



*Presidenza del Consiglio dei Ministri*  
*Dipartimento per gli Affari Sociali*



**OIDT** OSSERVATORIO ITALIANO  
PER LA VERIFICA DELL'ANDAMENTO DEL FENOMENO DELLE  
DROGHE E DELLE TOSSICODIPENDENZE

**The State of the Drug Problem in  
Italy (2000)**  
Annual Report to the European Monitoring  
Centre for Drugs and Drug Addiction

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## Introduction

The Lisbon-based European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), one of 11 decentralised European Community agencies, was set up in 1993 in response to the escalating drug problem in Europe and to demands for an accurate picture of the phenomenon throughout the European Union. Its task is to provide the Community and its Member States with 'objective, reliable and comparable information at European level concerning drugs and drug addiction and their consequences'.

The EMCDDA's main tasks are:

- collecting and analysing existing data;
- improving data-comparison methods;
- disseminating data and information;
- co-operating with European Union institutions, international partners and with non-EU countries.

To provide data and information and to develop and implement common instruments for data collection and evaluation, the European Information Network on Drugs and Drug Addiction (REITOX) was established. This consists of one National Focal Point (NFPs) in each of the 15 EU Member States and one at the European Commission.

In Italy, Law 45/99 and its related Decrees established the Italian Observatory for Drugs and Drug Addiction (OIDT), based within the Department of Social Affairs of the President of the Council of Ministers. The task of the OIDT was to provide the technical and scientific basis for understanding the drugs problem in Italy and for developing effective strategies and interventions to contain and reduce drug related problems.

Policy and strategy at the national level is determined by the National Co-ordination Committee consisting of Ministers from all the Departments with a role in tackling drug problems. The OIDT provides the technical and scientific support for the Committee.

To fulfil this task and to support implementation of effective strategies at the Regional and local levels, the OIDT is organised in three sectors: statistics and epidemiology, demand reduction and the National Focal Point. To support its work, it is advised by a Scientific Committee consisting of seven experts appointed by the Minister for Social Solidarity.

From late 1999, when the OIDT was brought into operation and through 2000, a primary task has been to assess the national situation using all the available data, to identify areas requiring development and to establish a work plan based on priority needs. As part of this process, epidemiological and statistical analysis was a priority to provide a basis for further activity, to measure the impact of interventions and to identify areas for development. Other priorities included establishing a data base of evaluated prevention, treatment and social re-integration programmes and creating a virtual library which could provide ready access to a wide range of documentation and research.

The placing of the National Focal Point within the OIDT gave an opportunity to review its work and to re-organise its functioning. As with all the work of the OIDT, in addition to work with all the relevant Ministries, the NFP uses external experts extensively. It thus seeks to link policy and planning with effective use of scientific expertise.

The specific role of the NFP involves co-ordinating national information to meet the EMCDDA's requirements for a set of core data, annual *National Reports* on the drug situation in each Member State and a national information network. For Italy, the position of the NFP within the OIDT will now provide effective inter-linking between national and international activity and will facilitate increased capacity to collect and analyse data, to

evaluate the impact of interventions and to develop responses which are relevant to identified need.

The core tasks of the Italian National Focal Point are:

- preparation of an Annual Report analysing the state of the drug problem in Italy
- preparation and submission of standard epidemiological tables to the EMCDDA,
- development and implementation of epidemiological key indicators covering: demand for drug treatment; drug-related infectious diseases; drug-related deaths; extent and pattern of drug use in the general population, and; prevalence of problem drug use
- development and implementation of the Exchange Drug Demand Reduction Activities (EDDRA) system
- implementation of the Joint Action on New Synthetic Drugs
- preparation of the information map on sources of data about drugs and drug misuse
- exchange of information at European and national levels
- maintenance of a web site ([www.puntofocale.it](http://www.puntofocale.it))

This report, prepared by the NFP, therefore represents one of the core tasks.

## **SUMMARY: MAIN TRENDS AND DEVELOPMENTS**

In 1999 there were a number of major developments affecting the organisation and provision of interventions in the drug field. Together, these have established a new framework which it is hoped will provide a long term basis for effective action to contain and reduce drug misuse and drug related problems.

### *National Framework*

Law 45/99 and its associated decrees established the basis for national planning and strategy and placed a new, focused National Drugs Observatory within the Department of Social Affairs of the Presidency of the Council of Ministers. The Observatory, advised by its Scientific Committee, has developed a work programme aimed at improving the epidemiological data available and the exchange of data between central government and the Regions and direct service providers.

In the same period, two regulations were agreed by the Permanent Conference for Relations between the State, the Regions and the Autonomous Provinces. These provide for a re-organisation of services in the drugs field and clear allocation of responsibilities between the Regions, the local Health Authority and direct service providers. The re-organisation was considered necessary because there was an inadequate relationship between the assessed need for interventions and their availability and because intervention services has become too focused on the most acute drug problems. Under the new arrangements, a more balanced focus is required to cover prevention, response to new and emerging needs, such as the use of synthetic drugs, non-injecting drug use, early intervention and treatment within prison. The agreements also provide the basis for minimum quality standards for services, the details of which are to be determined by the Regions. Included in these standards is the requirement for collaboration between services in a local network of provision and for minimum reporting requirements.

Law 45/99 also provided the basis for the allocation of the National Drugs Fund, with 75% of the resources allocated to the Regions and 25% retained for national projects. The Decree allocating the resources made specific linkage between the re-organisation of services, the implementation of national strategy and the development of training, monitoring and evaluation.

### *Epidemiology*

In terms of drug use in the general population, cannabis remains the most prevalent drug. Cocaine appears as the next most prevalent drug in all published reports, exceeding the prevalence of use of synthetic drugs.

In terms of problematic drug use, heroin by injection is the most common primary drug. There is evidence that newer users inject less frequently and use heroin by smoking. Cocaine as a primary drug of misuse is increasing amongst those attending the Ser.T for treatment. Cannabis is also a significant primary drug in some Regions. Reports suggest that multiple drug use, especially amongst those contacted through street work, is increasingly common.

Treatment demand has continued to increase annually. The mean age of clients attending the Ser.T for treatment has risen steadily over the years, as has the mean age of new clients. However, there has been an increase in the proportion of new clients in the under 24 age group. There are some signs that treatment demand is exceeding capacity.



The number of direct drug related deaths has continued to decline each year. The percentage of deaths amongst the older age groups has increased, suggesting that their relatively poor health has contributed to increased mortality. A specific study on drug related deaths has confirmed that deaths associated with the use of heroin are most common, followed by deaths associated with the use of cocaine. However, heroin related deaths commonly involve other substances as well, whereas cocaine related deaths tend only to involve cocaine.

The number of clients of the Ser.T testing positive for HIV, Hepatitis B or Hepatitis C has remained stable or declined. New clients of the Ser.T are less likely to test positive for a drug related infectious disease than existing clients of the Ser.T and female clients are more likely to test positive than male clients. There are indications that this represents increased sexual transmission whilst transmission by injecting drug use has stabilised or declined.

The number of people referred to the Prefect for unlawful possession of a listed drug has increased annually. Cannabis is the most common drug followed by heroin and then cocaine. Cocaine possession has shown a consistent increase over recent years whilst referrals for possession of most other drugs has remained broadly stable. Almost 30% of those referred for unlawful possession were between 18 and 20 years old.

The number of drug law offences has also increased annually. Over 80% of offences concerned drug sales and 11% concerned production or trafficking. 70% of offenders were Italians and 30% non-Italians. Cannabis was the drug most usually involved followed by heroin and cocaine. Between 1998 and 1997, whilst offences involving cannabis remained at about the same level, offences involving heroin declined substantially whilst those involving cocaine increased substantially.

29% of the prison population was assessed as drug dependent on admission into prison. Just under half were imprisoned for drug law offences and just over half for other offences. Over 37% of all prisoners were imprisoned for drug law offences.

Cannabis is the drug most commonly seized. A greater quantity of cocaine than heroin has been seized every year since 1993.

Problematic drug use is most prevalent in the central Regions of Italy and least prevalent in the southern Regions.

### *Demand Reduction*

The re-organisation of responses to drug use and drug problems arising from the regulations mentioned earlier has led to substantial activity at both the national and Regional levels. The Italian Observatory for Drugs and Drug Addiction, established within the Department of Social Affairs of the Presidency of the Council of Ministers and guided by a Scientific Committee, has established a work programme aimed at improving the knowledge base in terms of both the extent and nature of the problem and the effectiveness of interventions. All relevant Ministries participate in the Inter-Ministerial Group which has the aim of ensuring effective collaboration and integration between the range of demand reduction programmes.

At the Regional level, the development of the Regional plan, the definition of quality standards, monitoring, evaluation and reporting requirements and the establishment of co-ordination and review systems has required considerable work.

Within this emerging framework, demand reduction activity has seen several specific developments.

At the level of prevention of drug use and of drug related problems, there has been an integration between national and local campaigns and across different media (internet, video, printed, TV and radio). A main focus has been on synthetic drugs with the objectives of limiting their use and of limiting harm where they are used. As part of this overall development, a protocol has been agreed between the Government and the Union of Dance Hall Operators with the aim of improving the environment of discotheques, training staff and establishing effective operational links between discotheques and drug services.

A second area of development has been a focus on promoting sport free of drug use and as an alternative to drug use. To this end, there has been collaboration developed with sports associations culminating in a European conference in co-operation with the National Olympic Committee aimed at promoting these two objectives and developing further links between sports and drug prevention activities.

In terms of limiting drug related harm, the conference of outreach projects held in Bologna established ethical and operational principles for the operation of such projects. These were published as the Charter of Bologna and have formed the basis for the development of outreach work.

The number of people in treatment with the public treatment services (Ser.T) has continued to rise and now stands at over 142,000 people. There has been a decrease in the number of people reporting primary use of heroin and in those injecting heroin whilst there has been an increase in the number of people with primary use of cocaine. In terms of treatment, the trend towards longer term prescribing of methadone has been maintained and there has been a further decline in the percentage of people receiving psycho-social, rehabilitation or other pharmaceutical treatments. The number of drug dependent prisoners receiving treatment from the Ser.T has increased and an increasing percentage receive substitution treatment.

