effects caused by its use. Cannabis was followed by cocaine (36.2%), then amphetamines (6.7%) and finally opiates (6%)².

Polydrug use, meaning the use of more than one type of drug simultaneously, or the combined use of alcohol and drugs, is quite a common phenomenon. Although available data is limited, it is still possible

² Source: Zalesky A., Solowij N., Yu Cel M., Dan, et al: “Effect of long-term cannabis use on axonal fiber connectivity”. Brain, June 2010; Wadsworth E.J.K., Moss, S.C., Simpson S.A., Smith A.P. “A community based investigation of the association between cannabis use, injuries and accidents” – Journal of Psychopharmacology, 2005

to see that cannabis and cocaine are often used in combination, as are alcohol and cannabis or alcohol and cocaine.

The new Traffic Code, introduced by Law No. 120 of 29 July 2010, deals with driving in an altered psychological or physiological state with three specific Articles. In addition to the existing Articles 186, "Driving under the influence of alcohol", and 187, "Driving under the influence of drugs", we now find Article 186-bis, dealing with "Driving under the influence of alcohol for minors under 21 years of age, new drivers and for professional drivers qualified for the transport of people or goods". With the launch of the "Drugs on Street" Protocol, and based on the new regulatory system which provides for tougher penalties for transgressors, the number of checks and amount of monitoring on the roads has increased.

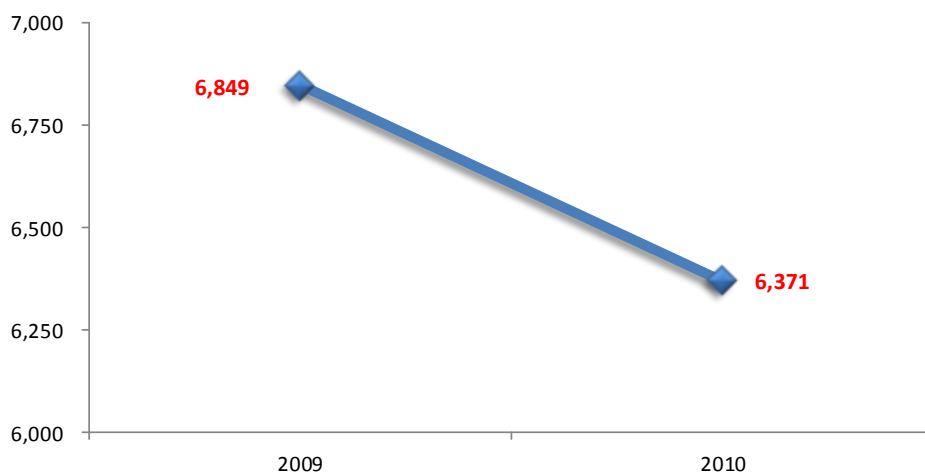
A comparative analysis of night-time accidents during the period of implementation of the D.O.S. Protocol, while street monitoring activities were on-going, and the same time period during the previous year, was conducted among municipalities participating in the project. In the majority of cases, the number of night-time accidents had fallen.

Calculations based on data from 19 out of 29 municipalities shows a drop both in the number of accidents and the number of injuries in 2010 in comparison with 2009, but an increase in the number of deaths. Moreover, the number of sanctions imposed was found to have decreased overall.

The new Traffic Code

Study of night-time accidents

Figure 9.8: Trend in traffic accidents, 2009-2010



Decrease in traffic accidents between 2009 and 2010

Source: Based on data from the Department for Anti-drug Policies – National Network for Drug- and Alcohol-related Accidents (NNIDAC) Project Framework – D.O.S. Protocol

9.3. Interventions in the criminal justice system

9.3.1. Alternatives to prison

Special cases concerning probation or release on parole into the care of social services are governed by Art. 94 of DPR 309/90 and can involve, in accordance with the Law, both alcoholics and drug addicts, although actually nearly all of the cases involve drug addicts.

Table 9.3: Drug addicts on probation or released on parole into the care of social services. The year 2011

| Characteristics | 2010 ⁽¹⁾ | | 2011 | | Diff.% | Δ% 2011/2010 |
|--------------------|---------------------|------|-------|------|--------|-----------------|
| | No. | % c | No. | % c | | |
| Gender | | | | | | |
| Men | 2,357 | 93.5 | 2,163 | 93.8 | +0.3 | -8.2 |
| Women | 165 | 6.5 | 143 | 6.2 | -0.3 | -13.3 |
| Total | 2,522 | | 2,306 | | | -8.6 |
| Nationality | | | | | | |
| Italians | 1,577 | 93.8 | 1,950 | 93.0 | -0.8 | +23.7 |
| Foreigners | 105 | 6.2 | 147 | 7.0 | +0.8 | +40.0 |
| Not known | 840 | 33. | 209 | 9.1 | -24.2 | -75.1 |
| Average age | | | | | | |
| Men | 37.6 | | 37.8 | | | +0.5 |
| Women | 36.7 | | 37.3 | | | +1.6 |
| Total | 37.6 | | 37.8 | | | +0.5 |
| Age groups | | | | | | |
| 18-24 | 145 | 5.7 | 107 | 4.6 | -1.1 | -26.2 |
| 25-34 | 828 | 32.8 | 757 | 32.8 | 0.0 | -8.6 |
| 35-44 | 1,028 | 40.8 | 963 | 41.8 | +1.0 | -6.3 |
| 45-54 | 421 | 16.7 | 392 | 17.0 | +0.3 | -6.9 |
| > 54 | 100 | 4.0 | 87 | 3.8 | -0.2 | -13.0 |

⁽¹⁾ 2010 data updated in 2012

Source: Ministry of Justice - Department of Prison Administration - Directorate-General for the Execution of External Sentencing

In 2011, a total of 9,223 new persons were placed in the care of social services. Of these, 2,306³ were drug addicts granted probation or parole under Art. 94 of DPR 309/90, accounting for a total of 25% of the total number of persons placed in the care of social services.

The number of subjects who have benefited from alternatives to imprisonment increased steadily from 2007 to 2010 (+31.5% in 2010 in comparison with the previous year), with the figures not changing to any significant extent in 2011 (Figure III.3.9). It should be noted that the significant decrease in the numbers of subjects placed on parole or probation with social services during the three-year period spanning the years 2005 to 2007, when numbers fell from over 16,000 subjects placed on parole or probation in 2005 to fewer more than 3,200 in 2007, can be attributed to the effect of the implementation of Law 241 of 31 July 2006, the Collective Clemency Bill. The application of this law, in addition to bringing about the dismissal of measures for those cases carried forward from previous years for which there were on-going proceedings involving offences committed on or before 2 May 2006 carrying custodial sentences of no more than three years, strongly affected the number of cases taken on by services during the course of the year.

In contrast to the trend in overall numbers of subjects placed on probation or parole, the number of drug addicts who have benefited from alternatives to imprisonment during the last three years under consideration has fallen (8.6% less than in 2010), as has the number of persons on probation or parole who are drug addicts as a percentage of

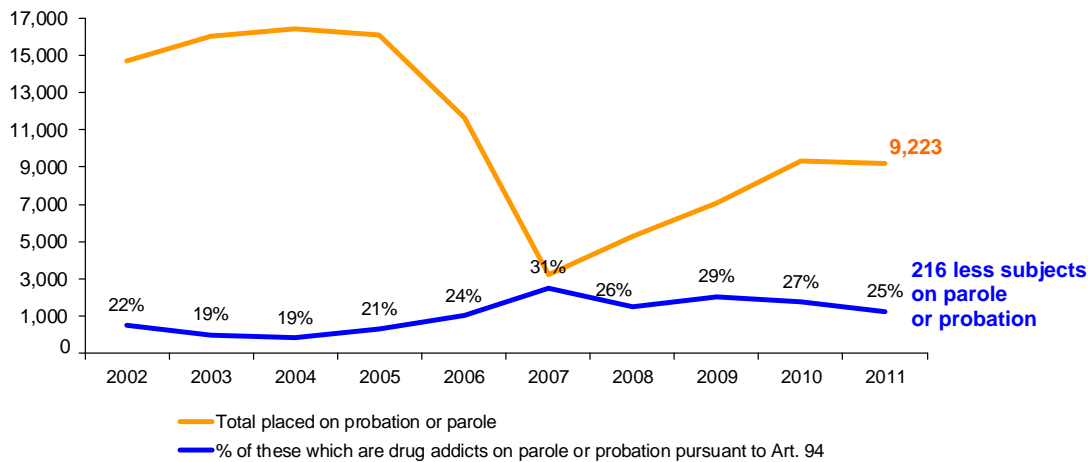
Decrease (-8.6%) in the number of drug-addicted subjects who were granted parole

In 2011, 25% of persons placed on probation or parole in the care of social services were drug addicts

³ This information differs from data cited in Chapter III.2.3.2 due to the difference in sources: information in this section is provided by the Ministry of Justice – Department of Prison Administration, while data in Chapter III.2.3.2 comes from the Department for Anti-drug Policies' Study on Drug Addicts in Prison – Form 1 – December 2011.

the total, fluctuating between 29% and 25% from 2009 to 2011.

Figure 9.9: Total subjects on probation or parole, and percentage of that total who are drug addicts placed on probation or parole pursuant to Art. 94. The years 2002 – 2011



Source: Ministry of Justice - Department of Prison Administration - Directorate-General for the Execution of External Sentencing

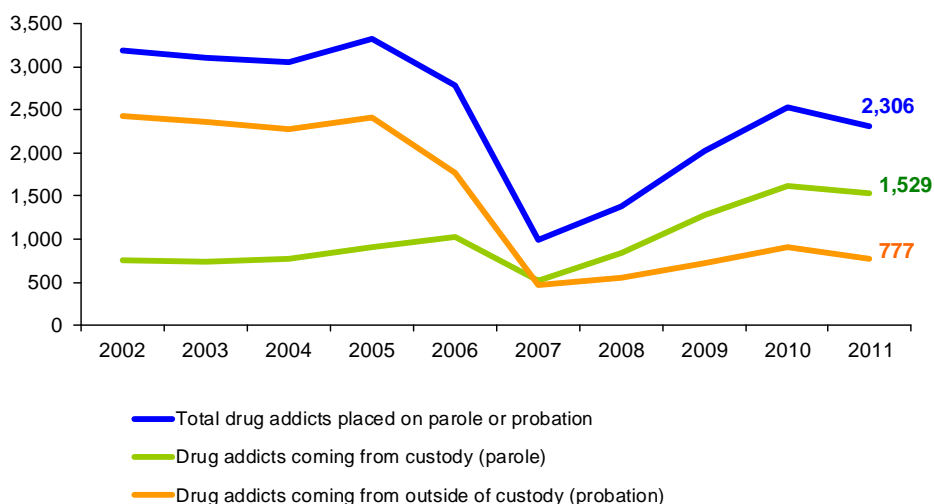
In line with figures from previous years, over 93% of subjects placed on parole or probation pursuant to Art. 94 were men. The average age was 37.8, a slight increase over the previous year (37.6 vs. 37.8), with a particular increase in persons between the ages of 35 and 44, which is the age group most greatly represented (41.8%).

Foreigners, whose numbers are never very high among subjects placed on parole or probation with the Office for the Execution of External Sentencing, comprised 7% of the total in 2011.

The number of subjects placed on parole with the Office of External Sentencing (UEPE) has grown over the last two years (Figure 9.10), rising from 36.7% in 2006 to 52.2% in 2007, to finally reach 66.3% in 2011. This figure should be viewed in light of the reduction of sentences established by Law 241/06 which, with the exception of a few types of crime, accelerated the possibility of benefiting from alternative measures for subjects given custodial sentences longer than six years and, at the same time, brought about a steep decline in the number of subjects serving sentences of up to six years in length who benefit from such alternative measures who might have been granted the possibility to benefit from them without first serving time in prison.

Large increase in the number of subjects placed on parole with the Office of External Sentencing: from 36.7% in 2006 to 66.3% in 2011

Figure 9.10: Number of drug addicts placed in care of social services coming from custody (parole) or from outside of custody (probation). The years 2002 – 2011



Source: Ministry of Justice - Department of Prison Administration - Directorate-General for the Execution of External Sentencing

As a percentage of the total number of subjects who benefited from parole or probation in 2010 in accordance with Art. 94 of DPR 309/90, 7.7% of persons sentenced using alternative measures had their alternative sentencing revoked, almost all as a result of the improper serving of the sentence. Another 18.6% of those serving alternative sentences saw their probation or parole end due to their proceedings being filed. In general, if we compare subjects' data based upon whether they had served prison time, we find that most revocations were for cases involving subjects on parole after having served custodial sentences (35.5% of revocations from parole as opposed to 19.0% from probation). The opposite is true for proceedings filed; most of those subjects who had their proceedings filed were on probation (64.5% of proceedings filed for subjects on parole vs. 81.0% for subjects on probation) (Figure III.3.14). Specifically, in comparison with 2010, there was a greater percentage of revocations for improper serving of sentence among those on parole and a greater number of revocations for other reasons for subjects on probation as well as subjects on parole.

More revocations among subjects on parole than among subjects on probation

9.4 Drug use and problem drug use in prisons

In Italy, in 2011, no studies were conducted on the use of psychotropic drugs among prison inmates. However, thanks to a new information flow, information is available regarding drug addicts and social and healthcare services provided to them inside prisons.

Specifically, a Decree of the Presidency of the Council of Ministers, issued on 1 April 2008, transferred responsibility for healthcare in prisons to Health Units, and thus the monitoring of inmates with drug-related problems, which had remained the responsibility of the Ministry of Justice – Department of Prison Administration until 2010, passed to the Regions, in accordance with the agreement signed at the Unified Conference on 18 May 2011.

Under this agreement, the Regions are required to collect data on inmates with alcohol- or drug-related problems by means of special forms, completed by the prison Operative Units of Public Drug Treatment Services.

These forms contain information on:

- The number of subjects with drug-related problems
- The number of subjects who have been diagnosed as having drug dependence (the main requirement for parole)
- The number of people requesting parole
- The number of people released on parole

This process is needed to monitor:

- The characteristics of inmates with regard to drug use
- Their treatment needs
- The willingness, availability and accessibility of probation or parole as alternatives to imprisonment

Using this new means of monitoring the prison population with alcohol- or drug-related problems, substance addiction is established based on clinical diagnosis (ICD-IX CM), and is not only based on medical history or self-reported.

9.4.1. Incarcerated adult drug addicts

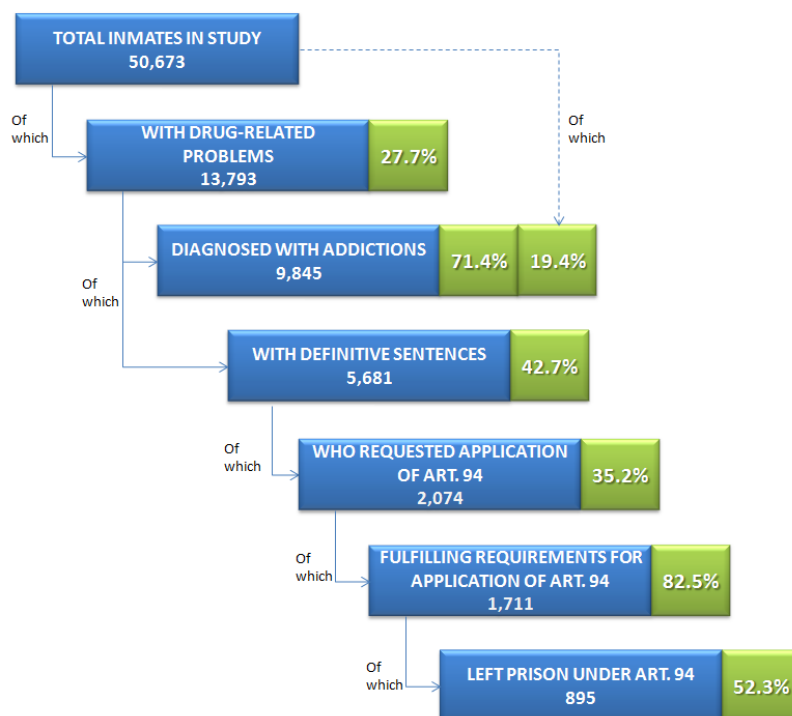
The new information flow was applied in all the Regions of Italy in 2012, on the basis of 2011 data; data for Sardinia and Liguria are not available, as they were not transmitted. Despite the fact that data quality was not always optimal and that some information was lacking, data was nonetheless gathered on 50,673 prison inmates, equal to 76% of the prison population according to figures from the prison population census conducted by the Ministry of Justice. This notwithstanding, the quality of the study conducted can be considered adequate and can certainly be improved upon for future editions.