The National Drugs Fund has been used to support to development of the national drugs strategy. A substantial amount of the money retained for projects proposed by Ministries has been used to improve data collection and analysis and information exchange between Ministries and the Regions. The Fund has also been used to pilot a number of national projects aimed at developing more effective responses to drug problems and to evaluating the impact of existing responses. At the Regional level, resources have been used from the Fund to support the re-organisation of treatment services and to develop a fuller range of interventions reflecting the assessed needs of the Region. In particular, there has been an increased focus on prevention, outreach work, treatment in prison and alternatives to prison and on combating social exclusion.

There has been increased attention paid to research and, in particular, to the evaluation of services and the implementation of quality standards. A substantial number of papers have been published concerned with treatment quality and treatment outcome, many of which have focused on client satisfaction with the service.

## **PART 1 NATIONAL STRATEGIES: INSTITUTIONAL & LEGAL FRAMEWORKS**

### **1. DEVELOPMENTS IN DRUG POLICY AND RESPONSES**

#### *1.1 Political framework in the drug field*

- 1.1.1 There has been little change in the political framework at the national level during 1999. The new arrangements described in the last report ([OIDT 2000](#)), with the establishment of the Italian Observatory for Drugs and Drug Addiction (OIDT), have been gradually brought into operation and the specific priorities for work have been established.
- 1.1.2 National policy is based on reducing the availability of drugs of misuse, reducing the likelihood that people will misuse drugs, providing treatment, rehabilitation and social re-insertion for those who have drug problems and reducing the harm associated with the misuse of drugs.
- 1.1.3 Increasingly, there has been an emphasis on quality and on evaluation and a number of major national projects have been initiated to provide both quantitative and qualitative data to inform the development of policy and practice. These are considered in the relevant sections of this report.
- 1.1.4 There has always been debate at the national level on the focus of drug policy and the way in which it should be taken forward. This has largely been a question of emphasis rather than of any substantial change in policy.
- 1.1.5 In Italy, considerable autonomy has been devolved to the regions, which have authority to determine local policy and influence practice. There is, therefore, some variation in policy across the country, depending upon local circumstances and an assessment of local needs.
- 1.1.6 In some Regions there have been moves to emphasise prevention of any drug misuse and to promote abstinence oriented interventions. There have also been increased calls for higher levels of autonomy at the regional level in terms of the priorities for the use, allocation and control of the National Drugs Fund.

#### *1.2 Policy implementation, legal framework and prosecution*

##### *Law and Regulations*

- 1.2.1 Arising from the law of 18 February 1999 n.45, which was described in the last report, a number of decrees and other instruments have been promulgated. Together, these have sought to create the essential framework for effective implementation of the national policy for tackling all aspects of drug misuse. A fuller description of these developments is included in Part 4, Section 12.
- 1.2.2 A Decree of the President of the Council of Ministers (Prime Minister) dated 28 April, 1999, established the organisation and functions of the National Co-ordinating Committee for Anti-Drug Activities.
- 1.2.3 Decrees from the Minister of Social Solidarity (1 June, 1999) and from the President of the Council of Ministers (10 September, 1999) established respectively the transfer of 75% of the National Drugs Fund to the Regions and Autonomous Provinces and defined the

general criteria for evaluating and funding projects submitted to the Regions by local authorities, local health authorities and private organisations.

- 1.2.4 On the 5<sup>th</sup> August, 1999, arising from the Permanent Conference for Relations between the State, the Regions and the Autonomous Provinces, an Act of Understanding was published for determining the minimum standards for authorising the functioning of and accrediting services for helping drug users
- 1.2.5 Decrees on 12 April 1999 and 14 September 1999 respectively established the Council of operators and experts in drug dependence and the organisation and functions of the Italian Observatory for Drugs and Drug Addiction (OIDT) within the Department for Social Affairs.
- 1.2.6 During 1999, the re-organisation of the public and private services for drug users has proceeded rapidly. This was necessary because the distribution of the large number of services (over 550 public treatment services and over 1,300 private services) did not match the distribution of need for services. On 21 January, 1999 a Regulation was agreed by the Permanent Conference for Relations between the State, the Regions and the Autonomous Provinces which established the basis for this re-organisation and the structure and responsibilities for planning, delivery, monitoring and evaluation of interventions. This development is described fully in Section 8 of this Report (Strategies in Demand Reduction at the National Level).
- 1.2.7 There have been no other significant legislative changes during the year, although the entry into force of Law 45/99 has had an impact on all aspects of the response to drug misuse in Italy.

#### *Prosecution Policy*

- 1.2.8 As described fully in the last report, unlawful possession of a controlled drug is an administrative, not a criminal offence. Policy and practice, therefore, is not to pursue the possession of controlled drugs although drugs may be found on a person in the course of other police operations.
- 1.2.9 Where criminal offences involve a drug misuser, prosecution policy remains to direct the drug misuser away from drug misuse. Depending upon the seriousness of the offence, the offender may be offered a substitute sanction or community measure. In both instances, the aim is to continue or to initiate treatment for the drug misuser and to reduce the likelihood of further offending.
- 1.2.10 In serious offences, a sentence of imprisonment may be imposed. However, the policy of providing or continuing treatment remains a primary objective. To this end, the Ser.T increasingly provide treatment services within the prison setting. Semi-detention, suspended sentences, monitored liberty and conditional release are also available and are extensively used to support the provision of treatment and rehabilitation.
- 1.2.11 A full description of all the measures available is given in the last Annual Report ([OIDT 2000](#)).

*Other important initiatives*

1.2.12 In November 2000 the Third National Drugs Conference was held in Genova. This conference is held every three years and acts as a major consultative conference on drug policy and strategy as well as a means of information sharing and dissemination of good practice. A full report on the outcomes of this conference will be included in the next report.

1.3 *Developments in public attitudes and debates*

*Perceptions of the drugs issue*

1.3.1 There has been continuing discussion about policy and strategies for responding to drug misuse within Italy.

1.3.2 Whilst there are extremes of views expressed about drug misuse, there remains a broad consensus that the basic elements of demand reduction and supply control should remain a high priority. The debate has to some extent focused on what should be the priorities within each element.

1.3.3 Within this debate, there is increasing support for changing the status of cannabis in the drug legislation. This perhaps reflects both the general level of life time use of cannabis within the population, a view that cannabis does not represent a serious drug problem and a sense that cannabis should be separated from other drugs which are perceived as more harmful.

1.3.4 Within Parliament, the 12<sup>th</sup> Permanent Parliamentary Commission of the Senate (Hygiene and Health) has undertaken an examination of the modalities and results of secondary and tertiary interventions in the drugs field as adopted in Italy and the experience of some other European countries (Senate 2000). Its report has just been published and the contents will be discussed more fully in the next report to the EMCDDA.

*Media representations*

1.3.5 Media coverage of drug misuse is varied. At one level, there remains the tendency to dramatise specific events such as a single death or a major drug seizure, although these may not be representative of the general situation. On the other hand, there are documentaries and articles which can provide valuable and accurate information. It remains the case that the visual media still has a tendency to use dramatic images when dealing with drug related stories.

1.3.6 Aware of the influence for better or worse of media presentation of the drugs issue, the National Prevention Campaign for 2000 included a seminar for the chief editors of the major national newspapers. It is hoped that these discussions will encourage a more thoughtful presentation of the issues in support of the overall drugs strategy.

1.4 *Budget and funding arrangements*

*Drug related expenditure estimates*

1.4.1 There is no central data available on all expenditure for drug and drug related activities carried out in Italy. Detailed data is available on the allocation of funds from the National Drugs Fund. However, expenditure

on drug related activities also includes regional and local funding for the provision of services and for specific projects, expenditure on law enforcement, the criminal justice system, and health and social services both within and outside the Ser.T and funding for private social organisations obtained from private sources or from outside Italy. Moreover, research, training, evaluation and quality assurance are undertaken in a variety of settings and may be funded through general funds of the organisation undertaking the activity or through specific grants. Central data on expenditure on these activities is only available where they are undertaken with financial support from the National Drugs Fund.

- 1.4.2 Although it has only been possible to a limited extent, some efforts have been made to identify the overall level of expenditure. Unfortunately, in most instances the data was insufficiently detailed to allow for an estimate of cost for any particular area of activity (law enforcement, research, treatment, etc).
- 1.4.3 There are similar problems in estimating the health service costs of drug treatment. Although information is available on the number of staff by profession for the public drug treatment services (Servizi per le Tossicodipendenze [Ser.T]), there is no similar information available for private drug treatment services. A national estimate of the total health care costs of drug addiction in Italy has been made, placing this at 1.000.000.000.000 lire (516.456.899 euro). This is based on an analysis of all costs of the local health services (Azienda Sanitaria Locale [ASL]) for 1998 and was reported in the annual report to Parliament prepared by the Department of Social Affairs ([Social Affairs 1999](#)).

*Allocation of the National Drugs Fund*

- 1.4.4 The most detailed information available concerns the allocation and use of resources made available from the National Drugs Fund. In the 1999 report ([OIDD 2000](#)) the legislative arrangements for the allocation of the fund were explained in detail. The total sum provided amounted to almost 610.000.000.000 lire (315.038.708 euro). Of this total, 25% was allocated to Ministries and Departments for national projects and 75% was allocated to the Regions. The allocation was determined by establishing the percentage of the national population resident in each region and the percentage of the total number of known drug dependents in treatment with the Ser.T in each Region to create an average percentage. This percentage was then used to determine the amount to be allocated to each Region. This allocation is shown in [Table 1](#).
- 1.4.5 At the national level, six Ministries submitted projects for funding from the National Drugs Fund (Defence, Education, Health, Internal Affairs, Justice and Labour). All the projects submitted were examined by a committee appointed by the Minister of Social Affairs which then submitted its recommendations to the Minister.
- 1.4.6 In total, 89 projects were approved. [Table 2](#) shows the distribution of resources by type of project and by Ministry/Sector.
- 1.4.7 At the Regional level, each Region established criteria and methods for the submission of project proposals, for receiving their fund allocation

from the National Drugs Fund and for assessing and selecting projects. National guidance was provided through the legislation which authorised the Fund, but Regions were expected to develop criteria and arrangements which reflected their own particular circumstances.