The goal of the study, in addition to substituting the data flow from the Ministry of Justice, was to permit the collection of data and information capable of better representing the situation of drug-addicted and alcoholic prison inmates and of establishing the number of subjects who have the right to benefit from and who do benefit from alternative measures under Art. 94 of D.P.R. 309/90.

Figure 9.11 shows the data collected during the course of the Department for Anti-drug Policies' monitoring of drug addicts in prison, carried out in 2012 on the basis of 2011 data.

The results of this survey reveal that 19.4% of inmates (9,845 subjects) were diagnosed with a clinical substance addiction, while a total of 27.7% of inmates (13,793) used drugs, although not all of these were addicted.)

Figure 9.11: Inmate population flow (percentages refer to the previous level)



There are 13,793 prison inmates with drug-use problems (27.7% of the prison population). Of these, 9,845 were diagnosed with an addiction (ICD IX CM), while the remaining 3,948 were diagnosed as users without addictions (ST 12 – IT 2)

Source: Based on the Department for Anti-drug Policies' Study on Drug Addicts in Prison – Form 1 – December 2011

*Note: during the course of 2011, 58.7% of parole cases were filed due to closure of proceedings

Turning our attention to the demographic characteristics of inmates with drug-related problems (either addiction or use), we find that 96.4% of these are men; additionally, within this group, 71.2% of men and 66.6% of women are between 25 and 44 years of age. Distribution according to age group, which always reveals a majority of men, shows the opposite trend among younger inmates, among whom we find a higher percentage of women (11.8% women and 9.3% men in the 18- to 24-year-old age group).

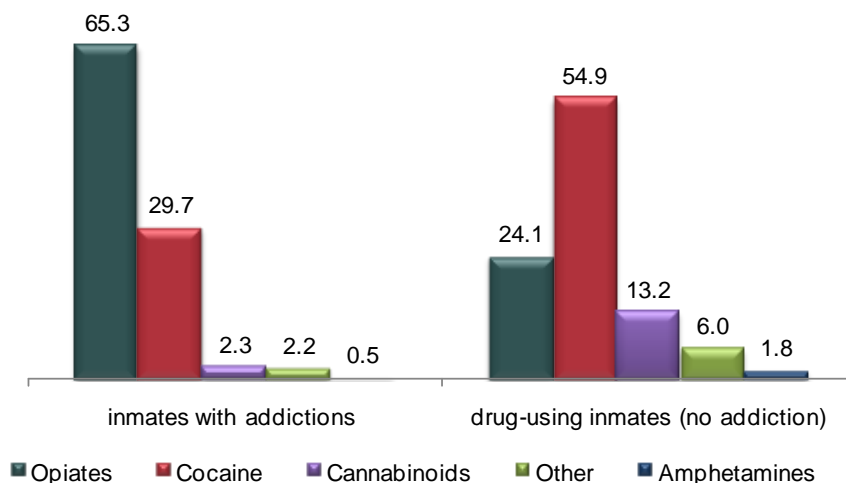
26.0% of drug-addicted inmates subjected to drug testing upon entering prison

50.7% of drug-addicted prison inmates are Italian citizens; in 33.8% of cases, nationality data is not available, and the remaining 15.4% are foreigners (of whom 85% come from outside of the EU).

If we consider type of use, for which data exists in 86.9% of cases, inmates with drug-related problems exhibit different choices in drug type based upon whether they have addictions (ICD –IX CM diagnosis) or simply use drugs: Among drug-addicted inmates (who account for 68.4% of inmates with drug-related problems), 65.3% of these, a total of 5,345 subjects, were diagnosed with opiate addictions, 29.7% (2,429 subjects) with cocaine addictions, while other types of drugs account for smaller percentages. Among inmates who simply use drugs, on the other hand, more than half of these (2,083 subjects) use cocaine. Percentages of non-addicted users of opiates and cannabinoids stand at 24.1% and 13.2%, respectively.

Choice of drug type differs between addicts and users

Figure 9.12: Subjects with drug-related problems by type of addiction and first drug used. Data in the form of percentages. The year 2011



Distribution of inmates with drug-related problems, according to types of drugs used
ST 12 – IT 2

Source: Based on the Department for Anti-drug Policies' Study on Drug Addicts in Prison – Form 1 – December 2011

It should be added that, regardless of whether inmates were diagnosed as addicts or users, 36.8% of subjects with drug-related problems (a total of 5,075 cases) were polydrug users at the time of entering prison.

36.8% of inmates with drug problems are polydrug users

9.4.2. Juvenile drug-users passing through the juvenile justice system

Up until the last edition of the Annual Report, the characteristics of drug-addicted minors in the prison system were studied based upon analyses of data from the Ministry of Justice, which collected information from individual juvenile custodial facilities throughout the country (Juvenile Correctional Institutions).

Ever since responsibility for healthcare in prisons was passed to Health Units, data regarding the situation of drug-addicted or alcoholic minors in prisons or other types of custodial institutions is gathered by Public Drug Treatment Units according to the principle of local competence.

For each subject, alcoholism or drug addiction according to the ICD –IX CM diagnosis is distinguished from mere use in the absence of a diagnosis. This year, information was collected from Correctional Institutions for Minors (a.k.a. IPMs), Reception Centres, Communities and Social Services for Juveniles; the Regions which sent monitoring data are shown in the table below.

Table 9.4: Regions which provided information on Juveniles with drug- or alcohol-related problems in correctional institutions or other custodial facilities. The year 2011

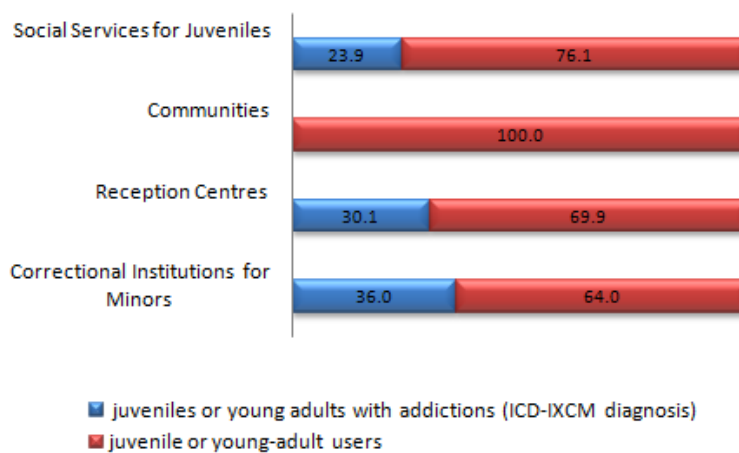
| Correctional Institutions for Minors | Reception Centres | Communities | Social Services for Juveniles |
|--------------------------------------|-------------------|-------------|-------------------------------|
| Piedmont | Piedmont | | Piedmont |
| Lombardy | Lombardy | | Lombardy |
| Lazio | Tuscany | Campania | A.P. Bolzano |
| Campania | Lazio | Calabria | Apulia |
| Apulia | Abruzzo | | Sicily |
| Calabria | Calabria | | |
| Sicilia | | | |

Source: Based on the Department for Anti-drug Policies' Study on Drug Addicts in Prison – Form 3 – 6 December 2011.

In view of the fact that information provided on a national level was only partial during this first year of the study, information on the total population of juveniles in custodial facilities for minors with drug-related problems in 2011 is not currently available. What follows, therefore, are some limited characteristics of the situation regarding juveniles with drug-related problems in custodial facilities, gathered in December 2011.

70.5% of these juveniles use drugs but were not diagnosed with addictions. If we divide the juveniles based upon the type of facility where they are held, we find that there are greater numbers of drug addicts (ICD IX diagnosis) in Reception Centres and Correctional Institutions for Minors, but hardly any in Communities.

Figure 9.13: Drug-addicted juveniles, by type of custodial facility. The year 2011

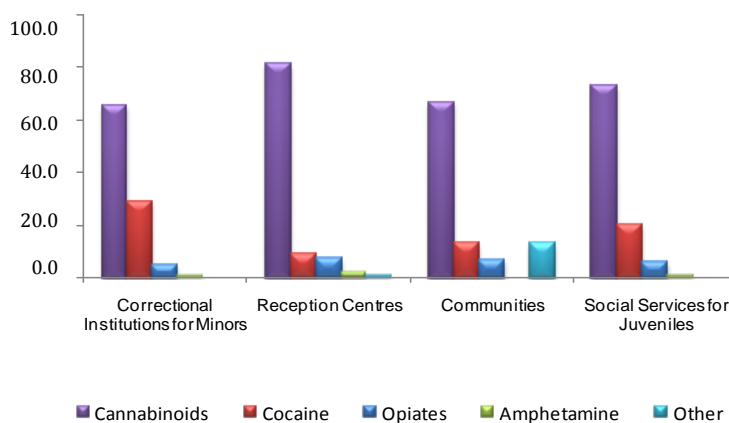


Source: Based on the Department for Anti-drug Policies' Study on Drug Addicts in Prison – Form 3 – 6 December 2011

Concerning the types of drugs used, most juvenile drug addicts, regardless of whether they have been diagnosed with addictions, use cannabinoids or, on a lesser scale, cocaine. The percentage of users of opiates or other types of drugs is low. In any case, 25.8% of juveniles exhibit polydrug-use behaviour upon entering custodial facilities or alternative measures.

A higher number of juvenile drug addicts use cannabinoids

Figure 9.14: Drug-addicted juveniles, by type of drug used and type of custodial facility. Data is given in the form of percentages. The year 2011



Source: Based on the Department for Anti-drug Policies' Study on Drug Addicts in Prison – Form 3 – 6 December 2011

58.8% of drug-addicted juveniles in the study receive treatment for their addictions. Of these, 78.8% undergo psychosocial treatment, 17.8% receive integrated pharmacological and psychosocial treatment and 3.4% receive only pharmacological treatment. It was found that only 11.9% of these minors (83 out of 697 subjects) were sent on to therapeutic, social-educational or social-rehabilitation communities.

9.5 Responses to drug-related health issues in prisons

9.5.1. Drug treatment

Observing data collected through application of the new information flow regarding inmates in the care of drug-addiction services, it was found that only 28.5% of drug-addicted inmates were subjected to testing for HIV (3,926 subjects), 30.8% to testing for HCV (4,245 subjects) and only 29.2% (4,029 subjects) to testing for HBV upon entering prison. Prevalence of positive results among those tested was equal to 7% for HIV, 44% for HCV and 25% for HBV.

Few tests for HIV,
HCV and HBV

Table 9.5: Subjects with drug-related problems undergoing treatment. The year 2011

| | Absolute values | % |
|--|-----------------|--------------|
| Inmates undergoing treatment | 10,822 | 78.5 |
| who receive: | | |
| <i>only pharmacological treatment</i> | 2,391 | 17.3 |
| <i>psycho-social treatment</i> | 3,648 | 26.4 |
| <i>integrated pharmacological and psychosocial treatment</i> | 4,457 | 32.3 |
| Inmates not provided being treated | 2,971 | 21.5 |
| Total | 13,793 | 100.0 |

78.5% of drug-addicted inmates receive treatments focusing on care and prevention

Source: Based on the Department for Anti-drug Policies' Study on Drug Addicts in Prison – Form 1 - December 2011.

Regarding drug-addiction treatment, it was found that 78.5% of inmates with drug-related problems undergo treatment in prison. The most commonly-used type of treatment appears to be integrated psycho-social and pharmacological treatment, which is provided to over 4,457 inmates.

10. DRUG MARKETS

This chapter, which describes the main characteristics of illicit drug supply in Italy, has the aim of providing the information needed to make conjectures regarding possible future developments in the demand for psychoactive drugs. This is done in full knowledge of the increasing complexity and constant evolution of a scenario which sees the continual appearance and introduction onto the market of new drugs or mixtures of already known drugs whose effects are partly or completely unknown.

The profile described in this chapter is based on data collected by the Central Directorate for Anti-drug Services of the Ministry of the Interior (DCSA) and also draws on the annual report on drug-trafficking in Italy, an information source to which reference should be made for further details and more in-depth analyses.

Preface

DCSA:
the principal source
of information

10.1. Drug production, supply and trafficking¹

Organized crime is becoming ever more global and is distinguished not only by its internationalisation, but also by a greater transnationality reflected in the establishment of cooperation between criminal groups from different countries, each of whose aim is to more efficiently manage its own business. These two characteristics – internationalisation and transnationality – are most often found in drug trafficking, which is the most typical example of both. The drug market thus becomes more vast not only because of the spread of new illicit psychoactive drugs or due to the creation of new markets and new routes, but mainly as a consequence of the multitude and variety of people and organizations involved and interconnected. Criminal groups develop, are replicated and made stronger by the drug trafficking they are involved in, and not only this. Drug trafficking also contributes to the creation and growth of the system of relationships that binds them together and which revolves around them, going beyond domestic borders and permitting the development of a network of transborder criminals who manage production, processing, trafficking, brokerage and dealing through the use of a system of a reticular nature. Furthermore, in recent years we have been witness to the phenomenon of poly-drug trafficking, which, in striving to meet ever more varied and changeable demand, reinforces accords and integration among these multiple organizations.

When analysing the information and data gathered, collated, handled and processed by the Central Directorate for Anti-drug Services and from national and international coordination activities (investigations conducted by Italian Law Enforcement Agencies), a clear picture of the national situation emerges which closely mirrors the global state of affairs. Indeed, according to the profile which emerges, the management of the majority of drug trafficking is distinguished by skilled and specialized organized crime syndicates seeking to collaborate with each other and reach agreements on operations.

The role of
organised crime

Drug trafficking
managed by mafia-
style associations

¹ Source: 2001 Annual Report on drugs trafficking, Central Directorate for Antidrug Services – Part 2., http://img.poliziadistato.it/docs/Ann_2011_Parteseconda.pdf

The most prominent of these syndicates are the home-grown, traditional structures of a mafia type (Cosa Nostra, 'Ndrangheta, Camorra and organized crime syndicates from the region of Apulia). Through the use of widespread and well-established branches both outside of their regions and abroad, these groups are capable of managing international trafficking operations of enormous size, in addition to carrying out their local operations. These organizations also benefit from Italy's unique shape, with its thousands of kilometres of coastline, as well as its geographic position, lying, as it does, in the centre of the Mediterranean Sea and at both the overland and sea termini of the well-known "Balkan Route". Additionally, it is near to the coast of North Africa, an important area for drug stockpiling as well as for drug production. These factors combine to make Italy one of the major points of access for drugs coming into Europe and thus a critical, strategic hub for all the international trafficking routes, both licit and illicit.

Italy: one of the principal trafficking areas and transit routes for illicit drugs

The effects of the presence and deep-rooted nature of mafia-style organized crime on these groups' Regions of origin, although less visible than in the past from some perspectives, continue to be seen in the number of persons charged with crimes which fall under Art. 74 of D.P.R. 309 of 1990 and are punishable under the same. Indeed, once again in 2011, nearly half of all persons charged with these most serious of crimes came from Sicily, Apulia, Campania and Calabria and are distributed nearly equally among those regions (Sicily with 12.02% of the national total, Apulia with 11.60%, Campania with 11.40% and Calabria with 11.17%). Data regarding the involvement of criminal organizations in drug trafficking show that Cosa Nostra continued its role in large-scale drug trafficking, both revitalising channels and contacts which, in the past, had made it the unrivalled leading player in heroin trafficking with North America, as well as stipulating new agreements and accords in order to build new international presence and exploit well-established logistical and operative bases such as those in South America, Spain and Northern Europe.

Sicily, Apulia, Campania and Calabria: highest numbers of persons charged with crimes

The Calabrian 'Ndrangheta is one of the major players in global cocaine trafficking. Its importance is such that, in 2008, the American Government included it on its "black list" (Foreign Narcotics Kingpin Designation Act) of the principal non-U.S. organizations devoted to drug trafficking. Over the last twenty years, the 'Ndrangheta has made Italy into a strategic centre for cocaine trafficking in Europe and the second-largest users' market after North America. Moreover, the organization has extensively exploited the commercial traffic in the port of Gioia Tauro (Reggio Calabria), a transshipment hub of great importance for merchandise being transported in containers from all parts of the world, destined mainly for markets in the Mediterranean and continental Europe, to such an extent that this port has become a nerve centre for South American cocaine trafficking. This port could also become strategic for the traffic of merchandise coming from emerging economies (Southeast Asia, India and China) to Western markets, and thus also for the maritime trafficking of heroin, which is embarked from the same locations (the port of Karachi for Afghan heroin and the port of Singapore for heroin from Myanmar), as well as for the trafficking of synthetic drugs and precursors, which are produced in China, India and Southeast Asia.