- 1.4.8 At the end of 1999, just over one quarter of the sum available to the Regions had been directly allocated to projects. The majority of Regions were still completing selection of projects to be funded. [Table 3](#) shows the number of projects proposed, funded or partially funded, or rejected and the amount allocated to the different sectors for those Regions which had provided information for 1999. The last column shows the average expenditure for each funded project .

## **PART 2 EPIDEMIOLOGICAL SITUATION**

### **2. PREVALENCE, PATTERNS AND DEVELOPMENTS IN DRUG USE**

#### *2.1 Main developments and emerging trends*

- 2.1.1 The establishment of the National Drugs Observatory has allowed work to be undertaken on prevalence estimates of both drug use and of problem drug use. Additionally, the ESPAD survey has provided information about prevalence of life time use of a range of substances by young people of school age.
- 2.1.2 From the ESPAD survey, from information from the Ministry of Defence and from Project AMR, along with data from a number of local studies, all confirm that the prevalence of drug use has continued to rise. Cannabis remains the most prevalent illicit drug, followed by cocaine. Synthetic drugs such as MDMA appear to be less prevalent. The most noticeable trend has been the continuing increase in the prevalence of cocaine both in terms of use and problem use.
- 2.1.3 Amongst people with drug problems approaching the Ser.T for treatment or contacted by outreach services, heroin is the most prevalent drug. There appears to be an increase in the number of people using heroin by methods other than injecting. There is also an emerging trend of larger numbers of non-Italians being contacted by outreach services, many of whom have entered illegally, who do not inject drugs and who have difficulty in accessing services.
- 2.1.4 Multiple drug use amongst those outside treatment, or who have transient contact with treatment services appears to be common although there is relatively little data available on this population.
- 2.1.5 The prevalence of drug related infectious diseases appears to have stabilised or declined. New clients of the Ser.T are more likely to test negative than clients already in treatment with the Ser.T and female clients are more likely to test positive than male clients. There are indications that sexual transmission, especially of HIV infection, may be becoming more important whilst transmission through injecting drug use may be reducing in significance, especially amongst female drug users.
- 2.1.6 The number of deaths directly attributable to drug misuse has continued to fall. Heroin remains the drug most usually involved, followed by cocaine. A majority of heroin related deaths usually involve at least one other substance and often alcohol and other drugs are involved. By contrast, cocaine related deaths normally involve cocaine alone.
- 2.1.7 Referrals to the Prefect for possession of a listed drug confirm the other data concerning prevalence of use and of problematic use. Cannabis is the most common drug, followed by heroin and cocaine. Referrals for possession of other drugs is relatively uncommon. This may, however, reflect policing priorities rather than actual prevalence of use.
- 2.1.8 The number of referrals to the Judicial Authorities for drug law offences increased in 1999. Sale of drugs is by far the most common



offence and the percentage of people referred for this offence increased over 1998. The percentage of non-Italians referred for drug law offences fell compared to 1998.

2.1.9 The downward trend through the 1990s in the percentage of prisoners assessed as drug dependent was reversed in 1999. At present it is not possible to say if this represents a true upward trend or just a temporary reversal. There was also an increase in the percentage of prisoners held for drug law offences over 1998 and in the percentage of non-Italians held for such offences.

2.1.10 No significant changes in the broad pattern of drug seizures occurred. Cannabis was the drug most commonly seized, followed by cocaine and heroin. This is the pattern which has existed through most of the 1990s. There have been some changes in the trafficking routes and this may reflect changes aimed at avoiding detection or the involvement of new groups in drug trafficking.

## 2.2 *Drug use in the population*

2.2.1 The major sources of information about drug use in the population have been the publication of the results of the school survey conducted as part of the European School Survey Project on Alcohol and Other Drugs (ESPAD) and the data provided by the Ministry of Defence on drug use within the armed forces. Secondary information comes from published reports from a variety of sources including universities, regions, Ser.T and private treatment services.

### *Drug use in the school age population*

2.2.2 The ESPAD survey is well known and only the Italian data will be reported here. Some 21,000 students from around 5,800 upper schools from throughout Italy were included in the study. Approximately 60% of the population in the age range 14 - 19 attends these schools and the survey therefore represented a sample of 1% of the school population and 0.4% of Italian residents in the 14 - 19 age group.

2.2.3 The first survey was conducted in 1995 and comparative figures are available for the use of alcohol, tobacco, cannabis, other illicit substances, tranquillisers and sedatives and alcohol with pills. [Table 4](#) shows the comparative results.

2.2.4 There are relatively small increases in consumption of alcohol, drunkenness and smoking cigarettes in the past 12 months. However, there is a noticeable increase in smoking cigarettes within the last 30 days. There has also been a substantial increase in the percentage reporting lifetime use of cannabis and, whilst the figures are small, the use of other illicit substances also shows an increase. On the positive side, the use of tranquillisers and sedatives and the use of alcohol with pills both show welcome reductions.

2.2.5 On the basis of these figures, extrapolated to the whole population, around 1.5 million young people between the ages of 14 and 19 have tried cannabis, around 500,000 have tried other illegal substances and around 400,000 have tried tranquillisers and sedatives at some point in their life.

- 2.2.6 [Table 5](#) shows in more detail the percentage of young people reporting use of alcohol, tobacco and other drugs in their life. A detailed comparison with the 1995 study is not shown but the previous tables show the broad trends quite clearly.
- 2.2.7 From this table, extrapolated to the whole 14-19 population, over 1,000,000 young people have tried alcohol and cannabis, around 300,000 have tried inhalants and around 225,000 have tried cocaine at some point in their life. Amphetamine and ecstasy are less likely to have been taken, but smoked heroin is at the same level (around 150,000 young people). Adding the figures for heroin use other than by smoking, the number of young people who have tried heroin exceeds that reporting use of either amphetamines, ecstasy or LSD. Crack remains a relatively rare drug within Italy confirmed by this data and by data from the Ser.T.
- 2.2.8 [Table 6](#) shows that the peak age for first use of various substances is largely what might be expected. The licit substances such as beer, wine, spirits and tobacco are tried earlier than the illicit substances. For both beer and wine, first use was when 11 years old or under. This reflects cultural patterns of consuming alcohol with meals within the family setting. First use of spirits is later, and again is likely to be within the context of the family, whereas first experience of being drunk peaks at 16 years old or older, almost certainly reflecting alcohol consumption with friends and away from parental or other adult supervision. First use of cigarettes peaks at 14 years old, but daily use does not peak until 16 years old or above.
- 2.2.9 By contrast, first use of all illicit substances begins to be noticeable at 14 years old but does not peak until 16 years old or over. This suggests that the major risk age is between 14 and 16 and that prevention efforts must be concentrated earlier than this if the upward trend in use noticed between 1995 and 1999 is to be halted and possibly reversed.

*Drug use in the armed forces*

- 2.2.10 Information from the Ministry of Defence is useful because it provides a picture of drug use amongst the male population considered most at risk to drug use. Italy has male conscription into the armed services and the data is therefore a useful picture of the situation within the general male population.
- 2.2.11 [Table 7](#) shows data for four years. Unfortunately there is no consistent information available about the number of people tested and the percentage of those tested found positive for one or more drugs. However, the available information does give a fair indication of drug use trends within the male population given that the majority of those testing positive were from people summoned for conscription or who were conscripts.
- 2.2.12 Whilst the overall number of drug users identified in the military services has fallen between 1998 and 1999, use of cannabis and cocaine both rose. As might be expected, cannabis is the most widely used drug. The absolute number of users fell between 1998 but the percentage of the total rose. Surprisingly, however, cocaine is the

next most common drug. Although with considerably fewer users, both the number of users and the percentage of the total rose between 1998 and 1999. For all other substances, with the exception of very small rises in morphine and alcohol, there was a decrease in both the absolute number of users and the percentage of the total using these substances.

- 2.2.13 The data from the Ministry of Defence shows some differences from that of the ESPAD study but does confirm a general picture. Cannabis in its various forms is the most widely misused drug from both data sets.
- 2.2.14 For the school age population (14 - 19 years old), more readily available substances, such as sedatives and tranquillisers and inhalants are the next most likely to be used. These are then followed by cocaine, hallucinogens, stimulants and heroin.
- 2.2.15 For males in the armed services, representing the next age group, sedatives and tranquillisers and inhalants hardly feature. The next group of drugs are cocaine followed by heroin and other opiates or opium derivatives.
- 2.2.16 These differences appear to confirm the findings of the ESPAD study that licit substances are used first, followed by more widely available substances such as sedatives, tranquillisers and inhalants. At 16 years old or over, use of the illicit drugs appears to increase and, therefore, a higher level of use of these substances might be expected in the older age group.

#### *Characteristics of drug users*

- 2.2.17 Both these studies identify features which appear to represent risk factors for the development of drug use and drug problems.
- 2.2.18 With the student population, the study found that those who had taken illicit drugs were more likely to be male and in general came from families with low levels of education, had not attained the expected educational level for their age and had relationship problems with their family, friends or teachers.
- 2.2.19 The material from the Ministry of Defence provides data about a the marital status, education, employment, frequency of use, first use and factors motivating use. This is shown in [Tables 8 - 13](#).
- 2.2.20 From this data, the majority of users were single ([Table 8](#)), had a low educational attainment ([Table 9](#)) and were manual workers or unemployed before they entered the Armed Forces ([Table 10](#)). In 1999, 42% used drugs a few times a year or a few times a month compared to 45% in 1998 ([Table 11](#)). However, the non response rate to this question in 1999 (27.5%) was higher than for 1998 (21.9%) and the percentage may not, therefore, be reliable. The majority used drugs for the first time after they had entered the armed forces ([Table 12](#)) and because of curiosity or group pressure ([Table 13](#)).
- 2.2.21 As with the prevalence data, the risk factors identified in the ESPAD study appear to be confirmed by the data from the Ministry of Defence, although it is concerned with an older population.

## 2.3 Problem drug use

### *Estimates of problematic drug use using different indicators*

- 2.3.1 The most recent national prevalence estimate of problem drug use was undertaken by the Epidemiological Section of the National Observatory on Drugs and Drug Abuse for the year 1999. Additionally, information from the data on the 'at risk' population and a range of indicators has been used to give an indication of prevalence.
- 2.3.2 The population of Italy on 1 January, 2000 was 57.7 million. The population between the ages 15 and 54 - the 'at risk' population - was 32.2 million and the population between 15 and 34 was 16 million. [Table 14](#) shows a breakdown of the 15-54 population by age group and sex.
- 2.3.3 [Figure 1](#) shows that 44.2% of the 'at risk' population lives in the northern regions, 19% in the central regions and 36.8% in the southern regions and the islands. However, if we compare the 'most at risk' population (15 - 34 age group) with the 'at risk' population, the percentages change: it increases in the southern regions (39.2%) and decreases in the central (18.3%) and northern (42.5%) regions.
- 2.3.4 A variety of indicators do not, however, reflect this population distribution. [Figure 2](#) shows the percentage distribution for the northern, central and southern regions of a number of indicators, including direct drug-related deaths, arrests for drug law offences, drug seizures and treatment demand.
- 2.3.5 As can be seen from this figure, with the exception of cannabis and cocaine seizures, the northern regions have the highest percentages for all the indicators and the percentage share for the northern regions exceeds that of its percentage share of either the 15-54 or 15-34 age groups.
- 2.3.6 By contrast, the percentage share for all the indicators with the exception of cocaine and cannabis seizures is below its percentage share for both the age groups in the southern regions.
- 2.3.7 With the exception of cannabis seizures, the percentage share of the indicators for the central regions broadly reflect the percentage share of the two age groups.
- 2.3.8 A second measure is the rate per 10,000 population in the 15-54 age range. [Table 15](#) shows the absolute number and the rate for four indicators, 2 concerned with treatment and two concerned with offences.
- 2.3.9 From this data, Piemonte and Toscana exceed the national rate for each of the indicators, whilst 6 regions (Lombardia, Trentino A.A., Veneto, Abruzzo, Molise and Campania) are below the national rate for each of the indicators.
- 2.3.10 [Figures 3 - 5](#) compare the rates for the northern, central and southern regions with the national rate. In addition to Piemonte (north) and Toscana (centre), four regions have rates for treatment at the Ser.T and for unlawful possession of listed drugs which exceed the national rate - Puglia (south), Marche (centre) and Liguria and Valle d'Aosta (north)

2.3.11 Taking this material together, suggests that drug use levels are higher in the northern regions, but that problematic drug use might be more evenly distributed in terms of the relative percentage of 'at risk' populations in the northern, central and southern regions.

2.3.12 It also suggests that in the northern and central regions, which have more concentrated urban centres and a more developed 'youth culture' have higher levels of 'recreational' drug use, such as ecstasy, LSD and cannabis. By contrast, the southern regions have lower levels of recreational use but potentially higher levels of use of drugs such as cocaine.

#### *National Estimates of problematic drug use*

2.3.13 Recent work undertaken in the context of developing the national information systems linked with the prevalence estimation methodologies proposed by the EMCDDA has resulted in two analyses of problem drug use. The first provides an estimate of problematic drug use by area of the country. The second provides an analysis by Province.

2.3.14 The estimate by area of the country used three methodologies, mortality multiplier, treatment multiplier and multivariate indicator. [Maps 1](#) and [2](#) show the estimated rates of problematic drug use by area per 1,000 of the total population and of the population in the age range 15 - 64. In both cases, the central Regions have the highest prevalence rate followed by the island Regions and the north western Regions. The total estimated number of problematic drug users in Italy was calculated to be 289,640 people. This is an increase on the estimated level for 1996 using the same methodologies, although they are not completely comparable as the age range used in 1996 was 15 - 54.

2.3.15 The estimates developed in 1996 ([Mariani 1999](#)) using a number of different methodologies are shown in [Table 16](#). The estimates are contained in a country report on drug use prevalence in Italy prepared for the EMCDDA. They led to an estimate of 254,000 injecting heroin users in Italy and a median of 259,000 injecting heroin users.

2.3.16 The data has some limitations, notably its focus on injecting heroin use. Whilst this undoubtedly represents the most problematic form of drug use, it is noteworthy that in 1999, 15% of people in treatment whose primary drug is heroin do not inject, whilst primary and secondary use of cannabis (which is not injected) and of cocaine (where less than 15% of users inject) have continued to increase annually.

2.3.17 Within Italy there are 20 Regions and 103 Provinces. The analysis by Province is, therefore, the most detailed national survey yet undertaken.

2.3.18 Seven indicators have been selected to describe the drug problem:

- The number of drug related deaths
- New cases of AIDS
- Drug dependents in prison
- People in treatment with a therapeutic community at 31/12
- People reported for drug law offences



- People referred to the Prefect for unlawful possession of a listed drug
- People in treatment with the Ser.T

2.3.19 This data ([Figure 6](#)) was reviewed for a three year period (1997-1999) and analysed leading to the Provinces being placed into one of three clusters.

2.3.20 The first cluster, which contains 76 Provinces, was characterised as having a relative low values for each of the indicators. The second cluster, containing 17 Provinces, was characterised as having high values for the Ser.T, therapeutic community and unlawful possession indicators. The third cluster, containing 10 Provinces, was characterised as having high values for the drug law offences, prison, AIDS cases and deaths indicators.

2.3.21 Nationally, 74% of the Provinces fell into Cluster 1, with 29% of the Provinces in the north, 13% in the centre and 32% of them in the south. In Cluster 2 there was 17% of the Provinces, with 6% in the north, 8% in the centre and 3% in the south. For Cluster 3, there was 9% of the Provinces, with 8% in the north, 1% in the centre and no Provinces from the south.

2.3.22 Within the broad geographical areas there are substantial differences ([Figure 6](#)). In the northern area, with 45 Provinces (44% of the national total), 67% are in Cluster 1, 13% in Cluster 2 and 20% in Cluster 3. In the central area, with 22 Provinces (21% of the total), 59% are in Cluster 1, 36% in Cluster 2 and 5% in Cluster 3. In the southern area, with 36 Provinces (35% of the total), 92% are in Cluster 1 and 8% in Cluster 2 with no Provinces in Cluster 3.

2.3.23 This data is not in itself an estimate of the prevalence of problem drug use but rather an analysis of a number of indicators, some of which inevitably reflect the level of service provision or of intervention activity. Moreover, some are indicators of use or seizure and may not therefore reflect problem use. It does, however, confirm a general picture that drug use is most prevalent in the northern area and least prevalent in the southern area and suggests that this will also be reflected in terms of problematic drug use.

### 3 HEALTH CONSEQUENCES

#### 3.1 *Drug treatment demand*

3.1.1 Data on drug treatment demand is collected by the Office for Drug Dependence and AIDS, which is part of the Department of Prevention of the Ministry of Health. The primary data source is the Annual Report of Activities in the Drug Dependence Sector ([Health 2000](#)). A secondary source is the Annual Report to Parliament on the State of the Drug Problem in Italy ([Social Affairs 2000](#)), prepared by the Department of Social Affairs in the Presidency of the Council of Ministers. Data on the population of Italy by Region and by age group and sex is from the National Institute of Statistics ([www.demo.istat.it/stima2000](http://www.demo.istat.it/stima2000)).

*Geographical distribution of treatment demand*

- 3.1.2 The trend in demand for drug treatment from services managed by the national health service - Ser.T (Servizi pubblici per le tossicodipendenze) has continued upwards throughout the 1990s. There was a slight fall between 1997 and 1998 but a further upsurge in 1999. [Figures 7 - 10](#) show the trend by area of the country and sex and by treatment demand from new and already known drug misusers.
- 3.1.3 As might be expected, the heaviest demand for treatment comes from the northern, most populated, regions. The rise in treatment demand for 1999 largely comes from these regions, with a smaller increase for the central regions and almost no change in demand for the southern regions.
- 3.1.4 Examining the treatment demand data more closely, the overall increase in demand in the northern regions was 5.8% up on 1998, with an increase of 6.1% for males and 5.2% for females. For the central regions the overall increase was 4.5% with a rise of 5.1% from males but only 1.2% from females.
- 3.1.5 The southern regions show a particularly interesting development. The overall demand for treatment rose by only .15% and there was a decline in treatment demand from males of 0.3%, following the decline of 1.5% between 1997 and 1998. However, there was an increase of 5% in treatment demand from females, reversing the decline in treatment demand from females observed last year.
- 3.1.6 Although it is still too early to establish a definite trend, the overall pattern seems to show a continuing steady rise in treatment demand in the northern regions, stabilization of treatment demand in the central regions and a decline in treatment demand from males and no clear pattern in treatment demand from females for the southern regions.
- 3.1.7 A second indicator of treatment demand is the number of clients in treatment in the Ser.T per 10,000 population. [Figures 11\(a\) - 13\(b\)](#) show the rate of male and female demand for treatment per 10,000 population for the northern, central and southern regions of Italy.
- 3.1.8 There are significant variations between regions and from year to year in some regions. Several regions show a steady decline over three years from both male and female drug users, for instance, Abruzzo and Puglia, whilst other regions show a consistent rise, such as Lombardia, the Autonomous Provinces of Bolzano and Trento, Veneto and Toscana.
- 3.1.9 What is less clear is the reason for significant changes in the rate per 10,000 population from year to year. For example, between 1998 and 1999, the rate increased by 25% for female clients in Molise and by almost 45% in Valle d'Aosta ([Figures 13\(b\)](#) and [11\(b\)](#)). There were also large changes in the rate for male clients in some regions between 1997 and 1998. It is possible that these changes are the result of changes in treatment availability and/or practice rather than representing a significant change in patterns and levels of drug misuse.