South American cocaine trafficking and the trafficking of merchandise from Southeast Asia

According to precise commercial analyses, it could be economical, in terms of both time and costs, for containerships sailing from Asia and bound for the West to offload their cargo at Gioia Tauro and continue overland from there, by road and rail, towards the ports of Northern

Europe (Rotterdam, Hamburg, Antwerp) to then be loaded once more onto containerships bound for New York, the hub for all of North America and Mexico. The danger is that this would further increase the 'Ndrangheta's potential and the danger they pose, extending their reach to the trafficking of heroin and synthetic drugs and precursors.

Turning to the topic of heroin, its trafficking routes and the organized crime involved with it, the Region of Apulia remains prominent. The quantity of heroin seized there is high, despite there having been a 39.54% drop in amount in 2011. Furthermore, Apulia is the Region where the highest quantity of marijuana was seized (38.79% of the national total); 1,467.37 kilos were seized at the port of Bari and another 629.90 kilos at the port of Brindisi. Apulia has therefore become an established crossroads for drug purchasing and transit (mainly heroin, in transit from the "Balkan Route", and marijuana, especially marijuana produced in Albania and containing a high amount of active principle).

In conclusion, statistical and operative analyses paint a picture of a national drug-trafficking situation which, like the bigger global picture, shows us a regime of "criminal agreement" where practical links are frequently forged, both within Italian borders and abroad, and not only between the traditional mafia factions but also between these and other endogenous and foreign criminal associations which either are producers or function as representatives for producers, in other words, intermediaries.

Apulia: heroin distribution and trafficking

10.2. Drug Operations and Seizures

Law Enforcement activities targeting the illicit drugs market are concentrated on three main fronts: drug production, trafficking and sales. The following section provides a summary of the activities to combat this phenomenon carried out by Law Enforcement Agencies in 2010 and their results.

Table 10.1: Anti-drug operations and seizures of illicit drugs. The year 2011

| | 2010 | | 2011 | | Δ % |
|----------------------------------|--------|-------|-----------|-------|---------|
| | No. | % | No. | % | |
| Anti-drug operations | | | | | |
| Seizure | 18,759 | 85.0 | 19,469 | 84.3 | +3.8 |
| Crime detection | 1,883 | 8.5 | 1,972 | 8.5 | +4.7 |
| Discovery | 1,339 | 6.1 | 1,530 | 6.6 | +14.3 |
| Other | 83 | 0.4 | 132 | 0.6 | +59.0 |
| Total | 22,064 | 100.0 | 23,103 | 100.0 | +4.7 |
| Seizures of illicit drugs | | | | | |
| Cocaine (kg) | 3,839 | 12.3 | 6,342 | 16.11 | +65.2 |
| Heroin (kg) | 944 | 3.0 | 811 | 2.06 | -14.1 |
| Hashish (kg) | 20,212 | 64.7 | 20,258 | 51.47 | +0.2 |
| Marijuana (kg) | 5,505 | 17.6 | 10,908 | 27.71 | +98.1 |
| Cannabis plants (no. of plants) | 72,538 | | 1,008,215 | - | +1289.9 |
| Synthetic drugs (units/doses) | 74,917 | - | 16,620 | - | -77.8 |

Increase in seizure operations

Decreases in volume for: heroin and synthetic drugs

Significant increase in numbers of cannabis plants

Increases also recorded for marijuana, cocaine and hashish

Source: Based on data from the Ministry of the Interior – the Central Directorate for Anti-drug Services

In 2011, Law Enforcement Agencies conducted a total of 23,103 anti-drug operations, a 4.7% increase with respect to the previous year, although the year with the highest number of operations during the last ten-year period remains 2009, with 23,272 operations.

In 84.3% of cases, anti-drug operations conducted by Law Enforcement Agencies led to the seizure of illicit drugs, 8.5% of operations led to additional crime detection and 6.6% of anti-drug activities led to the discovery of quantities of drugs (Table 10.1). Unlike the previous year, when three laboratories for the processing of cocaine and liquid hashish were discovered and dismantled, no drug-processing laboratories were discovered in 2011.

In particular, the “balance sheet” of the fight against drug trafficking in Italy in 2011 shows the seizure of over 39,000 kg of drugs and of over one million cannabis plants. In particular, the quantities of marijuana and cocaine seized showed an increase.

In 2011, 5,707.88 kg of drugs were also seized abroad by the competent Police Forces, thanks to reports made and international coordination activities conducted by the Central Directorate for Anti-drug Services, as well as to subsequent activities of the Italian Police Forces involved in investigations with foreign developments, that is, providing support to international operations. This amount should be added to the total amount of drugs seized within Italian borders in 2011.

4.7% increase in the number of anti-drug operations in 2011 (all-time high was reached in 2009)

Types of operations

Large number of cannabis plants seized

Table 10.2: Amounts of cocaine and marijuana seized in “maxi-seizure” operations – the years 2010-2011

| Region | Province | Cocaine > 20 Kg | | | Marijuana > 100 Kg | | |
|----------------|-----------------------|-----------------|--------|----------|--------------------|--------|----------|
| | | 2010 | 2011 | Diff. kg | 2010 | 2011 | Diff. kg |
| Calabria | Reggio Calabria | - | 525.5 | +525.5 | - | - | - |
| Campania | Naples | 172.8 | 43.5 | -129.3 | - | 327.1 | +327.1 |
| Emilia Romagna | Bologna | 39.1 | 27.9 | -11.2 | - | - | - |
| | Rimini | - | 46.7 | +46.7 | - | - | - |
| Lazio | Rome | 625.2 | 291.5 | -333.7 | 154.2 | 1040.2 | 886 |
| Liguria | La Spezia | - | 57.1 | +57.1 | - | - | - |
| Lombardy | Bergamo | 24.3 | - | - | - | - | - |
| | Brescia | 22.2 | 27.8 | 5.6 | - | 706.4 | +706.4 |
| | Como | - | 33.9 | +33.9 | - | - | - |
| | Milan | 309.9 | 172.9 | -137 | 378.7 | 147.3 | -231.4 |
| | Monza-Brianza | - | - | - | - | 182.1 | +182.1 |
| | Varese | 302.5 | 354.4 | 51.9 | - | 662 | +662 |
| Marche | Ancona | - | - | - | - | 548.3 | 548.3 |
| PA Bolzano | Bolzano/Bozen | 22.7 | 39.8 | 17.1 | - | - | - |
| Piedmont | Turin | 38.1 | 50.2 | 12.1 | - | - | - |
| Apulia | Bari | - | - | - | 183.5 | 1999.8 | 1816.3 |
| | Barletta-Andria-Trani | - | - | - | - | 401 | +401 |
| | Brindisi | - | - | - | - | 659.2 | +659.2 |
| | Lecce | - | - | - | 968.2 | 325.8 | -642.4 |
| Sardinia | Sassari | 29.8 | 512 | 482.2 | - | - | - |
| Sicily | Catania | - | 20.8 | +20.8 | 156.8 | - | - |
| Tuscany | Florence | 53.8 | 25.8 | -28 | 213.3 | 228.7 | 15.4 |
| | Leghorn | - | 351.3 | +351.3 | - | - | - |
| Total | | 1640.5 | 2581.2 | 940.7 | 2054.7 | 7227.9 | 5173.2 |

“Maxi-seizures” for cocaine and marijuana in provinces located on the coasts and at border crossings

Source: Based on data from the Ministry of the Interior – the Central Directorate for Anti-drug Services

Data regarding drug seizures are reported in Standard Table number 13 (ST_13_2012). In 2011, in contrast with the previous year, there was a dramatic 98.1% increase in marijuana seizures, while figures for hashish seizures remained largely unchanged (+0.2%). The largest amounts of cannabis derivatives were seized in Lazio (21.7% of the total), Lombardy (21%) and in Apulia (14.3%).

In the cocaine sector (the most lucrative of all drug-trafficking sectors) there was a 65.2% increase in the amount seized (6.3 tons) but a slight drop (2.48%) in the number of operations, which fell from 7,129 to 6,952). An analysis of seizures made at the borders brings to light another statistic which distinguishes the year 2011 with respect to cocaine. This drug, traditionally the most commonly seized at airports (mainly at Milan Malpensa and Rome Fiumicino) has also become the most commonly seized at the peninsula's ports. In addition to the already well-known port of Gioia Tauro (Reggio Calabria), the port of Genoa and, especially, those of Leghorn, La Spezia and Alghero also stand out. In the previous five-year period, drug seizures in the last three ports mentioned had been negligible to nil.

Turning our attention to the cocaine and marijuana "maxi-seizure" operations carried out in 2010 and 2011, where "maxi" means over 20 kg of cocaine and over 100 kg for marijuana, we find that these figures confirm our previous observation, with most of these being carried out in provinces located along the coasts or at border crossings. This is due to the fact that the large amounts thus seized were not destined only for the Italian market, since Italy serves as a transit zone for the rest of Europe (Table 10.1).

Investigative activities carried out over recent years reveal a new trend in strategies being employed by the principal criminal organizations (in particular the 'Ndrangheta and Camorra) whereby very large quantities of cocaine are introduced directly into Italian territory, bypassing the traditional phases of transit and stockpiling in the Iberian Peninsula or the Netherlands, which are the traditional ports of ingress into Europe for South American cocaine. An observation of maritime routes shows us that seizures of cocaine in Italian ports, which stood at 610.72 kg in 2008, rose to 1,358.86 kg in 2009, before falling slightly to 1,331.44 kg in 2010 and then rising to 3,626,54 kg in 2011, figures which serve as evidence of this trend.

In 2011 there was also found to be a 14.1% decrease in the amount of heroin seized by Law Enforcement Agencies (0.8 tons) as well as a 77% drop in the amount of synthetic drugs seized in comparison with 2010.

Regarding the seizure of cannabis plants, the Central Directorate for Anti-drug Services issued a warning about the spread of local production of illicit drugs by organized crime syndicates. Seizures of cannabis plants shot up from 72,538 plants in 2010 to 1,008,215 in 2011. The greatest number of plants were seized in Sicily, which accounted for 91.8% of the overall total, followed by Calabria (3.9%) on a smaller scale.

Trends in the quantities of drugs seized over the last fifteen years place cannabis derivatives at the top of the ranking, with a particularly high quantity, exceeding 40 tons, in the period spanning 1997 – 2003. Subsequently, two increases have been recorded, one in 2008, when Law Enforcement Agencies intercepted a quantity in excess of 37 tons, and another in 2011, when over 31 tons were intercepted.

Figures for the seizures of cocaine and heroin remain much less variable. Between 2002 and 2010, cocaine seizures fluctuated between 3.5 and 4.5 tons, but shot up to 6.3 tons in 2011. Heroin seizures, which had

Increase in
marijuana seizures
(+98%)

Increase in cocaine
seizures at Italian
ports

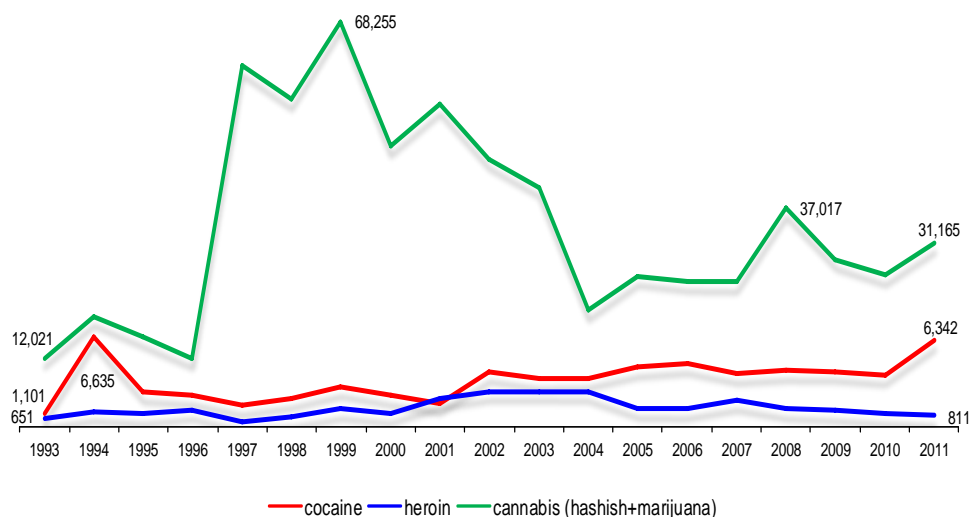
Decrease in seizures
of heroin and
synthetic drugs

Local production
and a dramatic
increase in the
number of cannabis
plants seized by
geographic area:
Sicily and Calabria

Trends in the
quantities of illicit
drugs seized

fluctuated between 1.0 and 2.5 tons from 2002 and 2010, fell to 0.8 tons in 2011, the lowest figure recorded in the last ten-year period (Figure 10.1).

Figure 10.1: Quantities of illicit drugs seized by Law Enforcement Agencies during the course of anti-drug operations. The years 1993 – 2011



Trends in heroin seizures remain stable

Increase in quantities of cocaine and cannabis seized in 2011

2007-2011 data updated

Source: Based on data from the Ministry of the Interior – the Central Directorate for Anti-drug Services

10.3. Price/purity

10.3.1 Price

Trends in retail and wholesale prices of drugs represent one of the variables which determine how drug demand relates to supply. It is therefore a variable of utmost importance when analysing the effects of national and international policies for anti-drug policy management. Furthermore, price trends, when their variability is significant, can be an indirect indicator of use trends. As a matter of fact, a drop in price usually corresponds to a reduction in demand or to the appearance on the market of a competitor drug or the rise of other alternative distribution networks.

The average total value of the drugs seized by Police Forces during the course of 2011 is approximately 467 million Euros (this figure does not include the value of synthetic drugs, which is difficult to calculate due to the numerous types which are available). An analysis of trends in wholesale and retail prices makes it reasonable to assume that drugs, despite the fact that their retail value has been in constant and on-going decline, represent a “safe investment” for organized crime syndicates, which are reassured by the fact that they are investing in a safe product which is always widely used.

Collection of retail-price information is currently the responsibility of the Central Directorate for Anti-drug Services, which processes information coming from the local police forces of twelve sample cities (Palermo, Reggio Calabria, Naples, Bologna, Venice, Florence, Trieste, Turin, Rome, Genoa, Milan and Verona).

Price analysis is based entirely on Standard Table Number 16 (ST_16_2012). As was mentioned earlier, in 2011 there were decreases in

the maximum and minimum prices of hashish and cocaine, as well as in the maximum price of lysergic acid (LSD) and the minimum price of marijuana. There was, however, a new increase in maximum prices of white heroin and ecstasy, while the minimum and maximum prices of brown heroin and amphetamines remained stable, as did the maximum price of marijuana (Table 10.3).

Table 10.3: Minimum and maximum price per unit (gram/dose/pill) of drug – The years 2010 and 2011

| Drug type | Minimum price | | | Maximum price | | |
|------------------|---------------|------|------|---------------|------|-------|
| | 2010 | 2011 | Δ% | 2010 | 2011 | Δ% |
| Hashish (g) | 8.9 | 8.3 | -6.8 | 13.5 | 11.5 | -14.2 |
| Marijuan (g) | 7.7 | 7.2 | -6.5 | 9.4 | 9.4 | 0. |
| Brown heroin(g) | 35.5 | 35.5 | 0.0 | 48.4 | 48.4 | 0.0 |
| White heroin (g) | 53.3 | 53.3 | 0.0 | 68.3 | 72.0 | +5.4 |
| Cocaine (g) | 57.9 | 55.4 | -4.3 | 80.4 | 80.3 | -0.2 |
| Amphetamines (g) | 16.0 | 16.0 | 0.0 | 17.4 | 17.4 | 0.0 |
| Ecstasy (dose) | 14.8 | 14.8 | 0.0 | 18.5 | 18.8 | +1.4 |
| LSD (dose) | 23.3 | 23.3 | 0.0 | 28.2 | 27.0 | -4.1 |

Different price variations:

Decrease in the prices of cannabis and its derivatives, cocaine and LSD

Brown heroin and amphetamine prices remain stable

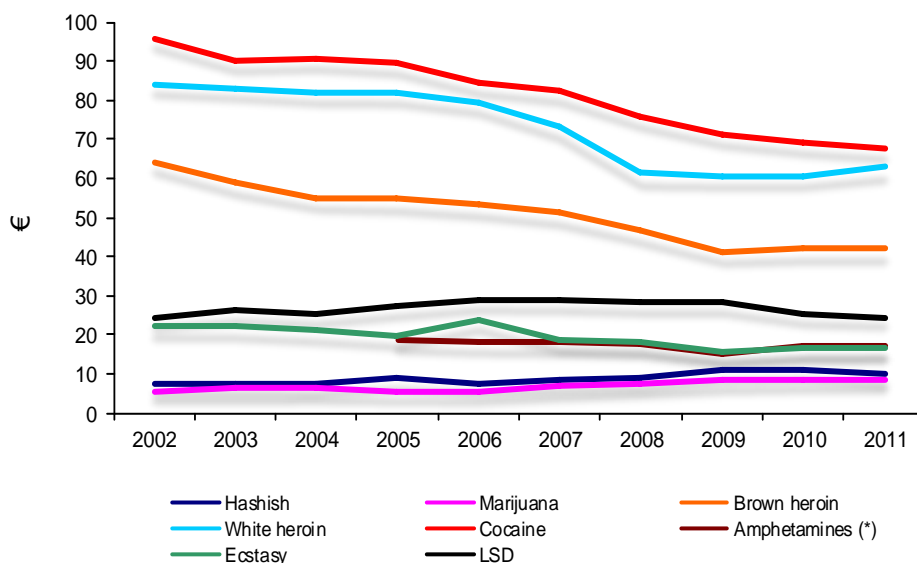
Increase in prices of white heroin and ecstasy

Source: Ministry of the Interior – the Central Directorate for Anti-drug Services

From 2002 to 2011, average prices have fallen from €96 to nearly €68 per gram for cocaine and from approximately €29 to little more than €25 for a dose of LSD; minimal increases were recorded for white heroin and ecstasy during the last year. Hashish price dropped slightly, while average prices for amphetamines, brown heroin and marijuana remained stable. Overall, price trends were found to be declining (Figure 10.2).