*Characteristics of those seeking treatment*

- 3.1.10 The mean age of people in treatment with the Ser.T has continued to rise for those already in treatment with the Ser.T. In 1991 it was 28.5 years for males and 27.9 for females. This had risen to 31.7 and 31.5 years respectively in 1999. For new clients of the Ser.T there has been a smaller increase from 26.1 (1991) to 28.1 (1999) for males and from 25.9 (1991) to 27.6 (1999) for females.
- 3.1.11 Looking at the rate per 10,000 population, the picture changes slightly ([Table 17](#)). The rate for the 15 - 24 year old population has risen between 1997 and 1999 from 38.4 to 40 and for the 35 - 54 year old population from 19.8 to 24.6 but it has declined slightly for the 25 - 34 year old population from 83.9 to 82. The increased rate for the older age group appears to confirm an aging population in treatment. The increased rate in the younger age group, however, suggests that problematic drug use is not decreasing and that treatment services might not have sufficient treatment slots available for the younger group.
- 3.1.12 A further consideration is new treatment demands as opposed to the overall level of treatment demand. [Figures 14](#) and [15](#) show new treatment demands by year as absolute numbers for each age group and the percentage of new treatment demands by age group.
- 3.1.13 Between 1998 and 1999 there was a 4.4% increase in new treatment demands. The largest numerical increases came from the 15-19 and the 35 or over age groups. This was also reflected in the percentage of new treatment demands coming from each age group, although here there was a slight increase in the percentage coming from the under 15 age group.
- 3.1.14 Based on the available data, especially a comparison of continuing treatment demand and new treatment demand, it is not clear whether the level of drug misuse requiring treatment is stabilising or whether the level of treatment demand is greater than existing service capacity with the result that new treatment demands cannot readily be accommodated. The re-organisation of the treatment services, which aims to better reflect treatment need in the distribution of services, may offer greater information about the situation.

*Primary and secondary drug use*

- 3.1.15 Other information relating to drug treatment demand and the characteristics of users concerns the primary and secondary drugs reported as being used by clients. [Table 18](#) shows the primary and secondary drug use of people attending the Ser.T as a percentage.
- 3.1.16 Over the last 10 years there has been a slow but consistent decline in the number of people using heroin as their primary drug (91.9% in 1990 to 83.6% in 1999). Over the same period there has been a slow but consistent increase in use of cocaine (0.9% in 1990 to 4.3% in 1999) or cannabis (4.1% in 1990 to 7.9% in 1999) as a primary drug.
- 3.1.17 In terms of secondary drug use, there has been a steady reduction in the use of benzodiazepines and cannabis but an increase in the use of cocaine and of other drugs.



- 3.1.18 As might be expected, there are Regional variations. [Tables 18\(a\) - 18\(u\)](#) show the recorded primary drug as a percentage for each Region of Italy. In general, the percentage of clients having heroin as their primary drug has remained static or gradually reduced over the last three years, although Calabria recorded a sharp increase in 1998 ([Table 18\(s\)](#)) which was maintained in 1999.
- 3.1.19 Over the 3 year period 1997-1999, 16 of the 21 Regions and Autonomous Provinces have recorded a persistent increase in the use of cocaine as a primary drug. Whilst the absolute numbers remain relatively small, representing some 6,100 clients with primary cocaine use, a further 21.4% reported cocaine and its derivatives as secondary drug use, representing around 30,500 people. The comparative figures for 1997 and 1998 are 3,150 and 4,400 respectively for primary and 20,850 and 25,600 respectively for secondary cocaine use.
- 3.1.20 With respect to other drugs, a few Regions have recorded a small increase in primary use of cannabis and of ecstasy and its analogues, but the number of people involved is generally very low.

### 3.2 *Drug-related mortality*

- 3.2.1 Data on direct drug related deaths is collected by the Central Directorate for Anti-Drug Services in the Department of Public Security of the Ministry of the Interior ([DCSA 2000](#)). A secondary source is the Annual Report to Parliament on the State of the Drug Problem in Italy ([Social Affairs 2000](#)) prepared by the Department of Social Affairs. Data on the population of Italy by Region and by age group and sex is from the National Institute of Statistics ([www.demo.istat.it/stima2000](http://www.demo.istat.it/stima2000)).
- 3.2.2 The slow decline in the annual number of direct drug-related deaths has continued after peaking in 1996. [Figures 16 and 17](#) show the number and the percentage of deaths by sex.
- 3.2.3 Male deaths have continued to decline every year since 1996 whilst deaths of female drug users fell substantially in 1997 but have risen in each of the following years.
- 3.2.4 Examining the number of deaths by age, there has been a reduction in all age groups with the exception of the 30-34 age range where there has been a very small increase ([Figure 18](#)). Looking at the percentage of all deaths by age group ([Figure 19](#)), however, there has been a decrease for the 20-24 and 25-29 age groups whilst there has been a continuing increase in the percentage of all deaths coming from the 30-34, 35-39 and 40 or over age groups.
- 3.2.5 This increase appears to have been largely accounted for by deaths among drug users in the 30-39 age group, as can be seen in [Figures 20 - 21](#). However, the percentage of all deaths accounted for by female drug users has steadily risen whilst there has been a decline in the percentage accounted for by male drug users ([Figures 22 - 23](#)).
- 3.2.6 The pattern of direct drug-related deaths appears to confirm the trend noted last year for deaths to be rising amongst the older drug using population and to be declining amongst the younger age groups. This suggests that the relatively poor health of the older population has contributed to the rise. It may also suggest that the younger age

groups, who are likely to have entered treatment at the time when there was greater focus on intermediate treatment interventions, such as methadone substitution treatment, have benefited from these developments.

- 3.2.7 Examining the Regional data, all regions registered a reduction in direct drug-related deaths with the exception of Campania, which showed a continuing, if small (3.7%) increase over 1998. Campania also had the largest percentage of deaths from the under 24 age group, with 20% of deaths in this group compared to the national average of 13%. Toscana (17.6%), Umbria, Friuli V.G. and Emilia Romagna also had higher death rates in this age group than the national average. These increases together resulted in a 1% rise in deaths in the 15-25 age group nationally (to 13.5%) continuing the rise noted in 1998 over 1997 (from 11.4% to 12.5%).
- 3.2.8 Under a study still in progress and reported in the Annual Report to Parliament ([Social Affairs 2000](#)), the Forensic Toxicologists Group of the Italian Society of Legal Medicine has been recording data on drug deaths in 19 Provinces since 1999. This data does not cover all the major metropolitan areas and only deals with cases where the judicial authority requested an autopsy and toxicological report. Nevertheless, the data does provide more detailed information than that available from the Special Register of Direct Drug-Related Deaths.
- 3.2.9 The study to date has found no significant variations in the number of deaths in any month, with an average of 50 per month. The percentage of deaths by age range largely reflects the pattern reported above, with 48% in the 31-40 age range and 31% in the 25-30 age group. It also confirms the trend of an increasing percentage of deaths in the older age ranges.
- 3.2.10 [Figures 24 - 27](#) show the number of deaths by main drug and the number of deaths by main drug and other contributing drugs. 88.6% of all the deaths identified involved heroin and one third of the total involved heroin alone. However, 39.5% of the total involved heroin plus other drugs or heroin plus other drugs and alcohol.
- 3.2.11 It is interesting to note that for both heroin and methadone related deaths, the number of deaths arising from the main drug plus other drugs is higher than the number of deaths where only the main drug was detected. By contrast, in cocaine related deaths, cocaine alone was by far the most likely cause of death.
- 3.2.12 The increasing role of cocaine in drug-related deaths is a cause for some concern and is discussed more fully under the special topic.

### 3.3 *Drug-related infectious diseases*

- 3.3.1 The primary source for data on drug-related infections is the Annual Report on Activity in the Drug Dependence Sector from the Ministry of Health ([Health 2000](#)). Secondary sources include the National Health Institute, the Annual Report to Parliament on the State of the Drug Problem in Italy ([Social Affairs 2000](#)) and work arising from the implementation of the EMCDDA infectious diseases indicator in Italy. Data on the population of Italy by Region and by age group and sex is from the National Institute of Statistics ([www.demo.istat.it/stima2000](http://www.demo.istat.it/stima2000)).

*Overall Situation*

- 3.3.2 The percentage of clients of the Ser.T tested and found HIV positive or positive for Hepatitis B has continued the downward trend noted for most of the 1990s. Infection with Hepatitis C, however, has remained high for the three years for which data is available. [Table 25](#) shows the number of tests conducted nationally and the percentage of clients of the Ser.T testing positive by year and Region. [Figure 28](#) shows the number of tests carried out for HIV and Hepatitis B and C and the number of positive test results.

*HIV Infection*

- 3.3.3 [Figure 29](#) shows the percentage of people found HIV positive by sex and by new clients and clients already in treatment with the Ser.T. In all cases, the percentage of positive test results has fallen after the slight increases noted last year. Clients already in treatment are much more likely to be HIV positive than new clients. This probably reflects their longer exposure to the virus as well as changing injecting behaviour amongst new clients. As has already been noted, there has been a continuing fall in the percentage of clients reporting injecting drugs and therefore a reduction in one of the most high risk behaviours for HIV transmission. Female drug users have a higher percentage of HIV infection than male drug users. This may suggest sexual transmission rather than through injecting behaviour.
- 3.3.4 At the regional level ([Table 25](#)), Emilia Romagna and Lombardia have the highest prevalence of sero-positivity, followed by Lazio and Sardegna. In Sardegna, the percentage of drug users testing positive has risen in each of the last two years (1997 - 20.1% to 1999 - 23.7%) whilst in all other Regions there has been a downward trend. It is also noticeable that in Sicilia there has been a general upward trend over the last four years (1996 - 6% to 1999 - 9.4%). It is not clear at present whether there are any specific factors leading to this contrary trend.

*Hepatitis B infection*

- 3.3.5 With regard to Hepatitis B infection, the slow downward trend over the 1990s has been maintained after the small increases noted in 1998. [Figure 30](#) shows the percentage of infected clients of the Ser.T by new clients and clients already in treatment and by sex.
- 3.3.6 As for HIV infection, female clients already in treatment are more likely to be infected than males in treatment and new clients, both male and female, are less likely to be infected.
- 3.3.7 At the regional level ([Table 25](#)), prevalence is higher in the northern Regions, with all the Regions except Valle d'Aosta and Liguria having over 50% of clients infected. Valle d'Aosta is a small Region with a low number of clients. The low rate in Liguria, however, is surprising and there is no immediate explanation for this. The prevalence in the north suggests that a major factor is drug using practices, given that Hepatitis B infection in the general population is higher in the southern Regions according to data from the National Institute for Health, which maintains a national register of the epidemiology of Hepatitis.

3.3.8 Overall, 8 Regions out of 20 reported an increased percentage of clients found positive for Hepatitis B over 1998, 3 in the north, 2 in the centre and 3 in the south. It is particularly noticeable that Sardegna is the only Region outside the north with over 50% of clients infected and that, as with HIV infection, it has been showing a consistent upward trend over the last 6 years. Together, the HIV and Hepatitis B data suggest that within the more isolated setting of an island Region, injecting practices and sexual transmission among the drug using population are major contributors to drug-related infections.

*Hepatitis C infection*

3.3.9 The level of Hepatitis C infection has remained consistently high amongst Ser.T clients already in treatment, with infection in males remaining at the same level over the three years for which figures are available and infection in females rising slightly over the same period. As before, the level of infection in new clients has fallen over this period. [Figure 31](#) shows Hepatitis C infection by new clients and those already in treatment with the Ser.T and by sex.

3.3.10 At the regional level ([Table 25](#)), Hepatitis C infection is widespread throughout the country but with 4 Regions (Trentino A.A., Liguria, Emilia Romagna and Sardegna having infection rates in excess of 80%. A further 4 Regions (Lombardia, Veneto, Friuli V.G. and Toscana) have infection rates in excess of 70%. This supports the view that drug use practices in the northern Regions appear to have led to increased levels of infection compared with the rest of the country.

*Geographical variations in infection rates*

3.3.11 There are no significant differences between male and female infection rates for existing clients of the Ser.T in any of the Regions. However, there are some noticeable differences between male and female infection rates for new clients.

3.3.12 In 5 Regions (Friuli V.G., Liguria, Umbria, Calabria and Sardegna), infection rates for new male clients are significantly higher than for new female clients. The reverse is true in 4 Regions (Veneto, Emilia Romagna, Toscana and Basilicata), where the infection rate in new female clients is significantly higher than for males. Given the short time over which data on Hepatitis C infection has been collected, this may not be more than a normal statistical variation. However, it is worth noting that in all 3 years, Friuli V.G. has had significantly higher infection rates amongst new male clients and that in two of the three years, Liguria, Umbria, Calabria and Sardegna have had significantly higher rates of infection in new male users. Only Basilicata has had a significantly higher infection rate in new female users in two of the last three years. This situation is, therefore, one which will require continued surveillance.

3.3.13 The situation in Sardegna merits specific consideration. For all three infections it has experienced increased infection rates amongst the clients of the Ser.T. The trend appears to have begun in 1996 and it suggests that there may have been specific circumstances around this

time which have had an impact upon the drug using population. Further examination would be required to determine these.

### 3.4 *Other drug-related morbidity*

3.4.1 There is limited information available within Italy with regard to other drug-related morbidity. No data is readily available at the national level on non-fatal drug emergencies, drugs and driving or on psychiatric co-morbidity.

3.4.2 There have been some local reports and studies on bacterial infections and endocarditis associated with drug injection, for instance, in Campania ([Social Affairs 2000](#)). However, no data from these reports is available.

3.4.3 Similarly, there has been increasing concern about psychiatric co-morbidity, however, there is no recent epidemiological information available on this topic. Research is currently underway and information is expected to be available for the next report to the EMCDDA.

## 5. SOCIAL AND LEGAL CORRELATES AND CONSEQUENCES

### 4.1 *Social problems*

4.1.1 No systematic data is available at the national level on social problems associated with drug misuse. Local reports from street services have, for instance, reported on the characteristics of drug users contacted by them, but it is not clear to what extent these represent a national picture.

4.1.2 Drug users identified within the armed services, for instance, included 27% of people who were unemployed before enlistment ([Table 10](#)). However, for 75% of drug users, their first drug use was after recruitment ([Table 12](#)) and therefore no correlation between unemployment and drug use can be made.

4.1.3 A study in Bologna ([Pavarin and Salsi 1999](#)) in the first half of 1998 examined the characteristics of people contacted by the street service. In this period, 369 people were contacted, 305 males and 64 females. 34.5% of those contacted had never been in contact with the Ser.T, 30.4% had been in contact in the past and 35.1% were current clients of the Ser.T.

4.1.4 Almost 50% of those contacted did not live in Bologna and 6% were non-Italian. 14.4% had no settled accommodation and 9.5% were 'on the street'.

4.1.5 In general, the study found that the younger age group contacted were non-Italians or were from outside Bologna and were more likely to be 'on the street', never to have been in contact with the Ser.T or a therapeutic community, to use psychopharmacological substances and never to have taken an HIV or Hepatitis test. By contrast, the older group tended to be without settled accommodation, to misuse alcohol and use heroin and to be in contact with the Ser.T or a treatment service. A general characteristic of both groups was that they were much more likely to be multi-drug users and to inject drugs.



4.1.6 The picture presented by this study, focused in the central area of Bologna and concentrated around the main railway station, is not dissimilar to studies reported elsewhere in Europe. It may well reflect, therefore, a common pattern in major urban centres in Italy, especially in the northern and central areas.

#### 4.2 *Drug offences and drug-related crime*

4.2.1 The primary source of data for drug possession, drug related offences and drug dependents within the prison system is the Annual Report to Parliament on the State of the Drug Problem in Italy ([Social Affairs 2000](#)). The primary source of data for drug law offences is the Annual Report of the Central Directorate for Anti-Drug Services, Department of Public Security of the Ministry of the Interior ([DCSA 2000](#)). Data on the population of Italy by Region and by age group and sex is from the National Institute of Statistics ([www.demo.istat.it/stima2000](http://www.demo.istat.it/stima2000)).

##### *Drug possession*

4.2.2 Possession of listed drugs is an administrative, not a criminal offence in Italy. A person found in possession of a listed drug is referred to the Prefect who warns of the dangers of drug use and invites the person to discontinue drug use.

4.2.3 In 1999, some 32,826 individuals were referred for unlawful possession of a listed drug. Of these, 27,132 were referred for a single instance of possession and 5,694 were referred on two or more occasions for unlawful possession. In total, there were 42,991 referrals for possession.

4.2.4 Of the referrals for possession, cannabis was the drug most commonly found on an individual. 79% of possession referrals involved cannabis. Heroin was the next most common drug, accounting for 10.7% of referrals, followed by cocaine with 6.5% of all possession cases.

4.2.5 The mean age of people in unlawful possession of listed drugs was 23 with 77.2% of all instances in the age range 18-30. In fact, 29.8% of cases of unlawful possession were in the age group 18-20. 12.6% of offenders were over 30. This latter percentage has remained steady over recent years. 93.8% of offenders were male and only 6.2% female. [Figure 32](#) shows the age distribution of people referred for unlawful possession of a listed drug in 1999.

4.2.6 3,390 individuals referred for unlawful possession were juveniles (under 18), representing 10.2% of all possession offences. Of these, 92.9% were male and only 7.1% female. This represents an increasing percent of such offences coming from this age group and is a cause for some concern. This reflects the comparative findings of the ESPAD study where there was a noticeable increase in the number of students who had used cannabis and/or other illegal substances. What is less clear is the reason for this increase, although it may reflect a wider availability.

4.2.7 The Regional picture is interesting. In terms of the percentage of referrals for possession, Lazio, Lombardia and Toscana provide 37.3% of all referrals, 36.9% of male referrals and 42.9% of female

referrals. This changes, however when the rate per 10,000 population is considered.

- 4.2.8 [Table 26](#) and [Maps 3 and 4](#) show the referral rate per 10,000 population by sex for the 15-54 age range and the 10-17 age range. From these, it can be seen that Liguria, Sardegna, Toscana and Valle d'Aosta have the highest rates for the population aged 15-54. This is also true for the male and female populations in this age range.
- 4.2.9 For referrals of people under 18, an age range of 10-17 has been selected. Again, Liguria, Sardegna, Toscana and Valle d'Aosta have the highest rates for the overall population in this age range and for males. However, the situation changes for females in this age range, with almost all the northern Regions exceeding the national rate and three of the four central Regions, whilst of the southern Regions, Sardegna is at the national rate and all other regions are significantly below it.
- 4.2.10 Another measure is the rate of re-offending. Looking at the rate per 10,000 population in the age ranges 15-54 for people referred two or more times for possession ([Map 5](#)), Liguria, Toscana and Valle d'Aosta have over twice the national rate of 1.8 per 10,000. They are followed by Marche, Piemonte, Sardegna, Lazio, Emilia Romagna and Umbria. All other Regions have rates below the national rate.

#### *Drug Law offences*

- 4.2.11 In terms of drug law offences, a total of 34,297 people were referred to the Judicial Authorities in 1999. This was an increase of 3.4% over 1998. [Figure 33](#) shows the number of referrals to the Judicial Authorities by year and drug involved.
- 4.2.12 [Table 27](#) shows the offences for which people were referred. The percentage of people referred for offences of production and trafficking and for selling drugs increased between 1998 and 1998 whilst the percentage fell for other offences.
- 4.2.13 Of those referred, 70.7% were Italians and 29.3% were non-Italian. This compares with 68.3% and 31.7% respectively in 1998. Of the non-Italian referrals, the overwhelming majority were not legally resident in Italy.
- 4.2.14 Following referral, a person may be allowed to remain at liberty or may be placed under restrictions, including remanded to prison. In 1999, 35.1% of Italians remained at liberty (1998 - 34.9%) and 64.9% were placed under restrictions (1998 - 65.1%). By contrast, 11.6% of non-Italians remained at liberty (1998 - 12.7%) and 88.4% were under restrictions (1998 - 87.3%). For Italians, these percentages seem to reflect the relative seriousness of the offence as well as individual circumstances. For the non-Italians it appears to reflect the fact that the majority are not legally resident in Italy, and the seriousness of the offence may be a lesser factor.