General average price trend from 2002 to 2011 shows a downturn

Figure 10.2: Average prices per drug dose. The years 2002 – 2011



Standard Table 16: average prices in Euros

(*) Data for amphetamine prices are only available beginning in 2005

Source: Based on data from the Ministry of the Interior – the Central Directorate for Anti-drug Services

10.3.2 Purity

The data on the purity of drugs comes from analyses conducted by the Drug Investigation Section of the Police Scientific Service of the Central Anti-crime Directorate of the State Police (Standard Tables 14 and 15), as set forth in the specifications established by the European Monitoring Centre for Drugs and Drugs Addictions. The data recorded refers to both high-quantity seizures and street seizures.

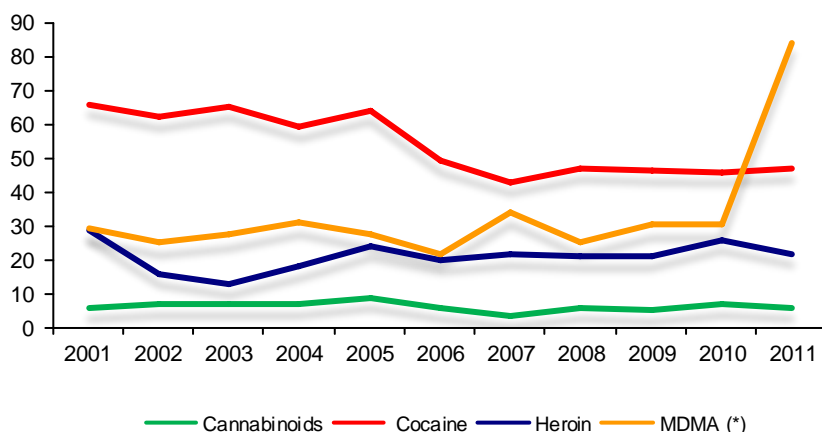
In 2011, the average percentage of active principle found in the samples analysed decrease both for cannabinoids (THC), falling from 7% to 6%, and for heroin, dropping from 26% to 22%. The percentage of pure drug in cocaine increased slightly, while the number of mg of MDMA contained in each pill/unit rose from 30 mg in 2010 to 84 mg in 2011. However, these figures are the results of analyses carried out on a small sample of drugs, and are therefore subject to high variability both within the sample itself as well as in comparison with samples of drugs collected at different times (Figure 10.3 and Table 10.4).

Decrease in % of active principle in cannabinoids and heroin

% of active principle in cocaine remains stable

Increase in mg of MDMA per pill/unit

Figure 10.3: Average percentage of pure drug in drugs discovered by Law Enforcement Agencies in the years 2001 to 2011



ST_14_2012: Average percentage of pure drug found in drugs

(*) MDMA figures refer to the average weight in mg per pill/unit.

Source: Based on data from the Ministry of the Interior – Central Anti-crime Directorate of the State Police

Table 10.4 contains the maximum, minimum, average and median values of active principle found in illegal psychoactive drugs in 2011. Variability is very high, ranging from 0.4% to 14.8% for cannabinoids, from 13% to 86% for cocaine and from 2% to 78% for heroin, while the weight in mg of MDMA per pill/unit ranged from a minimum of 35 mg to a maximum of 135 mg. All variation registered may also be the result of combining the types of seizures (large shipments or retail), since drugs seized in these two different situations can have very large differences in percentage of active principle.

High variability in quantities of active principle – ST_15_2012

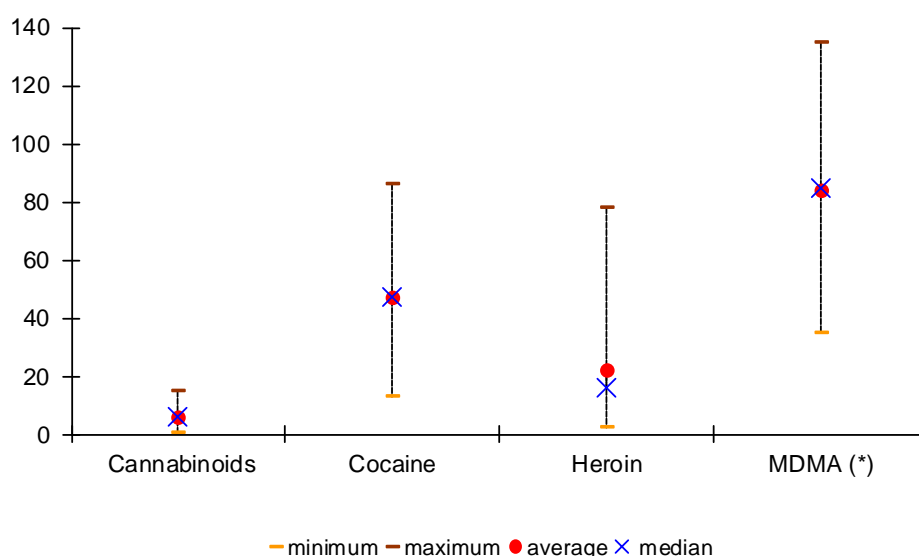
Table 10.4: Minimum, average, median and maximum active-principle values found in illicit psychoactive drugs. The year 2011

| | Cannabinoids | Cocaine | Heroin | MDMA(*) |
|---------|---------------------|----------------|---------------|----------------|
| minimum | 0.4 | 13 | 2 | 35 |
| average | 6.0 | 47 | 21.9 | 84 |
| median | 6.0 | 47 | 16 | 85 |
| maximum | 14.8 | 86 | 78 | 135 |

(*) MDMA figures refer to the average weight in mg per pill/unit.

Source: Based on data from the Ministry of the Interior – Central Anti-crime Directorate of the State Police

Figure 10.4: Variability in the quantity of active principle in illegal psychoactive drugs discovered by Law Enforcement Agencies in 2011



(*) MDMA figures refer to the average weight in mg per pill/unit.

Source: Based on data from the Ministry of the Interior – Central Anti-crime Directorate of the State Police

With regard to the percentage of active principle of cannabis and its derivatives, it should however be pointed out that the Warning System has detected extremely high percentages in some drugs seized in 2012 (38% in skunk plants and 58% in hashish oil), with a trend towards the selection and production of plants with ever higher levels of active principle. This preliminary data, which will have to be verified over time together with supply trends, verifiable via internet and through customer demand, points to a tendency to attempt to select and introduce onto the markets plants and intensive growing methods capable of producing ever higher levels of THC.

Part B

Selected Issues

11. RESIDENTIAL TREATMENT FOR DRUG USERS IN EUROPE

EMCDDA
Foreword

Residential treatment has historically been a substantial component in the range of treatment and rehabilitation options for drug users in many European countries. Although today, in an era of rationalism, residential facilities are being closed, the interest is still alive as to what they can offer to the population of dependent users who seek treatment and recovery. Partly, the dwindling availability of residential services can be seen as a result of recent efforts across Europe to contain drug treatment spending, among other public pay. A fuller explanation can be gained for these changes by turning to the history of drug treatment and examining any prominent influences and preferences in relation to treatment philosophies, which in different countries would have shaped unique drug treatment provision landscapes.

Today there is a need to examine residential treatment facilities. Outpatient treatment and rehabilitation is not always a realistic option, particularly for a select group of drug dependent clients, who need the safety, care and structure that residential settings provide. The aim is therefore to provide a Europe-wide overview of residential treatment, including country specific features of its history and current role in the wider drug-treatment systems, as well as exploring the availability and diversity of residential treatment programmes.

As proposed by the EMCDDA, this chapter provides an overview of the Italian situation with regard to existing regulations in the sphere of rehabilitation and social reintegration of drug dependent clients, national strategies, the types of facilities and treatments available and, finally, treatment demand in terms of clients.

Concerning information sources, flows regarding social-rehabilitation facilities and their clients are collected by the Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources of the Ministry of the Interior, while classifications of social-rehabilitation facilities, in accordance with the criteria laid down in the State-Regions Accord Act, are gathered by means of the information flow from Regional Administrations. Some information about treatments provided to clients in the care of social-rehabilitation facilities is collected by the public drug addiction services which provide care within the facilities themselves.

Sources and
information flows

11.1. History and policy frameworks

History of social-rehabilitation facilities in Italy

The term “therapeutic community” was first applied to social-rehabilitation facilities in 1946, when Thomas Forest Main thus described the groups and activities created by the English psychiatrists of the Northfield Group. The term “therapeutic community” was officially recognized by the World Health Organization in 1953, upon completion of a study which proposed transforming psychiatric hospitals into therapeutic communities.

In the early 1960s, Italy began to acquire importance in terms of the drug-use phenomenon. Unlike in the United States, where drug use had spread among counterculture youth and through the marginalized strata of

The inception of
drug use in Italy

society, drug use in Italy developed as the preserve of small groups of élite.

The sale of drugs was initially the province of lone dealers but, as the phenomenon became more widespread among youth, in suburban areas and in factories, evolving into a profitable business, organized crime became involved, substituting hashish and marijuana with opiates, which pose much greater health risks.

In 1973, the first overdose death was recorded in Italy, caused by heroin, with cocaine making its appearance in the 1980s.

The majority of therapeutic communities came into being in the late '70s and during the course of the '80s. Most of these still exist, offering different approaches to the drug addiction problem and implementing different operational strategies.

During the '80s and '90s, the use of cocaine and other drugs besides opiates began to rise, partly due to the fear kindled by the spread of the HIV virus through needle sharing on the part of heroin users. The early '90s saw the advent of ecstasy, mostly among young people frequenting discotheques and rave parties.

The birth and proliferation of therapeutic communities was one of the answers society provided to counter the ever-wider spread of this phenomenon in Italy. The therapeutic models proposed and the methodology upon which communities base the services they provide have always constituted an important resource, especially during that time when an effective, well-structured institutional response to the drug problem had not yet been organized. The diverse nature of the solutions put forward by professionals working in communities is, in part, the fruit of the different ideological points of reference adopted by the different individual facilities and by the social and cultural backgrounds of their varied types of clients.

Every operational strategy required, and still requires, a philosophy regarding the roots of drug addiction and a consequent therapeutic approach.

There are essentially three operational strategies:

- basic strategy
- strategy based on work and on social reintegration
- specialized strategy focusing on psychotherapy

Today, a number of communities still interpret the phenomenon as having roots in psychological issues stemming from harmful experiences during the early stages of life and adolescence, while for others, drug addiction is the result of disappointment or inadequacy in personalities that are particularly sensitive to society's realities. Some communities present themselves as surrogate families which help individuals to become self-sufficient and take responsibility for their own lives, while others present themselves as alternative micro-societies.

Social-rehabilitation facilities sometimes employ treatment methodologies that involve a shared model for living and aim to construct drug-free personalities capable, once they have concluded their therapy programme, of transferring the ideals they have acquired and internalized to the outside world as well.

Some of these facilities place great importance on work activities, with the goal of encouraging drug-dependent individuals to grow, moving out of the adolescent stage in which drugs have blocked them, by acquiring skills and assuming personal responsibilities upon which they can draw once they have completed their therapy programmes.

Other facilities, with the help of psychoanalysis and individual and group

The first drug-related death

Therapeutic communities came into being in the late '70s and throughout the '80s.

Operational strategies in therapeutic communities

The work approach

psychotherapy techniques, focus on helping those undergoing treatment to become aware of the deeply-rooted conflicts which led to their unhealthy behaviours. The aim of this approach is to help individuals gain the ability to recognize and manage their own unconscious tensions.

The therapeutic approach

Over the course of over thirty years of existence, facilities for the rehabilitation of drug addicts have improved and broadened the range of treatment options they offer. A large number of communities train their own staff and many more have stipulated agreements with the Ministry of Justice to take in drug-dependent prison inmates who have to serve alternative sentences.

The last 30 years have seen a great increase in the range of types of treatment available

Some structures take in drug-dependent mothers with children, those suffering from AIDS, alcoholics, people who have developed other forms of psychiatric morbidity in addition to their drug addiction or those suffering from other addictions such as dependency on tobacco or compulsive gambling.

Today, drug use and abuse are no longer limited to a certain type of drug or to marginalized individuals, but involve every social class and age group, and drugs are widely available in those social venues frequented mostly by young people who are well-adjusted in their school or work environments. It is for this reason that communities have diversified their treatment programmes, adapting them to individual needs and to the new types of drug users, many of whom are poly-users of drugs and alcohol.

Few, however, have a strong personal motivation to begin treatment, and only some of those who enter communities complete their programmes. Since treatment relies most strongly on an individual's willingness to succeed, the positive outcome of treatment is linked to the ability of the therapeutic community staff to motivate the drug addict during the reception phase.

The delicate phase of social reintegration

The stage when the client leaves the community, a comparatively protected environment, to be reintegrated into society, is a delicate phase which requires a programme of mentoring by professionals, and some communities expect family members of the drug-dependent clients to be involved in these different phases of the rehabilitation programme.

Changes in types of drugs being used and methods of use require all those who are involved in this field to rethink the role of private non-profit services within the complex landscape of therapeutic alternatives.

From a regulatory standpoint, social-rehabilitation facilities, like public drug addiction services, fall under the umbrella of the Consolidated Law of Presidential Decree (DPR) 309/90. Concerning the rehabilitation and reintegration of drug addicts, the law provides, under Part X, an entire section devoted to the competences of the responsible Regional, Provincial and Local Authorities' and Local Health Units regarding the care of drug addicts.

DPR 309/90

Specifically, Article 113, "Responsibilities of the Regions and Autonomous Provinces", assigns the responsibility for prevention, treatment and rehabilitation activities for drug addictions to the Regions and Autonomous Provinces. Concerning facilities, the same Article, under Paragraph b), states that public drug addiction services and private facilities that engage in prevention, treatment and rehabilitation activities in this field must possess the structural, technological, organizational and functional requisites listed under Article 116. Meanwhile, regarding accessibility of services, Paragraph c) states that regulations governing institutional accreditation of services and facilities ensure, in accordance with the criteria set forth in Legislative Decree No. 502 of 30 December 1992,

Competences of responsible institutional entities in the field of addictions

equal access to service facilities and to the services provided by both public services and accredited private facilities.

The functions of services and authorized facilities are governed by Art. 113, Paragraph d) which, for facilities devoted to rehabilitation and reintegration, lays down the following responsibilities:

1) Analysing the clinical, social, health and psychological conditions of the drug dependent addict, also in relations with his family.

4) Drafting, implementing and monitoring a therapeutic and social-rehabilitation programme, in respect of each client's individual freedom to choose his treatment facility.

In addition to the public services offered by Local Health Units, care for drug addicts may also be given by non-profit Ancillary Agencies which may perform their activities for the prevention of psychological and social deprivation, assistance, treatment, rehabilitation and reintegration of drug addicts, or associations, agencies created by them for the purpose of educating young people, encouraging the social and cultural development of their personality, vocational training and job counselling.

In addition to the functions performed by the services assigned to provide social and healthcare assistance to drug-dependent individuals, other responsibilities in terms of rehabilitation are also assigned to Local Authorities and are governed by Art. 114 of DPR 309/90.