#### *Drug related offences*

- 4.2.15 There is no comprehensive data on drug-related offences. There is no readily available data on sentencing or direct correlation between those referred to the Judicial Authorities for a drug law offence and

actual convictions. The available data deals only with juvenile offenders or with persons sentenced to imprisonment for their offence.

- 4.2.16 In 1999, 1,440 juvenile offenders identified as drug users were referred to the Juvenile Justice Service. This was a slight increase on the number referred in 1998 (1,418). 78.2% were between 14 and 17 and almost 95% were male.
- 4.2.17 Only partial data is available on the juvenile offenders. For 400 offenders, the offence for which they were referred is recorded. The majority were referred for offences against the drug laws (62%) or for various forms of theft (33.7%). However, only 12.5% were assessed as drug dependent, with 35.7% assessed as regular users and 51.8% as occasional users.

### *Prisoners*

- 4.2.18 In terms of prisoners, the total prison population in 1999 was 51,604 people. This was an increase of 8.5% over 1998. Drug dependents represented 29.3% of the prison population (1998 - 28.5%). This is a reversal of the broad trend over the 1990s which has seen a gradual reduction in the percentage of prisoners who were drug dependent. There is a slight difference between the percent of all male prisoners assessed as drug dependent (29.2%) and the percent of all female prisoners assessed as drug dependent (31.5%). The respective figures for 1998 were 28.4% and 29.9%.
- 4.2.19 Of the drug dependent prisoners, 48.9% were imprisoned for a drug law offence and 51.1% for other crimes. This is a reversal of the position in 1998 when 50.1% were imprisoned for drug law offences and 49.9% for other crimes. The reason for this change is not clear and it is difficult to determine whether this is a real change given the time lapse between the committal of the offence, trial and sentencing.
- 4.2.20 In terms of drug law offences, 37.4% of all prisoners were sentenced for a drug law offence in 1999 compared to 36.2% in 1998. 61.8% of such offences were committed by non-drug dependents (1998 - 60.5%). Of prisoners sentenced for drug law offences, 38.9% were non-Italians (1998 - 36.3%).

### *4.3 Social and economic costs of drug consumption*

- 4.3.1 Other than the data reported earlier ([1.4](#)), there is no additional data currently available about the social and economic costs of drug consumption.
- 4.3.2 There is no current national estimate about the total consumption of listed drugs nor of the expenditure on drugs. An overall estimate of demand for drugs has not been conducted, but based on the estimates of the prevalence of drug use and on the prevalence of problematic drug use, the evidence suggests that there has been a continuing increase in the overall demand for listed drugs. There is little evidence at present that this demand is declining although some indicators, for instance treatment demand, may suggest that problematic drug use is not increasing whilst drug use generally is increasing.



## 5. DRUG MARKETS

### 5.1 *Availability and supply*

5.1.1 The primary data source for drug markets is the Annual Report of the Central Directorate for Anti-Drug Services ([DCSA 2000](#)).

#### *Availability*

5.1.2 As has already been noted ([2.3](#)), there appear to be some regional differences in availability and supply.

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

5.1.4 Heroin is also available throughout the country, although the focus of availability appears to be the major urban areas.

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

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

5.1.7 LSD and other drugs remain relatively rare although the number of people referred to the Judicial Authorities for drug law offences involving these drugs has increased between 1998 and 1999 in all parts of Italy.

5.1.8 The observable trends appear to be for a continuing decline in heroin use. Cannabis availability and use appears to show a continued increase throughout the country. Cocaine availability appears to be increasing and to be more widespread. Amphetamine, especially ecstasy and its analogues appear to be available in the northern and central regions but to be less available in the southern regions.

#### *Supply*

5.1.9 In terms of trafficking patterns, this also varies according to the drug involved. Heroin appears to arrive at the main sea ports and airports and then to be distributed through an internal network. The sources of supply appear to be primarily Turkey, the Balkan countries and their immediate neighbours. In 1998, 94% of the total heroin seized came from these sources, rising to 97.5% in 1999

5.1.10 Cocaine appears to be primarily brought into Italy through major airports and then to be distributed within the country. The major sources of supply are Latin American countries and Spain. In 1998, these countries accounted for 90% of the total amount seized and this rose to 95% in 1999, with Colombia identified as the source for 73% and Spain for 10% (21% and 8.7% respectively in 1998)

5.1.11 In 1999, hashish was predominantly brought into the country from Afghanistan, Morocco and Spain. This is a change from 1998 when there were no seizures involving Afghanistan as a source. However, as the situation relates to one single large seizure accounting for almost half of all the hashish seized in 1999, the general trend still

appears to involve Morocco and Spain as the major source countries. Sea routes appear still to be the major point of entry along with the major international airports, followed by re-distribution within the country.

- 5.1.12 The situation with marijuana is somewhat different. In 1999 the source of supply was almost exclusively Albania and the main points of entry into Italy were Trieste and Puglia. In 1998, Albania accounted for 63% of the total quantity seized and Ghana for 37%.
- 5.1.13 With regard to amphetamines (including ecstasy) and LSD, Holland is the main source of supply, accounting for 97% and 100% respectively of the total amount seized. The vast majority of seizures occur in the northern and central Regions although there have been significant seizures of both drugs in Sicily and Sardegna. This appears to reflect the internal demand and supply systems which are focused in the northern and central Regions, especially in those areas which have a developed youth culture in which drug use is one element.

## 5.2 Seizures

- 5.2.1 In terms of drug seizures, it has not been possible to obtain data on the number of seizures for each of the main drugs and, therefore, no comparison is possible with data from earlier years.
- 5.2.2 The quantity of drugs seized rose significantly for all substances with the exception of LSD. [Figures 34 - 38](#) show the total quantity seized by year for each of the main drugs.
- 5.2.3 There are significant differences between the drugs as to where the seizures were made. These may be an indication of distribution and use patterns as well as trafficking routes related to the physical bulk of the drugs.
- 5.2.4 81% of all the heroin seized was found within Italy in 1999, compared to 90% in 1998. 19% was seized at the borders and 17% at the sea border. In 1998, the quantity of heroin seized at the borders was more evenly distributed between land (2%), sea (5%) and air (3%) borders. The change in 1999 may well reflect the increased supply from Turkey and the Balkan countries and the relative ease of the sea crossing to a large coastline which it is extremely difficult to patrol fully.
- 5.2.5 With regard to cocaine, the quantity seized within Italy and at the borders shows a considerable change between 1998 and 1999. The quantity seized within Italy fell by over 50% between 1998 and 1999, from 67% to 30%. At the borders there was also a significant change. Whereas in 1998, 29% of the total quantity seized was at the air borders and only 4% at the land and sea borders, in 1999, 50% of the quantity seized was at the sea borders, 18% at the air borders and 2% at the land borders. This appears to reflect a single large seizure in Calabria when 1,441 kilos of cocaine were seized.
- 5.2.6 Cannabis seizures show a similar change in the location of seizures. 57% of the quantity seized was at sea borders (1998 - 22%) whilst 43% was seized within Italy (1998 - 77%). This change appears to reflect firstly a single very large seizure from Afghanistan and secondly the involvement of Albania as a major source with a simple sea

crossing to Italy. By contrast, cannabis plants appear to be grown within Italy with Reggio Calabria continuing to be the Province in which cannabis is grown on a commercial scale.

5.2.7 By contrast with the other drugs, amphetamines (including ecstasy) and LSD were seized predominantly within Italy in both 1998 and 1999. For amphetamines, 97% of the total amount seized was within Italy (1998 - 91%). For LSD, 80% was seized in Italy (1998 - 19%). In both cases, seizures at the borders were most likely to occur at land borders. The major seizures of both drugs occurred almost exclusively in northern and central Italy, confirming the pattern of use and availability referred to above.

5.2.8 The upward trend in seizures in 1999 is extremely difficult to interpret. At one level it clearly reflects successful drug control operations but data on drug use and problematic use suggest that demand has also continued to increase. The amount seized may, therefore, only reflect increased trafficking activity.

### 5.3 *Price, purity*

5.3.1 There is no data available on the purity of drugs either at the street or the trafficking levels. It is hoped that it will be possible to collect such data for the next report.

5.3.2 In terms of the price of drugs, the Central Directorate for Anti-Drug Services of the Ministry of the Interior has collected information on both wholesale and street level prices. The system for collecting the information is through information on drug prices registered in 12 Italian cities. These are major cities and are in locations where there is the highest prevalence of drug misuse. They may not, therefore, be an accurate reflection of prices or the range of prices for different drugs in different Italian locations. Information from previous years is not available so comparison of prices over time is not possible.

5.3.3 Information may come from drug users themselves, user dealers, treatment services, informants and suppliers. It is registered by the local police force and the annual price range is calculated on the basis of the reports from all the cities to provide upper and lower limits for the price of the main drugs. [Table 28](#) shows the price ranges at wholesale and street level in both lire and euro.

5.3.4 Because of the lack of earlier data it is not possible to make any meaningful comment on the price data. It is hoped that similar data will be available in future allowing analysis and commentary.

## 6. TRENDS PER DRUG

### 6.1 *Cannabis*

6.1.1 Cannabis remains the most prevalent drug within Italy accounting for the vast majority of referrals for possession and drug seizures.

6.1.2 Data on prevalence of use within the general population confirms the dominance of cannabis as the most used drug. The ESPAD study, data from the Ministry of Defence and local reports and studies all support this view.