Specifically, the text of the law states that, as part of the social welfare functions vested in municipalities and the mountain communities, using the services where possible of associations and ancillary agencies, also through their consortia, or through special centres managed by themselves or through their associations, without being managed for profit, recognized or eligible for recognition, they shall pursue the following objectives with regard to the prevention and rehabilitation of drug addicts:

a) preventing marginalization and social deviance by designing and implementing, directly or indirectly, programmed schemes;

b) collecting and analysing data, in conjunction with the school authorities, on the local causes of deprivation in the family and society, which encourage the deviance of young people and failure to attend school;

c) enabling drug addicts to attend school, find work and be reintegrated into society.

Concerning care, Part XI governs those articles of the law having to do with preventative, curative and rehabilitation work. Art. 120, Paragraph 1, states that anyone who personally uses narcotic and psychotropic substances may request the public drug dependence service or an authorized private structure, after having carried out the necessary inquiries and having spoken to the person concerned, to a therapeutic and social rehabilitation programme tailored for the person which may, where the psychological and physical conditions of the drug addict makes it possible, in conjunction with the centres and using the services of the social solidarity cooperatives and authorized associations, include initiatives designed to bring about the full incorporation into society of the person concerned through counselling and vocational training, work of public utility or social solidarity. Under the treatment programmes which include such methods, drug treatment therapies and psychological and pharmacological treatment as appropriate may be arranged. The drug dependence service shall monitor the implementation of the programme on the part of the drug addict.

Following significant and diverse evolution of the responsibilities of the agencies and associations collaborating with public drug addiction

Functions of facilities authorized to offer social-rehabilitation services

Ancillary Agencies comprising facilities authorized to provide social and healthcare assistance in support of Drug Addiction Services

Preventative, curative and rehabilitation work under DPR 309/90

services in every sector of the field, encouraging, on the one hand, dialogue between public and private sectors and reciprocal enhancement of their analyses and knowledge of issues and, on the other hand, allowing for shared training experiences and the realization of joint projects, the State-Regions Accord Act of 5 August 1999 defined the minimum standards required for private healthcare services to obtain authorization for operation and accreditation to assist drug-dependent individuals.

This regulatory act lays down requirements for subjects, facilities, operations, staff and staff training within agencies and associations which carry out preventative, curative and rehabilitation activities whose goal is the protection and restoration of the health of persons who use or are addicted to narcotic and/or psychoactive drugs. Furthermore, this act defines criteria for accreditation, service sectors, treatment programmes and their planning as well as access to services, in addition to other functions.

The services which must be provided by agencies or associations which aspire to accreditation are divided into the following areas of service, based upon the programme's overall structure:

- 1) reception services
- 2) therapeutic-rehabilitation services
- 3) specialized treatment services
- 4) pedagogical rehabilitation services
- 5) integrated multidisciplinary services

Reception services are defined by the fact that they may provide the following services:

- non-selective patient reception, including those undergoing pharmacological treatments, of a length of no more than ninety days
- assessment of the overall state of health of the patient, including the diagnosis of any infectious diseases linked to drug addiction
- where possible, the design of a global treatment programme and identification of the type of facility most suited to provide it
- counselling and psychological support
- guidance and support sessions for patients' families
- general medical care for health problems requiring attention during the patients' stay in the facility and in support of pharmacological treatments where necessary

Therapeutic-rehabilitation services are defined by the fact that they may provide the following services:

- reception of patients possessing pre-established characteristics who do not use substances of abuse
- reception of patients undergoing pharmacological replacement treatments as necessary
- multidisciplinary diagnostic monitoring (possibly conducted by public services personnel) according to Regional quality procedures
- implementation of a detailed and personalized treatment programme of no more than eighteen months, with related monitoring of the psychological and physiological conditions of the patient, and modification of said programme as necessary
- individual and/or group counselling and psychological support, to be provided in a continuous fashion and, where suitable, structured individual or group psychotherapy sessions scheduled according to each individual patient's needs
- management of each individual patient's general health problems as

The 5 August 1999
State-Regions
Accord

Areas of service as
established under
the State-Regional
Accord Act of 5
August 1999

Reception services

Therapeutic-
rehabilitation
services

appropriate according to the type of issue and its seriousness, a service for which personnel must be available a minimum of three hours per week

Specialized treatment services are defined by the fact that they may provide the following services:

- reception of patients with pre-defined characteristics, specific medical/psychotherapeutic treatment issues (e.g. psychiatric problems, women who are pregnant or postpartum, etc.)
- multidisciplinary diagnostic assessment (performed by public service personnel) in accordance with Regional quality procedures; management of issues (medical and non) which fall under specialist categories, including involving recourse to pharmacological treatments and the monitoring these entail
- all remaining therapeutic-rehabilitation services, where these are not contraindicated

Specialized
treatment services

Pedagogical rehabilitation services are defined by the fact that they may provide the following services:

- reception of patients with pre-defined characteristics who do not use substances of abuse and who are not undergoing replacement pharmacological treatments; multidisciplinary diagnostic assessment (performed by public service personnel when necessary) in accordance with Regional quality procedures
- implementation of a detailed and personalized treatment programme of no more than thirty months in length whose goal is to focus on restoring the patient's social integration abilities and improving his or her life in terms of relationships, employing a pedagogical-educational methodology, with related monitoring of the psychological and physiological conditions of the patient, and modification of said programme as necessary
- continuous individual and/or group psychological support where suitable
- medical assistance for health problems requiring attention during the period of observation, as necessary

Pedagogical
rehabilitation
services

Integrated multidisciplinary services are defined by the fact that these programmes, activities and services are at least potentially available in public facilities, and that they fulfil the requirements (both structural and productive) established for them. The accreditation for these types of services is for an entire package of services offered, and excludes their partial accreditation as parts of other service areas. It is the Regions which, when establishing criteria for accreditation of public service operative units, take decisions on the details of these types of programmes, including:

Multidisciplinary
services

- a) the types and numbers of working personnel, expressed as a staff-to-patient ratio
- b) the structural requirements, based on the type of services being provided
- c) criteria for accessing services and manner of access, partly to avoid different treatments being duplicated
- d) minimum operating hours for the service and maximum wait-time on any waiting lists
- e) the obligation to accept patients without subjecting them to any type of entry selection and to make available to them all services guaranteed under the law and Regional provisions

Regions regulate the manner by which, in special cases, patients can be transferred to other accredited services, in accordance with the rules as

set forth in (the following) Art. 19.

According to the criteria for registering facilities in the Regional and Provincial rolls for Ancillary Agencies, Agencies which are mentioned in a special table and which manage facilities for the rehabilitation and social reintegration of drug addicts as set forth in the State, Regions and Autonomous Provinces Accord Act, the facilities are classified as follows:

- Residential facilities (offering lodgings and residential activities)
- Semi-residential facilities (offering a place to stay and daily activities of no less than eight hours per day, at least five days a week, or, in other words, at least forty hours per week, which may be distributed differently.
- Non-residential/outpatient facilities (offering a place to stay and activities for a total of less than forty hours per week)

Classification of
Ancillary Agencies
in residential, semi-
residential and
outpatient facilities

The National Action Plan 2010 - 2013

On a national level, in 2010, the Department for Anti-drug Policies of the Presidency of the Council of Ministers drafted the National Action Plan on Drugs 2010-2013, approved in the 29 October 2010 session of the Council of Ministers. The document establishes the simultaneous development of four different parts:

1. The National Action Plan (NAPD - actual strategic recommendations)
2. Individual Regional Programmes (RP) which are to be carried out in a completely independent fashion by the individual Regions and Autonomous Provinces
3. Methodological guidelines
4. National Projects in support of the Plan

The Action Plan as a whole is the sum of these four parts which, in order to be effective, must provide an explanation of general strategies by means of lists of goals and actions, of organizations assigned the responsibility of carrying these out and of using outcome indicators and which will, at the same time, have to monitor individual Regional plans and calculate, as best as possible, the resources allotted to them. In addition, guidelines are provided for the principal action areas as well as a series of national projects in support of the NAPD which will involve numerous operative units.

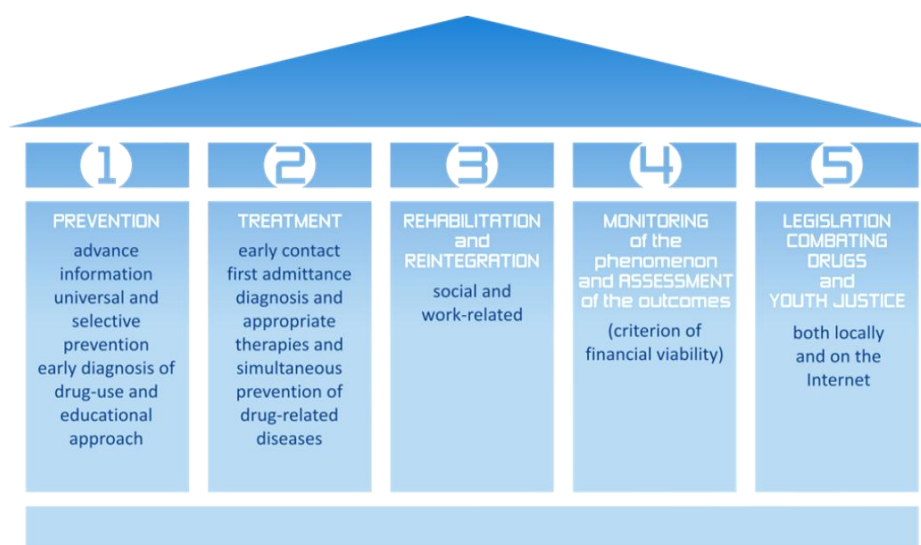
The new National Action Plan is logically subdivided into 5 principal action areas:

1. **Prevention** - Information provided early, starting in elementary schools and with the support of families and schools; continuing universal prevention but with projects targeting, above all, individuals with behavioural problems (selective prevention). Launching projects for the early detection of drug use and alcohol abuse (It's never too early); encouraging educational approaches to the problem.
2. **Treatment and diagnosis of drug addictions** – Encouraging early outreach projects for drug addicts not yet undergoing treatment. Increasing the number of individuals accessing therapeutic communities and the proper, rational use of replacement drugs in Public Drug Treatment Units. Continuing projects for the prevention of drug-related diseases (HIV, the hepatides, TBC).
3. **Rehabilitation and reintegration** – Focusing more strongly on increasing social and work integration programmes, encouraging forms of self-financing for those therapeutic communities which are

The 5 principal
action areas of the
National Action
Plan on Drugs
2010-2013

- capable of providing drug-dependent individuals with job training and placing them on real, concrete paths to reintegration in the work world.
4. **Monitoring and assessment** – Making information systems more timely and efficient in order to more rapidly become aware of variations in the phenomenon and thus be able to more quickly plan necessary responses. At the same time, introducing systems which make it possible to evaluate the real results obtained from the different types of treatments (outpatient or residential), and make the presence of such systems a necessary “funding criterion” for facilities.
 5. **Legislation, the fight against drugs and juvenile justice** – Beginning a process of renewal of the primary regulations having to do with drug addiction, in order to render them more suitable for different needs in the field. Continuing to maintain pressure in the fight against drugs and organized crime, both within national borders and on the Internet.

Figure 11.1: The five action areas of the National Action Plan on Drugs 2010-2013

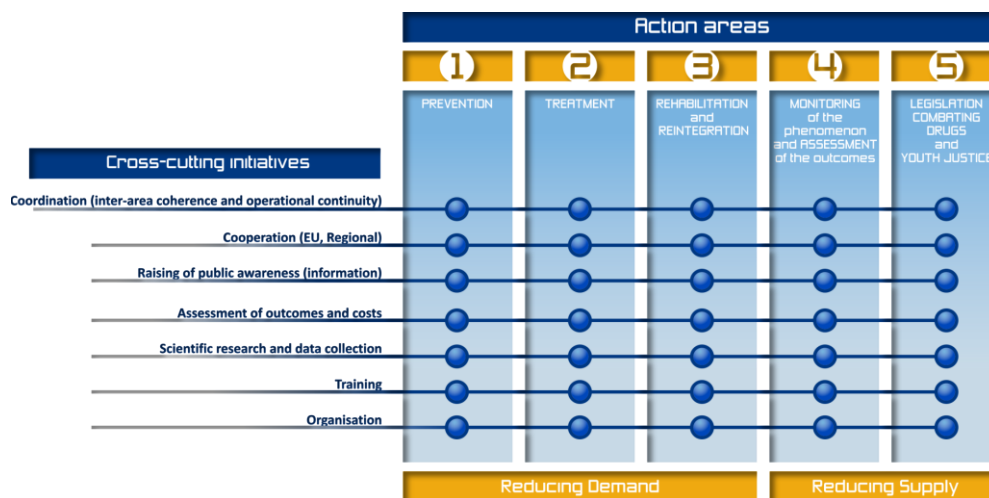


Source: The Department for Anti-drug Policies

As set forth in European recommendations, a series of **transversal actions** are provided for each of the five action areas. These have to do with coordination, cooperation, raising public awareness, assessing results and costs, scientific research and data collection, training and organization. Each of the five action areas is provided with a series of transversal actions having to do with coordination, cooperation, raising public awareness, assessing results and costs, scientific research and data collection, training and organization, according to the following scheme. These transversal actions represent the action recommendations which should be followed for each of the five action areas in order to improve the overall effectiveness of the plan.

Transversal actions within the action areas

Figure 11.2: The transversal actions of the five action areas



Source: the Department for Anti-drug Policies

All the countries of Europe are in agreement regarding the fact that the drafting of a national action plan is born of the imperative need to be in possession of recommendations for the creation of anti-drug projects. The aim is to protect future generations from the tragedy of drug addiction and alcoholism spawned by the use of drugs and alcohol abuse, in full knowledge of the fact that in our country, as in every other State in Europe, such a plan is critical if we wish to take on the issues of the proliferation of drugs and of drug use and alcohol abuse in a coordinated and effective manner.

Our nation, like other European countries, will take on the responsibility of responding to the drug problem by means of an integrated approach involving reduction of drug supply and demand on the basis of the principles of shared responsibility and proportionality, in accord with the basic principles of dignity of those individuals who are affected by the drug problem worldwide, including drug addicts and in full respect of basic freedoms and of human rights. However, on this topic, it must be pointed out that Italian law and, more importantly, the ethical principles which underlie preventative, curative and rehabilitation work, do not recognize the "right to take drugs" as a human right because of the irrefutable harm it can cause to health, the negative consequences it can have on third parties who come into contact with individuals who use these substances and the serious losses it causes on a social level.

As mentioned above, among the five principal action areas of the National Action Plan on Drugs (NAPD), one is specifically devoted to the rehabilitation and social and work reintegration of drug addicts. Rehabilitation and reintegration are the central features of the plan, underlining the belief that total recovery of drug-dependent individuals and their full reintegration into society is not only always possible but of fundamental importance. In order to do this, the NAPD proposes a number of concrete solutions involving the launch of special units devoted specifically to reintegration.

The NAPD goals relevant to this area, which are flanked within the document by specific actions and assessment indicators to monitor results attained, are as follows:

1. Reduce criminal and illegal activities, besides prostitution, among drug addicts through the promotion of specific programs of reintegration into society and work.
2. Standardise at national level the principles and main methods of rehabilitation and reintegration.
3. Promote concrete actions and specific projects to increase rehabilitation activities in both the social and interpersonal sphere of drug addicts undergoing treatment with drug addiction services and in therapeutic communities
4. Improve the level of education and job skills of drug addicts in treatment
5. Promote the development, within the Addiction Departments, of operating units which specialise in reintegration activities
6. Supplement and coordinate reintegration work among the various local agencies (Public Drug Treatment Units, Therapeutic communities, local and provincial administrations, hospitals, business associations).
7. Involve companies and public administrations (Town Councils, Provinces, Local Health Authorities) directly in social and work reintegration for drug addicts, through the allocation of contracts to social cooperatives operating in this sector.
8. Encourage the reintegration of drug addicts into the work cycle of ordinary companies.
9. Direct organisations which deal with social and work reintegration to develop corporate social responsibility programs in order to promote the creation of organisations for reintegration which can produce income and thus self-finance their own activities.
10. Promote a specific national project for the rehabilitation and reintegration into society and work to support the process of national innovation in this sphere.

NAPD 2010-2013
goals for the
rehabilitation and
reintegration action
area

With reference to the final objective, the Department for Anti-drug Policies, in the context of the launch of the 2010-2011 DPA Projects Plan (funded with a budget of approximately 26 million Euros), allocated 34% of that budget solely to a project devoted to the social and work reintegration of drug addicts (the RELI Project).

The RELI project

This project, of key importance, aims to define, promote and proliferate an integrated social and work reintegration model for both public services and the private non-profit sector, based firstly on the support and creation of “productive units” capable of hosting drug-dependent individuals during their rehabilitation in order to ease their work reintegration. These productive units are intended to be strongly oriented toward social enterprise work, with workers receiving regular pay (with a managed and regulated credit line) and producing goods or services which can be placed on the market, creating income which could partially or totally cover operating costs.

Objectives of the
RELI Project

The project thus intends to give rise to a process of cultural and organizational transformation in the attempt to create a “structural variation” in the systems of care which have existed until today, in order to free those organizations which are responsible for reintegration, as far as is possible, from welfare-type thought processes and create conditions of

self-sufficiency for these types of activities and for the organizations which conduct them.

There is an intention of creating a nationwide coordination group for the various local entities which will manage to become involved in the project. This coordination group will have two components: firstly, the productive units, meaning organizations belonging to either public services or private non-profit which are equipped with units devoted to social and work reintegration; secondly, support and collaboration units, meaning those administrations and organizations capable both of creating conditions favourable for the allocation of contracts to the productive units and of identifying possible companies which have not fulfilled their hiring quotas for individuals with disabilities or which are in a situation to offer job positions.

The productive units would thus be easily and effectively supported by public companies offering non-complex maintenance contracts, as well as by private companies with local specialised labour requirements who could therefore provide direction for productive units' professional training programmes, thus creating conditions where their specific labour requirements were fulfilled and at the same time raising the probability work reintegration for the clients of those productive units.

Methodologies
employed in the
creation of the RELI
project

11.2. Availability and characteristics of residential treatment

Social-rehabilitative facilities

Table 11.1: Social-rehabilitative facilities for drug addicts operating in Italy on 31/12/2011, by type of care provided

| | Social-rehabilitative facilities | | | | | | | | | | | |
|-----------------------|----------------------------------|------------|-----------|------------------|------------|-------------|------------|------------|-------------|--------------|--------------|-------------|
| | Residential | | | Semi-residential | | | Outpatient | | | Total | | |
| | 2010 | 2011 | Δ % | 2010 | 2011 | Δ % | 2010 | 2011 | Δ % | 2010 | 2011 | Δ % |
| Abruzzo | 14 | 14 | 0 | 4 | 3 | 25 | 8 | 7 | -12.5 | 26 | 24 | -7.7 |
| Basilicata | 7 | 5 | -28.6 | 1 | 0 | -100 | 5 | 5 | 0 | 13 | 10 | -23.1 |
| Calabria | 25 | 23 | -8 | 10 | 9 | -10 | 3 | 3 | 0 | 38 | 35 | -7.9 |
| Campania | 20 | 21 | 5 | 8 | 5 | -37.5 | 12 | 11 | -8.3 | 40 | 37 | -7.5 |
| Emilia Romagna | 83 | 86 | 3.6 | 23 | 19 | -17.4 | 15 | 16 | 6.7 | 121 | 121 | 0.0 |
| Friuli Venezia Giulia | 9 | 8 | -11.1 | 5 | 6 | 20 | 6 | 6 | 0 | 20 | 20 | 0.0 |
| Lazio | 29 | 29 | 0 | 13 | 10 | -23.1 | 9 | 7 | -22.2 | 51 | 46 | -9.8 |
| Liguria | 24 | 24 | 0 | 5 | 7 | 40 | 6 | 4 | -33.3 | 35 | 35 | 0.0 |
| Lombardy | 134 | 134 | 0 | 20 | 19 | -5 | 29 | 29 | 0 | 183 | 182 | -0.5 |
| Marche | 32 | 31 | -3.1 | 13 | 14 | 7.7 | 10 | 8 | -20 | 55 | 53 | -3.6 |
| Molise | 6 | 5 | -16.7 | 0 | 0 | 0 | 2 | 2 | 0 | 8 | 7 | -12.5 |
| AP Bolzano | 2 | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 3 | 3 | 0.0 |
| AP Trento | 4 | 4 | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 6 | 6 | 0.0 |
| Piedmont | 68 | 66 | -2.9 | 3 | 4 | 33.3 | 8 | 6 | -25 | 79 | 76 | -3.8 |
| Apulia | 47 | 46 | -2.1 | 17 | 19 | 11.8 | 19 | 20 | 5.3 | 83 | 85 | 2.4 |
| Sardinia | 23 | 22 | -4.3 | 2 | 0 | -100 | 8 | 8 | 0 | 33 | 30 | -9.1 |
| Sicily | 26 | 26 | 0 | 7 | 7 | 0 | 8 | 8 | 0 | 41 | 41 | 0.0 |
| Tuscany | 55 | 53 | -3.6 | 19 | 18 | -5.3 | 8 | 8 | 0 | 82 | 79 | -3.7 |
| Umbria | 27 | 27 | 0 | 4 | 4 | 0 | 1 | 1 | 0 | 32 | 32 | 0.0 |
| Valle d'Aosta | 1 | 2 | 100 | 0 | 1 | - | 0 | 0 | 0 | 1 | 3 | 200.0 |
| Veneto | 79 | 80 | 1.3 | 46 | 44 | -4.3 | 18 | 18 | 0 | 143 | 142 | -0.7 |
| Total | 715 | 708 | -1 | 202 | 191 | -5.4 | 176 | 168 | -4.5 | 1.093 | 1.067 | -2.4 |

1% decrease in the number of residential facilities, 5.4% decrease in semi-residential facilities and 4.5% decrease in outpatient facilities

Source: The Interior Ministry – Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources

On 31 December 2011, according to Ministry of Health and Interior Ministry Sources, there were a total of 1,067 social-rehabilitative facilities operating in Italy. The majority of these were residential facilities (66.4%), followed by semi-residential facilities (17.9%) and outpatient facilities (15.7%). In comparison with 2010, there has been a 2.4% decrease (26 facilities) in the number of social-rehabilitation facilities, a decrease which has affected a greater number of semi-residential facilities (5.4%) and outpatient facilities (4.5%).

1,067 social-rehabilitative facilities, of which 66.4% residential communities

An examination of the distribution of social-rehabilitative structures throughout the country reveals a higher concentration in the northern Regions. In 2011, as in 2010, 17% of these were located in Lombardy, 13% in Veneto and 11% in Emilia Romagna. When comparing 2011 data to 2010 data in view of possible reorganizations of services, we mainly find an increase in drug addiction services in Lombardy (+11) and in Campania (+3), while, concerning social-rehabilitative facilities, we can see a decrease in the number of residential facilities in Calabria, Basilicata, Piedmont and Tuscany (-2). Regarding other types of facilities, Emilia Romagna reports a decrease in semi-residential facilities (-4) and Lazio and Campania both report a reduction by 3 (Table 11.1).

Higher concentration of facilities in the north

If we draw a distinction between public health facilities and those belonging to private non-profit, we find a higher percentage distribution of Public Drug Treatment Units in the Autonomous Province of Bolzano, in Sicily, in Campania and in Lazio (Figure 11.3).

Figure 11.3: Distribution of social and healthcare facilities for drug addicts, by type and by Region - the Year 2011



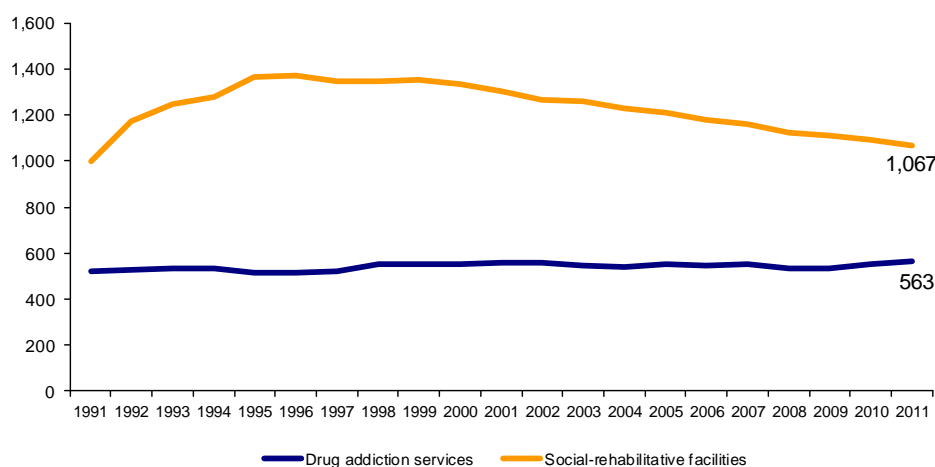
Source: Based on data from (1) The Ministry of Health; (2) The Interior Ministry – Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources

Trends in numbers of social and healthcare facilities over the past twenty years show an increase in numbers of services in operation for drug addicts, which rose from 518 in 1991 to 563 in 2011, an 8.7% increase. The trend in numbers of social-rehabilitative facilities shows much greater fluctuation; according to reports from the Ministry of the Interior, numbers of social-rehabilitative facilities rose during the early '90s, due to the effect of Law 162 of 1990, which led to an increase in the number of both public and private health services dealing with the ever-growing treatment demand for drug addictions. This increase in numbers of facilities peaked at 1,372 units in 1996, followed by a slow decline which became more significant beginning in 2002, falling to 1,067 existing facilities in 2011.

An 8.7% increase in the number of Public Drug Treatment Units between 1991 and 2011

Decrease in social-rehabilitative facilities since 1996

Figure 11.4: Trends in the number of social and healthcare facilities for drug addicts - the Years 1991-2011



Source: Based on data from the Ministry of Health

During the course of the first quarter of 2012, Regional Authorities, as set forth in the Framework for State-Regional Accord Act of 5 August 1999, conducted a survey regarding the recognition of private non-profit facilities (accredited/authorized Ancillary Agencies pursuant to Articles 115 and 166 of DPR 309/90) and public diagnostic - therapeutic - rehabilitation facilities. From information gathered from all the Regions and Autonomous Provinces (with the exception of Valle D'Aosta) on a specific online platform created by the Department for Anti-drug Policies, it was found that there were a total of 52 residential and semi-residential private diagnostic - therapeutic - rehabilitative facilities which were not or could not be included in the survey as specified under the State-Regional Accord Act, 15 less than in the previous year (Table II.2.2). The number of residential facilities fell steeply, continuing the trend already observed in the previous year (-31.8% in comparison with 2010) as did the number of semi-residential facilities (-30.4% in comparison with 2010). The types of services which fall under the category of "Reception" Services according to the Accord Act Framework increased (+6,7%); it is not possible to make a direct comparison between numbers for residential and semi-residential facilities in 2010 and 2011, since, in 2011, there were a large number of facilities for which a type was not indicated. On the other hand, the number of facilities which fell under the category of therapeutic-rehabilitative decreased by 10%, the number of pedagogical-rehabilitation services fell and so did the number of services offering specialized

State-Regions Accord Act of 5 August 1999

31.8% decline in the number of residential facilities

6.7% increase in reception services

Specialized treatment services fell by 13.1%

treatments (-13.1%). There are a total of 153 facilities which fall in the category of specialized treatment, of which 26% provide services for patients with dual diagnoses, 20% are for alcoholics, 16% are residences for patients with AIDS and 12% provide services for women with children.

Table 11.2: Private diagnostic - therapeutic - rehabilitative facilities according to Framework of the State-Regional Accord Act of 5 August 1999, by type of facility and type of care provided. The years 2010 – 2011

| | Residential | | | Semi-residential | | | Not specified | | | Total facilities | | |
|--|-------------|------------|--------------|------------------|------------|--------------|---------------|-----------|-------------|------------------|------------|--------------|
| | 2010 | 2011 | Δ % | 2010 | 2011 | Δ % | 2010 | 2011 | Δ % | 2010 | 2011 | Δ % |
| <i>Pathological addictions in general (not included or able to be included in the survey under the Accord Act Framework)</i> | | | | | | | | | | | | |
| Reception services Art. 11 | 35 | 21 | -40.0 | 10 | 6 | -40.0 | - | 21 | n.c. | 45 | 48 | 6.7 |
| Therapeutic-rehabilitative Services Art. 12 | 353 | 285 | -19.3 | 77 | 49 | -36.4 | - | 53 | n.c. | 430 | 387 | -10.0 |
| Specialized treatment services Art. 13 | 170 | 136 | -20.0 | 6 | 12 | 100.0 | - | 5 | n.c. | 176 | 153 | -13.1 |
| 13 a) Dual diagnosis | 53 | 36 | -32.1 | 3 | 3 | 0.0 | - | 1 | n.c. | 56 | 40 | -28.6 |
| 13 b) Mothers with children | 24 | 18 | -25.0 | - | 0 | n.c. | - | 0 | n.c. | 24 | 18 | -25.0 |
| 13 c) Alcoholics | 29 | 28 | -3.4 | 1 | 2 | 100.0 | - | 1 | n.c. | 30 | 31 | 3.3 |
| 13 d) Cocaine addicts | - | 1 | n.c. | 1 | 1 | 0.0 | - | 0 | n.c. | 1 | 2 | 100.0 |
| 13 e) Pathological gamblers | - | 0 | n.c. | - | 5 | n.c. | - | 0 | n.c. | 0 | 5 | n.c. |
| 13 f) Juveniles | 14 | 14 | 0.0 | 1 | 1 | 0.0 | - | 1 | n.c. | 15 | 16 | 6.7 |
| 13 g) Couples | 1 | 1 | 0.0 | - | 0 | n.c. | - | 0 | n.c. | 1 | 1 | 0.0 |
| 13 h) Crisis centres | 14 | 5 | -64.3 | - | 0 | n.c. | - | 1 | n.c. | 14 | 6 | -57.1 |
| 13 i) AIDS Residences | 24 | 24 | 0.0 | - | 0 | n.c. | - | 1 | n.c. | 24 | 25 | 4.2 |
| 13 l) Other | 11 | 9 | -18.2 | - | 0 | n.c. | - | 0 | n.c. | 11 | 9 | -18.2 |
| Pedagogical rehabilitation services Art. 14 | 155 | 114 | -26.5 | 32 | 25 | -21.9 | - | 0 | n.c. | 187 | 139 | -25.7 |
| Integrated Multidisciplinary Services Art. 15 | 10 | 10 | 0.0 | 1 | 0 | 100.0 | - | 0 | n.c. | 11 | 10 | -9.1 |
| Other accredited programmes | - | 0 | n.c. | - | 0 | n.c. | - | 0 | n.c. | 0 | 0 | n.c. |
| Total | 767 | 596 | -22.3 | 149 | 108 | -27.5 | - | 85 | n.c. | 916 | 789 | -13.9 |

n. c.= figure not able to be calculated

Source: Based on data from the Regions and Autonomous Provinces

In addition to the private facilities, there were a total of 193 public (residential, semi-residential or unspecified) diagnostic-therapeutic rehabilitative facilities in the Regions participating in the survey. Principally, 43% are therapeutic-rehabilitative facilities, 32.6% are specialised treatment facilities and 18.7 % are reception facilities. Of the specialised treatment facilities, 38% provide treatment for alcoholics, 23.8% to minors and 12.7 to dual-diagnosis patients.

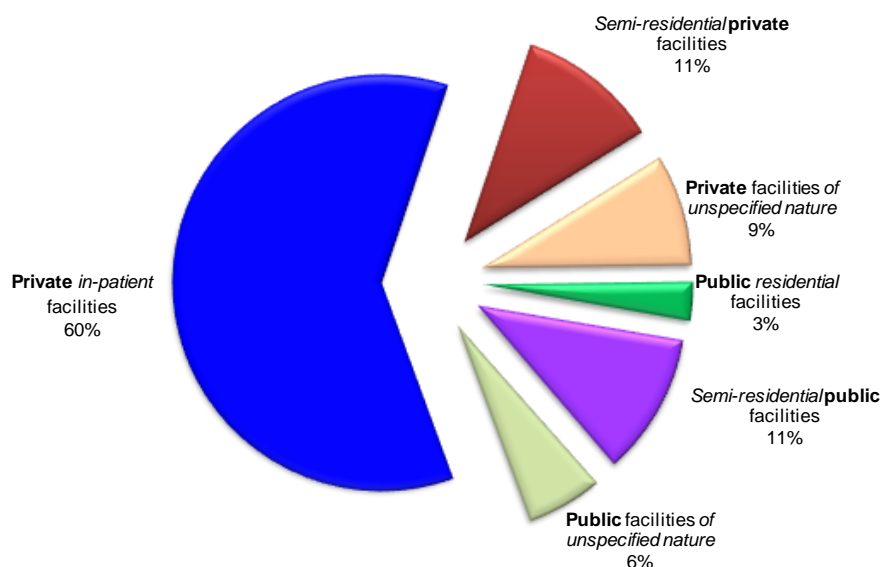
Decrease in in numbers of crisis centres, dual diagnosis services and services for women with children

Table 11.3: Public diagnostic - therapeutic - rehabilitative facilities according to Framework of the State-Regional Accord Act of 5 August 1999, by type of facility and type of care provided. The year 2011

| | Residential | Semi-residential | Not specified | Total facilities |
|--|-------------|------------------|---------------|------------------|
| <i>Pathological addictions in general</i> | 0 | 5 | 6 | 11 |
| <i>Reception services</i> | 1 | 2 | 33 | 36 |
| <i>Therapeutic-rehabilitation services with no further specifications (including pharmacological replacement treatments)</i> | 11 | 63 | 9 | 83 |
| <i>Specialized, Art. 13</i> | 16 | 38 | 9 | 63 |
| 13 a) Dual diagnosis | 5 | 1 | 2 | 8 |
| 13 b) Mothers with children | 0 | 0 | 0 | 0 |
| 13 c) Alcoholics | 1 | 21 | 2 | 24 |
| 13 d) Cocaine addicts | 1 | 3 | 0 | 4 |
| 13 e) Pathological gamblers | 0 | 1 | 1 | 2 |
| 13 f) Juveniles | 2 | 12 | 1 | 15 |
| 13 g) Couples | 0 | 0 | 0 | 0 |
| 13 h) Crisis centres | 1 | 0 | 1 | 2 |
| 13 i) AIDS residences | 1 | 0 | 1 | 2 |
| 13 l) Other | 5 | 0 | 1 | 6 |
| Total | 28 | 108 | 57 | 193 |

Source: Based on data from the Regions and Autonomous Provinces

Figure 11.5: Percentage distribution of diagnostic therapeutic and rehabilitative public and private facilities according to the Framework for the State-Regional Accord Act of 5 August 1999. The year 2011



Source: Based on information from the Regions and Autonomous Provinces:

Clients in the care of social-rehabilitative facilities

As of 31.12.2011, according to sources from the Ministry of the Interior, there were a total of 16,923 clients receiving care from social-rehabilitative facilities operating throughout the Italy, most of whom (11,371 subjects, or 67.2%) were receiving care in residential facilities, followed by outpatient services (4,183, or 24.7%) and finally semi-residential facilities (1,369, or 8.1%).

In comparison with numbers from 2010, we can see a 13.1% increase in the number of clients in facilities on 31.12, an increase which was more marked for outpatient services, which increased by 20.6%, and residential facilities (+11.7%).

16,923 clients in social-rehabilitative facilities on 31/12/2011, of whom 11,371 in residential facilities

Table 11.4: Clients in Social-rehabilitative facilities for drug addicts on 31.12.11, by type of care being received

| | Social-rehabilitative facilities | | | | | | | | | | | |
|-----------------------|----------------------------------|--------------|-------------|------------------|-------------|------------|-------------|-------------|-------------|--------------|--------------|-------------|
| | Residential | | | Semi-residential | | | Outpatient | | | Total | | |
| | 2010 | 2011 | Δ % | 2010 | 2011 | Δ % | 2010 | 2011 | Δ % | 2010 | 2011 | Δ % |
| Abruzzo | 174 | 154 | -11.5 | 34 | 38 | 11.8 | 99 | 73 | -26.3 | 307 | 265 | -13.7 |
| Basilicata | 76 | 97 | 27.6 | 0 | 0 | - | 0 | 28 | - | 76 | 125 | 64.5 |
| Calabria | 255 | 345 | 35.3 | 25 | 23 | -8.0 | 1000 | 5 | -99.5 | 1280 | 373 | -70.9 |
| Campania | 324 | 446 | 37.7 | 58 | 21 | -63.8 | 0 | 183 | - | 382 | 650 | 70.2 |
| Emilia Romagna | 1937 | 2058 | 6.2 | 60 | 50 | -16.7 | 51 | 229 | 349.0 | 2048 | 2337 | 14.1 |
| Friuli Venezia Giulia | 51 | 44 | -13.7 | 14 | 17 | 21.4 | 76 | 25 | -67.1 | 141 | 86 | -39.0 |
| Lazio | 330 | 491 | 48.8 | 230 | 252 | 9.6 | 30 | 1201 | 3903.3 | 590 | 1944 | 229.5 |
| Liguria | 219 | 276 | 26.0 | 19 | 20 | 5.3 | 26 | 12 | -53.8 | 264 | 308 | 16.7 |
| Lombardy | 2374 | 2276 | -4.1 | 229 | 162 | -29.3 | 178 | 1443 | 710.7 | 2781 | 3881 | 39.6 |
| Marche | 469 | 483 | 3.0 | 76 | 92 | 21.1 | 130 | 149 | 14.6 | 675 | 724 | 7.3 |
| Molise | 62 | 60 | -3.2 | 0 | 0 | - | 4 | 0 | -100.0 | 66 | 60 | -9.1 |
| PA Bolzano | 10 | 16 | 60.0 | 0 | 0 | - | 65 | 0 | -100.0 | 75 | 16 | -78.7 |
| PA Trento | 135 | 128 | -5.2 | 44 | 39 | -11.4 | 1290 | 68 | -94.7 | 1469 | 235 | -84.0 |
| Piedmont | 1026 | 1282 | 25.0 | 63 | 86 | 36.5 | 90 | 121 | 34.4 | 1179 | 1489 | 26.3 |
| Puglia | 409 | 528 | 29.1 | 40 | 44 | 10.0 | 37 | 257 | 594.6 | 486 | 829 | 70.6 |
| Sardinia | 260 | 410 | 57.7 | 0 | 0 | - | 67 | 98 | 46.3 | 327 | 508 | 55.4 |
| Sicilia | 192 | 345 | 79.7 | 80 | 146 | 82.5 | 194 | 106 | -45.4 | 466 | 597 | 28.1 |
| Toscana | 854 | 850 | -0.5 | 157 | 150 | -4.5 | 25 | 122 | 388.0 | 1036 | 1122 | 8.3 |
| Umbria | 300 | 259 | -13.7 | 40 | 44 | 10.0 | 3 | 18 | 500.0 | 343 | 321 | -6.4 |
| Valle d'Aosta | 13 | 15 | 15.4 | 0 | 6 | - | 37 | 0 | -100.0 | 50 | 21 | -58.0 |
| Veneto | 713 | 808 | 13.3 | 139 | 179 | 28.8 | 67 | 45 | -32.8 | 919 | 1032 | 12.3 |
| Total | 10183 | 11371 | 11.7 | 1308 | 1369 | 4.7 | 3469 | 4183 | 20.6 | 14960 | 16923 | 13.1 |

11.7% increase in the number of clients in residential facilities, 4.7% increase for semi-residential facilities and a 20.6% increase in outpatient clients

Source: Ministry of the Interior – Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources

Trends in clients receiving care from social-rehabilitative facilities from 2000 to 2011 reveal a prevalence of male subjects; fluctuation among this group influences the overall trend for treatment during the time period in question.

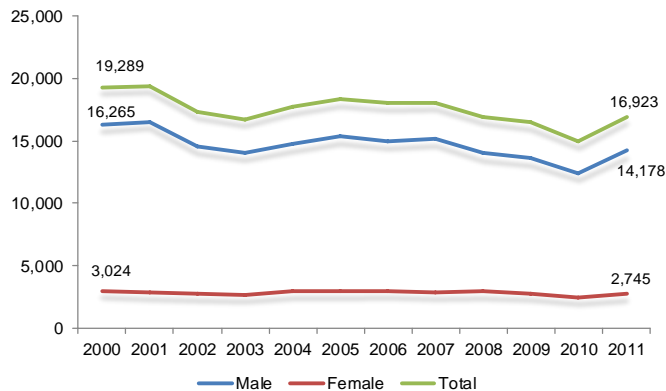
From 2000 to 2003, we find a downturn in the trend of clients receiving care from these types of facilities (19,289 clients on 31.12.2000 vs. 16,725

Increase in numbers of clients during the last year

clients on 31.12.2003), followed by fluctuations lasting until 2010 (14,960 clients in 31.12.2010), and then by an increase over the last year (16,923 clients on 31.12.2011).

The trend in numbers of female clients in social-rehabilitative facilities is more stable, showed recorded variations equal to a 9.2% drop.

Figure 11.6: Clients present in social-rehabilitative facilities on 31 December of each year of reference - The years 2000 – 2011

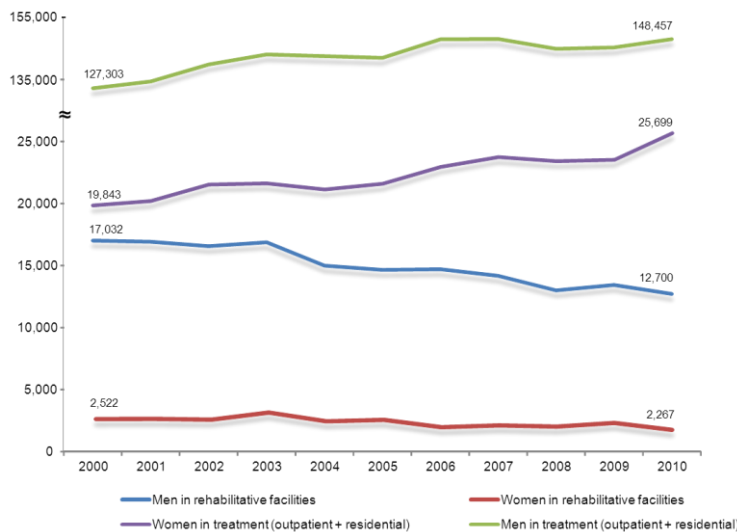


Source: Based on data from the Ministry of the Interior

Data on clients undergoing treatment in social-rehabilitative facilities is also collected by another information flow: the Ministry of Health information flow, which is comprised of clients receiving care and treatment from addiction services, some of whom are in social-rehabilitative facilities. Unlike the Ministry of the Interior information flow, which provides us with a “snapshot” of clients in the care of social-rehabilitative facilities on a certain date, the drug addiction services information flow of the Ministry of Health provides information on clients entering social-rehabilitative facilities during the course of the year, a figure which therefore shows us client “flow”.

Differences between information flows from the Ministry of the Interior and the Ministry of Health

Figure 11.7: Persons receiving care from drug addiction services (either as part of outpatient programmes or within social-rehabilitative facilities) and persons entering social-rehabilitation facilities - The years 2000 – 2010



Source: Based on data from the Ministry of Health

Trends in the total numbers for people receiving care from addiction services and for those who entered social-rehabilitative structures during the period of reference reveal different characteristics for the genders. The total number of clients receiving care from services rose for both genders between 2000 and 2011 (men from 127,303 to 148,457; women from 19,843 to 25,699), in contrast with a decrease in the number of men in social-rehabilitative facilities during the same time period (falling from 17,032 to 12,700), while numbers of women entering facilities during the period of reference remained largely stable (2,522 vs. 2,267).

The increase in the total number of female clients in the care of addiction services is largely attributable to a rise in the number of women receiving outpatient treatment.

Fewer men entering
social-rehabilitative
facilities

11.3. Quality management in residential treatment

In 2011, in order to complete its coverage of the National Action Plan's four components in the rehabilitation action area, the Department for Anti-drug Policies put together a theoretical-practical manual regarding the social and work reintegration of individuals with addictions.

Daily experience in the treatment of drug addicts has highlighted the fact that, if the proper support is not provided during the stages of rehabilitation and reintegration, then these can represent the weak link in the therapeutic process, presenting a high risk of recidivism. It was this practical evidence which gave rise to the need to proceed to develop an idea capable of envisioning an operational model which, basing itself upon the multiple factors which comprise the condition of drug addiction, takes into account the social and rehabilitative aspects as integral, fundamental parts of the treatment process for drug-addicted individuals.

Confirmation of the above can be found in the resolution approved during the 54th Session of the UN Commission on Narcotic Drugs in Vienna in March 2011, "Promoting rehabilitation- and reintegration-oriented strategies, aimed to promote health and social well-being among individuals, families and communities, in response to drug use disorders and their consequences" (CND, 21-25 March 2011). This resolution underlines the importance of a multi-sector approach coordinated between government agencies and non-governmental organizations, guaranteeing that special attention is paid to rehabilitation and social reintegration activities in the context of general programmes to reduce drug use and its consequences. The importance of social reintegration as an instrument to combat the social stigmatization and marginalization of drug addicts is also highlighted as an integral part of prevention and early treatment access programmes aimed to promote health and social well-being between individuals, families and community.

This resolution, approved by all the States, is reconfirmed within the National Action Plan, which identifies the social and work reintegration of drug addicts as a central feature of new anti-drug policy in our country.

The manual provides a series of strategic recommendations, based on these premises, regarding principles of recovery-oriented approaches, meaning those oriented towards the recovery and cure of the individual, laying down the principles on which organizations and departmental systems should consistently base themselves when formulating their strategies. The publication is born of the need to have an available base of shared, scientifically-oriented methodologies which those working in the

field can draw upon when developing new operational models with a pragmatic, concrete approach, ever-more oriented towards the recovery and cure of the drug-addicted individual through the development and consolidation of life skills.

In the operational practice of Public Drug Treatment Departments and Therapeutic Communities, reintegration is traditionally part of the final phase of any therapeutic programme (diagnosis, care and treatment, reintegration). In the proposed model, however, the basic idea is the incremental logic of the healing process, in which every phase is integrated with the others, with each becoming more powerful as a result, in a process that is circular, not linear. Introducing rehabilitation activities into the treatment process from the very beginning makes it possible for the individual to recover and develop those social and work skills which are needed to attain self-sufficiency and social integration as quickly as possible.

The incremental logic of the treatment process unfolds gradually in response to the resources and difficulties presented by the subject during the course of his personalized therapeutic programme.

Moreover, the approach presented focuses attention on the resources of the individual and his social context, as well as on the strengthening of his abilities, thus going beyond a model centred around deficiencies and faults which need repairing. Although this model centres its attention mainly around the drug-addicted individual, it is also important to underline the importance of his or her social context, which should not only be considered a backdrop for treatment, since each individual's well-being is also determined by the social environment he inhabits. It is therefore essential to promote social policies which aim to encourage the development and maintenance of healthy and positive contexts of living, full of stimuli for personal growth and improvement.

Part C

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List of tables

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

Table 1.1: National and international regulations issued in 2011.

Table 1.2: Social costs of the drug-use phenomenon. The year 2010

Table 1.3: Estimate of costs due to loss of work capacity. The year 2010

Table 1.4: Estimate of the costs attributable to enforcing the Law. The year 2010

Table 1.5: Estimate of social and healthcare costs. The year 2010

Table 1.6: Estimate of drug users, by type. The years 2010-2011

Table 1.7: Average daily/weekly/annual cost according to two minimum and maximum hypotheses, by type of user

Table 1.8: Estimate of costs for the purchase of drugs, by type of user. The years 2010-2011

Table 1.9: Estimate of costs (in millions of Euros) for the purchase of drugs, by type of user. The year 2010

Table 1.10: Estimate of costs (millions of Euros) of Law Enforcement activities for prevention and the fight against drugs. The year 2010

Table 1.11: Estimate of the costs (in millions of Euros) of trial-related activities. The year 2010

Table 1.12: Estimate of costs (in millions of Euros) for incarceration of drug addicts in penitentiaries. The year 2010

Table 1.13: Estimate of costs (in millions of Euros) per drug addict placed on probation as an alternative sentence. The year 2010

Table 1.14: Estimate of the costs (in millions of Euros) of hospital care for drug users. The year 2010

Table 1.15: Estimate of the costs (in millions of Euros) for care for drug-related diseases. The year 2010

Table 1.16: Estimate of the costs (in millions of Euros) for loss of productive capacity. The year 2010.

2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED GROUPS

Table 2.1: Distribution of subjects to be interviewed as part of the postal population survey - GPS-DPA 2012 – according to the sample design, by age and geographic area

Table 2.2: Distribution of percentage of response for the postal population survey - GPS-DPA 2012 by geographic area

Table 2.3: Prevalence of drug use in the general population aged 15-64 (one or more times in the last 12 months). The years 2010 and 2012

Table 2.4: Use of heroin and other opiates (% prevalence) in the general population

aged 18-64. The year 2012

Table 2.5: Use of cocaine or crack (% prevalence) in the general population aged 18-64. The year 2012

Table 2.6: Use of cannabis (hashish or marijuana) (% prevalence) in the general population aged 18-64. The year 2012

Table 2.7: Use of stimulant drugs (% prevalence) in the general population aged 18-64. The year 2012

Table 2.8: Use of hallucinogen (% prevalence) in the general population aged 18-64. The year 2012

Table 2.9: Conditional prevalence distribution of polydrug users in the general population aged 18-64 who had used drugs in the 30 days prior to the survey. The year 2012

Table 2.10: Distribution of the first-stage units by region and type of academic institution. The year 2012

Table 2.11: Drug use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2011 and 2012

Table 2.12: Heroin use (% prevalence) in the student population aged 15-19. The years 2011 and 2012

Table 2.13: Cocaine use (% prevalence) in the student population aged 15-19. The years 2011 and 2012

Table 2.14: Cannabis use in the student population aged 15-19. The years 2011 and 2012

Table 2.15: Stimulant use (% prevalence) in the student population aged 15-19. The years 2011 and 2012

Table 2.16: Hallucinogen use (% prevalence) in the student population aged 15-19. The years 2011 and 2012

Table 2.17: Distribution of conditional prevalence of polydrug users in the student population aged 15-19 in the 30 days prior to the survey. The year 2012

Table 2.18: Provenance and number of subjects on whom data was provided. The year 2011

Table 2.19: Drug tests performed on Armed Forces personnel. The years 2007 - 2011

Table 2.20: Subjects tested within the Carabinieri Corp. The years 2007 - 2011

3. PREVENTION

Table 3.1: Number of universal and selective prevention information campaigns conducted by the Regions and Autonomous Provinces during the course of 2011

4. PROBLEM DRUG USE

Table 4.1: Prevalence estimates of subjects requiring treatment, by drug type. The years. 2010-2011

Table 4.2: Zelterman estimates for cocaine user population sizes, for both New and Already Known users, and relative confidence intervals, by geographic area.

The year 2009.

Table 4.3: Horvitz-Thompson, Zelterman and Chao estimates for the size of the population of COCAINE users, both New and Already Known, and relative confidence intervals. The

year 2009.

Table 4.4: Horvitz-Thompson, Zelterman and Chao estimates for the size of the population of CANNABIS users, both New and Already Known, and relative confidence intervals. The year 2009.

5. TREATMENT DEMAND AND AVAILABILITY

Table 5.1: Diagnostic - therapeutic - rehabilitative facilities according to the Framework for State-Regional Accord Act of 5 August 1999, by type of facility and type of care provided. The years 2010 – 2011

Table 5.2: Transmission of data on addiction services activities according to the Ministerial Decree 11 June 2010 and Ministerial Decree 20 September 1997 information flows. The year 2012

Table 5.3: Drug use among Drug Addiction Services clients, according to primary drug type. The years 2010 - 2011

Table 5.4: Drug use among Drug Addiction Services clients, according to secondary drug type. The years 2010 - 2011

Table 5.5: Injecting drug use by clients undergoing treatment with Drug Addiction Services. The years 2010 - 2011

6. HEALTH CORRELATES AND CONSEQUENCES

Table 6.1: Accidents and their causes, absolute values and percentages, the years 2009-2010

Table 6.2: Confirmed violations of Articles 186 and 187 of the Traffic Code and percentages of the total for each of these – Italy – the years 2009-2011

Table 6.3: Trend in deaths by overdose, by gender and year of death. The years 1999 – 2011

8. SOCIAL IMPLICATIONS AND SOCIAL REINTEGRATION

Table 8.1: Percentage distribution of drug addiction services clients according to type of employment, gender and type of client (new or returning). The year 2011

Table 8.2: Percentage distribution of drug addiction service clients according to housing situation, by gender and type of client (new or returning). The year 2011

Table 8.3: Total amount dedicated by Regions and Autonomous Provinces to finance social reintegration projects over the course of 2011

9. DRUG-RELATED CRIME, PREVENTION OF DRUG-RELATED CRIME, AND PRISON

Table 9.1: Characteristics of persons reported to the Prefectures by Law Enforcement Agencies pursuant to Art. 75. The years 2010 - 2011

Table 9.2: Characteristics of charges brought before the Judicial Authorities by Law Enforcement Agencies for violations of Articles 73 and 74 of DPR 309/90. The year 2011

Table 9.3: Drug addicts on probation or released on parole into the care of social services.

The year 2011

Table 9.4: Regions which provided information on Juveniles with drug- or alcohol-related problems in correctional institutions or other custodial facilities. The year 2011

Table 9.5: Subjects with drug-related problems undergoing treatment. The year 2011

10. DRUG MARKETS

Table 10.1: Anti-drug operations and seizures of illicit drugs. The year 2011

Table 10.2: Amounts of cocaine and marijuana seized in “maxi-seizure” operations – the years 2010-2011

Table 10.3: Minimum and maximum price per unit (gram/dose/pill) of drug – The years 2010 and 2011

Table 10.4: Minimum, average, median and maximum active-principle values found in illicit psychoactive drugs. The year 2011

11. RESIDENTIAL TREATMENT FOR DRUG USERS IN EUROPE

Table 11.1: Social-rehabilitative facilities for drug addicts operating in Italy on 31/12/2011, by type of care provided

Table 11.2: Private diagnostic - therapeutic - rehabilitative facilities according to Framework of the State-Regional Accord Act of 5 August 1999, by type of facility and type of care provided. The years 2010 – 2011

Table 11.3: Public diagnostic - therapeutic - rehabilitative facilities according to Framework of the State-Regional Accord Act of 5 August 1999, by type of facility and type of care provided. The year 2011

Table 11.4: Clients in Social-rehabilitative facilities for drug addicts on 31.12.11, by type of care being received

List of graphs

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

Figure 1.1: Allocation of funds within the 2011 Projects Plan

Figure 1.2: Distribution of the social costs by macro-category. The year 2010

2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED GROUPS

Figure 2.1: Projects launched by the Department for Anti-drug Policies for monitoring drug use in the general and student populations

Figure 2.2: Drug use in the general population aged 15-64 (at least once in the last 12 months). The years 2001 – 2012

Figure 2.3: Heroin use (% prevalence) in the general population aged 15-64 (at least once in the last 12 months). The years 2001 - 2012

Figure 2.4: Cocaine use (% prevalence) in the general population aged 15-64 (at least once in the last 12 months). The years 2001 – 2012

Figure 2.5: Cannabis use (marijuana or hashish) (% prevalence) in the general population aged 15-64 (at least once in the last 12 months). The years 2001 – 2012

Figure 2.6: Stimulant use (ecstasy or amphetamines) (% prevalence) in the general population aged 15-64 (at least once in the last 12 months). The years 2001 – 2012

Figure 2.7: Use of hallucinogens (% prevalence) in the general population aged 15-64 (at least once in the last 12 months). The years 2001 – 2012

Figure 2.8: Drug use in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2012

Figure 2.9: Heroin use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2012

Figure 2.10: Cocaine use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2012

Figure 2.11: Cannabis use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2012

Figure 2.12: Stimulant use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2012

Figure 2.13: Hallucinogen use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2012

Figure 2.14: Distribution of the average number of doses of CANNABIS consumed per day (per 1,000 inhabitants) in each city over the two-year period 2010-2011 and corresponding confidence intervals

Figure 2.15: Distribution of the average number of doses of COCAINE consumed per day (per 1,000 inhabitants) in each city over the two-year period 2010-2011 and corresponding confidence intervals

Figure 2.16: Distribution of the average number of doses of HEROIN consumed per day (per 1,000 inhabitants) in each city over the two-year period 2010-2011 and corresponding confidence intervals

Figure 2.17: Distribution of the average number of doses of METHAMPHETAMINE consumed per day (per 1,000 inhabitants) in each city over the two-year period 2010-2011 and corresponding confidence intervals

Figure 2.18: Distribution of the average number of doses of MDMA (ECSTASY) consumed per day (per 1,000 inhabitants) in each city over the two-year period 2010-2011 and corresponding confidence intervals

Figure 2.19: Distribution of grams per day of KETAMINE detected in each city over the two-year period 2010-2011 and corresponding confidence intervals

Figure 2.20: 1st level Drug testing, positive results comparison 2009-2011

Figure 2.21: Flow of subjects subjected to testing and verification – The year 2011

Figure 2.22: 1st Level Drug Testing by age group and result. The year 2011

Figure 2.23: 2nd-level clinical verification – analysis by drug type and diagnosis – The year 2011

3. PREVENTION

Figure 3.1: Distribution of educational activities and didactic methodology employed in educational activities focusing on personal and/or social skills – the 2011/2012 academic year

Figure 3.2: Distribution of creative activities to promote prevention conducted in higher secondary schools – the 2011/2012 academic year

Figure 3.3: Number of universal prevention project plans targeting nuclear families launched, on-going or concluded in 2011

Figure 3.4: Percentage distribution of different programmes at the local-community level explicitly referred to in official documents on healthcare and/or social policies in 2011.

Figure 3.5: Distribution of explicit references to prevention activities targeting at-risk groups in official documents on healthcare and/or social policies in 2011

Figure 3.6: Distribution of explicit references to prevention activities targeting families in official documents on healthcare and/or social policies in 2011

Figure 3.7: Percentage distribution of prevention campaigns conducted by the Regions and Autonomous Provinces in 2011, by type of mass media

Figure 3.8: Percentage distribution of prevention campaigns conducted by the Regions and Autonomous Provinces in 2011, by subject matter

4. PROBLEM DRUG USE

Figure 4.1: Prevalence estimates per thousand residents aged 15-64. The years 2005-2011

Figure 4.2: Prevalence estimates (per thousand residents aged 15-64) of subjects requiring treatment for opiate use. The year 2011

5. TREATMENT DEMAND AND AVAILABILITY

Figure 5.1: Distribution of health and social services structures for drug addicts by type and by region – The year 2011

Figure 5.2: Percentage distribution of diagnostic therapeutic and rehabilitative public and private facilities according to the Framework for the State-Regional Accord Act of 5 August 1999. The year 2011

Figure 5.3: The existence of official documents for the assessment of treatment quality. The year 2011

Figure 5.4: Outline of the organisation of the flow of treatment data – The year 2011

Figure 5.5: Percentage distribution of the sample of clients undergoing treatment with Drug Addiction Services according to type of client and primary drug of use. The year 2011

Figure 5.6: Age at first use, age at first treatment and latency period, by gender. The year 2011

Figure 5.7: Clients undergoing treatment with Drug Addiction Services by type of contact – Absolute values and index values (Base year 2000 = 100) – The years 2000 - 2011

Figure 5.8: Average age of clients undergoing treatment with Drug Addiction Services by type of contact and by gender. The years 1991 - 2011

Figure 5.9: Percentage distribution of clients undergoing treatment with Drug Addiction Services, by primary drug. The years 1991 – 2011

Figure 5.10: Percentage distribution of clients undergoing treatment with Drug Addiction Services, by secondary substance. The years 1991 - 2011

6. HEALTH CORRELATES AND CONSEQUENCES

Figure 6.1: Prevalence of HIV-positive service clients among clients on whom tests were performed, by Region. The years 2006 -2011 (Part 1)

Figure 6.2: Prevalence of HIV-positive service clients among clients on whom tests were performed, by Region. The years 2006 -2011 (Part 2)

Figure 6.3: Percentage of subjects eligible for testing who were actually tested for HBV and prevalence of positive test results, by Region. The years 2006 to 2011 (Part 1)

Figure 6.4: Percentage of subjects eligible for testing who were actually tested for HBV and prevalence of positive test results, by Region. The years 2006 to 2011 (Part 2)

Figure 6.5: Prevalence of HCV-positive clients, by Region The years 2006 to 2011 (Part 1)

Figure 6.6: Prevalence of HCV-positive clients, by Region. The years 2006 to 2011 (Part 2)

Figure 6.7: Trends in alcohol-related traffic accidents, deaths and injuries in Italy, the years 2007-2010 – absolute values

Figure 6.8: Trends in drug-related traffic accidents, deaths and injuries in Italy, the years 2007-2010 – absolute values

Figure 6.9: Trend in deaths by overdose, by gender and year of death. The years 1999-2011

Figure 6.10: Trends in index values for deaths by acute narcotic drug-induced intoxication in Europe and in Italy. The years 1985 – 2009 (Base year 1985 = 100)

Figure 6.11: Percentage distribution of deaths by overdose in the male population, by age group. The years 2005 – 2011

Figure 6.12: Percentage distribution of deaths by overdose in the female population, by age group. The years 2005 – 2011

Figure 6.13: Percentage of deaths attributed to overdose, by drug type. The years 1999 – 2011

Figure 6.14: Rate of drug-related hospital admissions ending in death (hospitalisations per 100,000 residents), by gender. The years 2006 – 2010

Figure 6.15: Percentage of drug-related hospital admissions ending in death and not ending in death, by drug type. The year 2010

Figure 6.16: Percentage of drug-related hospital admissions ending in death, by drug type. The years 2006 - 2010

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

Figure 7.1: Assessments of availability of death by acute drug intoxication priority prevention programmes. The year 2011

Figure 7.2: Assessment of availability of drug-related infectious disease prevention services in therapeutic communities – the year 2011

Figure 7.3: Assessment of availability of drug-related infectious disease prevention services in prisons – the year 2011

Figure 7.4: Assessment of accessibility of drug-related infectious disease prevention services in therapeutic communities – the year 2011

Figure 7.5: Assessment of accessibility of drug-related infectious disease prevention services in prisons – the year 2011

Figure 7.6: Assessment of availability of paraphernalia (where present) employed in education to acquire prevention skills. The year 2011

8. SOCIAL IMPLICATIONS AND SOCIAL REINTEGRATION

Figure 8.1: Percentage distribution of unemployed drug addiction services clients according to drug type and type of client (new or returning) – The year 2011

Figure 8.2: Percentage distribution of homeless drug addiction services clients according to type of drug and type of client (new or returning). The year 2011

Figure 8.3: Assessment of the availability of housing services specifically targeting current and former drug users. The year 2011

Figure 8.4: Assessment of the availability of employment services specifically targeting current and former drug users. The year 2011

9. DRUG-RELATED CRIME, PREVENTION OF DRUG-RELATED CRIME, AND PRISON

Figure 9.1: Trends in index values (*) for offences (criminal and non) in violation of drug law within EU Member States, by drug type. The years 2004 - 2009

Figure 9.2: Trends in index values (*) for illicit conduct in violation of drug law (Art. 74, Art. 74 and Art. 75) reported in Italy. The years 2004 - 2009

Figure 9.3: Percentage distribution of persons reported pursuant to Art. 75, by major age groups. The years 1990 – 2011

Figure 9.4: Percentage distribution of persons reported pursuant to Art. 75, by drug type. The years 1991 – 2011

Figure 9.5: Persons charged with crimes during the course of anti-drug operations conducted by Law Enforcement Agencies, percentages of foreigners, women and minors charged. The years 1993 – 2011

Figure 9.6: Persons charged with crimes during the course of anti-drug operations conducted by Law Enforcement Agencies, by type of illegal substance seized. The years 1993 – 2011

Figure 9.7: Results of checks carried out on the sample of drivers tested for alcohol and drugs.

Figure 9.8: Trend in traffic accidents, 2009-2010

Figure 9.9: Total subjects on probation or parole, and percentage of that total who are drug addicts placed on probation or parole pursuant to Art. 94. The years 2002 – 2011

Figure 9.10: Number of drug addicts placed in care of social services coming from custody (parole) or from outside of custody (probation). The years 2002 – 2011

Figure 9.11: Inmate population flow (percentages refer to the previous level)

Figure 9.12: Subjects with drug-related problems by type of addiction and first drug used. Data in the form of percentages. The year 2011

Figure 9.13: Drug-addicted juveniles, by type of custodial facility. The year 2011

Figure 9.14: Drug-addicted juveniles, by type of drug used and type of custodial facility. Data is given in the form of percentages. The year 2011

10. DRUG MARKETS

Figure 10.1: Quantities of illicit drugs seized by Law Enforcement Agencies during the course of anti-drug operations. The years 1993 – 2011

Figure 10.2: Average prices per drug dose. The years 2002 – 2011

Figure 10.3: Average percentage of pure drug in drugs discovered by Law Enforcement Agencies in the years 2001 to 2011

Figure 10.4: Variability in the quantity of active principle in illegal psychoactive drugs discovered by Law Enforcement Agencies in 2011

11. RESIDENTIAL TREATMENT FOR DRUG USERS IN EUROPE

Figure 11.1: The five action areas of the National Action Plan on Drugs 2010-2013

Figure 11.2: The transversal actions of the five action areas

Figure 11.3: Distribution of social and healthcare facilities for drug addicts, by type and by Region - the Year 2011

Figure 11.4: Trends in the number of social and healthcare facilities for drug addicts - the Years 1991-2011

Figure 11.5: Percentage distribution of diagnostic therapeutic and rehabilitative public and private facilities according to the Framework for the State-Regional Accord Act of 5 August 1999. The year 2011

Figure 11.6: Clients present in social-rehabilitative facilities on 31 December of each year of reference - The years 2000 – 2011

Figure 11.7: Persons receiving care from drug addiction services (either as part of outpatient programmes or within social-rehabilitative facilities) and persons entering social-rehabilitation facilities - The years 2000 – 2010