- 6.1.3 The data also shows that cannabis use is becoming more prevalent and suggests that there is an increase in drug related problems associated with the use of cannabis. The ESPAD study noted that lifetime use of cannabis amongst pupils had risen from 19% in 1995 to 33% in 1999. Ministry of Defence figures also show a continuing increase, although the year on year information is not entirely comparable. Data on treatment demand shows cannabis increasing annually as a primary drug whilst declining as a secondary drug.
- 6.1.4 Given the level of seizures and the widespread availability of cannabis, it is not surprising that there is such widespread use. It appears to have become established in the general population.
- 6.2 *Synthetic drugs (amphetamines, ecstasy, LSD, other/new synthetics)*
- 6.2.1 LSD and amphetamines appear never to have gained great popularity and this is confirmed by a number of different indicators. Referrals for possession of either drug are comparatively rare, the quantity of either drug seized is extremely low and treatment demand arising from use of these drugs is negligible.
- 6.2.2 Ecstasy, on the other hand, appears to have a relatively high level of use among the younger population, especially in the northern and central Regions. The number of doses of ecstasy seized in 1999 was more than twice that seized in 1998. Reports from outreach services and from projects focused on the new drugs confirm the upward trend, although referrals for possession of ecstasy remain low in comparison to the reported level of use.
- 6.2.3 There appears to be some geographical differences in relation to the use of ecstasy. This may be related to the more developed youth culture in the northern and central Regions, with many more youth oriented events and locations.
- 6.3 *Heroin/opiates*
- 6.3.1 In terms of problematic drug use, heroin remains the most prevalent drug. However, there are some signs that the rate of increase in use may be declining. Over the last five years there has been a slow but clear reduction in the percentage of people attending the Ser.T who report heroin as their primary drug whilst the percentage reporting heroin as a secondary drug has remained stable over the same period. Balanced against this, however, has to be the estimates of injecting heroin use which suggest that a substantial number of heroin users remain outside the treatment system.
- 6.3.2 The quantity of heroin seized in 1999 showed a substantial increase over 1998 and reverses the downward trend in seizures from the peak in 1991. However, a single large seizure of over 100 kilos and two seizures of over 50 kilos, accounting for 12.5% of the total quantity seized, may have slightly distorted the trend.
- 6.3.3 Referrals for possession of heroin have remained relatively stable for the last two years after falling considerably between 1997 and 1998. Direct drug related deaths, however, are predominantly associated with heroin use, either alone or in combination with other drugs or alcohol.

- 6.3.4 Overall, the picture remains unclear with regard to the trend for heroin. Some indicators suggest that use may be slowly declining whilst other indicators suggest that the trend is stable or may be slightly upwards.
- 6.3.5 There are indications from a number of sources (Drogatel, various Ser.T, etc) and from the national data collected by the Ministry of Health which suggest that younger drug users are less likely to inject heroin and more likely to smoke it. Whilst this may be an important trend in terms of drug related morbidity, it may also be a sign of a resurgence of heroin use.
- 6.3.6 Use of other opiates remains insignificant and no data suggests that there has been any change in recent years.

#### 6.4 Cocaine/crack

- 6.4.1 Crack cocaine is extremely rare in Italy and none of the national data, nor published reports nor anecdotal reports suggests that crack has gained any following within Italy.
- 6.4.2 The situation with regard to cocaine is less clear. The number of referrals for possession has been increasing annually, as has the percentage of people citing cocaine as their primary drug when seeking treatment. Cocaine as a secondary drug has also been rising. However, the percentage of people in treatment with the Ser.T who use cocaine remains very low.
- 6.4.3 Both the ESPAD study and the data from the Ministry of Defence show cocaine use to be increasing. The rise in use amongst the school age population is relatively small for reasons given in the detailed report on this study. The continuing rise in use amongst armed forces personnel, however, where cocaine is the second most reported drug, suggests that the general level of use is increasing although this has not yet been reflected in treatment demand.
- 6.4.4 The quantity of cocaine seized has fluctuated over the last five years, but has remained relatively stable at around 2,500 kilos per annum. Since 1993 the quantity of cocaine seized has always been substantially higher than the quantity of heroin seized. It is not clear whether this reflects more effective policing of cocaine or a higher demand for cocaine and consequent increased trafficking activity.
- 6.4.5 Other indirect indicators, such as calls to Drogatel, show a much higher percentage of calls related to cocaine than is reflected in the indicators mentioned above. It also appears to be more evenly spread geographically with cocaine use reported from all parts of the country.
- 6.4.6 Overall, the trend with regard to cocaine appears to be upward with increasing numbers using it. The available information seems to suggest two separate but related patterns. In areas where there is a developed drug culture, cocaine use is a small but significant part of that culture. In areas where cocaine is brought into the country, there appears to be local supply as well as distribution to other parts of the country. There is, therefore, a pattern of wider use in the metropolitan areas and pockets of use related to the trafficking and supply routes.

6.5 *Multiple use (including alcohol, pharmaceutical products, solvents)*

- 6.5.1 There is relatively little information available about multiple drug use at the national level. However, some data from different sources suggests that this is a developing issue.
- 6.5.2 The work of the Forensic Toxicologists Group shows that almost 60% of the 607 direct drug related deaths which they identified involved at least two substances. In 17.3% of cases the other substance was alcohol alone and in 42.5% of cases other substances were involved. This data in itself suggests that multiple drug use is an important factor in drug related mortality.
- 6.5.3 Data from the Ministry of Health about secondary drug use amongst those attending the Ser.T also suggests that multiple drug use is not uncommon, especially of cannabis, cocaine, benzodiazepines and alcohol.
- 6.5.4 More localised published reports also indicate that a significant number of people contacted through outreach work use more than one drug (cf. [Pavarin and Salsi](#) 1999, [Macchia and Giannotti](#) 2000, [Secchi et al](#) 2000). It is not always clear from these reports whether other drugs are used simultaneously or as substitutes when the preferred drug is not available.
- 6.5.5 From the data available, limited as it is, there appears to be an upward trend in multiple drug use. This has been a matter of particular concern in terms of young users of synthetic drugs where the tendency to mix drugs, including alcohol, has been noted. It was in recognition of this fact that the 2000 National Drugs Campaign specifically targeted the issue of multiple drug use in its material.

**7. DISCUSSION**

7.1 *Consistency between indicators*

- 7.1.1 As was noted last year, there is a limited relationship between indicators arising from different sources. However, there is a broad consistency between the indicators which suggest that they do represent general trends. For instance, the ESPAD data, the data from the Ministry of Defence and data from the national drugs help line, Drogatel, all show common trends in terms of the development of substance use, patterns of substance use and the drugs most frequently used.
- 7.1.2 The data from the Ministry of Health on problem drug users attending the Ser.T for treatment is consistent with local data reported in published papers or in papers presented at regional and national conferences. It also confirms, given the time lapse between drug use and the first approach for treatment, a gradual move away from injection of drugs and a wider pattern of drug use with heroin use declining but use of other drugs increasing.
- 7.1.3 The law enforcement data also seems to confirm these trends, with cocaine and ecstasy seizures being substantial and larger than seizures of heroin. Cannabis seizures have consistently represented the largest quantity of listed drugs seized. The data on referrals for unlawful possession of listed drugs is not, however, consistent with

the other indicators. This may reflect the fact that possession of a listed drug is an administrative offence with low enforcement priority. Discovery of a listed drug may occur in the course of other policing operations and not be the focus of the policing operation.

## 7.2 *Implications for policy and interventions*

7.2.1 The re-organisation of services for drug dependence, which is discussed fully later in this report, is a direct result of a review of the information arising from a variety of indicators. It is expected that this re-organisation will lead to an improvement in the range of services and their geographical spread. It is also expected that it will lead to more effective linkage between prevention, treatment and social re-insertion interventions and will ensure that populations which have previously been disadvantaged will have improved access to prevention and treatment services.

## 7.3 *Methodological limitations and data quality*

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

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

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

7.3.4 The data from the Ministry of Justice in so far as it deals with prisoners is of good quality in terms of drug law offences but of more variable quality with respect to drug dependent prisoners. In the latter instance the assessment of drug dependence is a combination of clinical signs, of self-declaration and of staff assessment. There is no clear consistency between the data from the Ministry of Health on

prisoners receiving methadone treatment and data from the Ministry of Justice dealing with the same topic. Similar problems arise with information on offenders passing through the Juvenile Justice Service.

- 7.3.5 Reports from the Regions and Autonomous Provinces are variable and they do not follow common reporting methodologies. This makes comparative analysis difficult and provides limited capacity to analyse general and specific trends either nationally or geographically.
- 7.3.6 In light of the variability of data quality and the methodological limitations associated with the different data sets, the OI DT has placed a high priority on improving data quality. Work is currently planned and in many instances has already been commissioned to pilot new reporting and monitoring systems and to improve methodological and data quality aspects.
- 7.3.7 A major methodological limitation has been the inability to cross refer between data sets produced by the different Ministries. The OI DT has been examining with key Ministries the possibility of developing a system based on data for an individual drug user rather than on aggregate data for different aspects of the drug problem. This work is still in the early stages but assuming privacy constraints can be overcome it would allow cross reference between data sets and analysis of elements of an individuals drug career.



## PART 3 DEMAND REDUCTION INTERVENTIONS

### 8. STRATEGIES IN DEMAND REDUCTION AT NATIONAL LEVEL

#### 8.1 *Major strategies and activities*

- 8.1.1 The national framework for demand reduction involves a number of Ministries, all with specific roles. Central to the framework is the National Co-ordination Committee and the Italian Observatory for Drugs and Drug Addiction (OIDT).
- 8.1.2 The National Co-ordination Committee was first established under Law 309/90 and was re-constituted in 1999 under the new drugs law 45/99. It is formally under the chairmanship of the President of the Council of Ministers (Prime Minister) but in practice this role is delegated to the Minister for Social Solidarity within the Prime Minister's Department.
- 8.1.3 Membership is drawn from all the main Ministries and Departments, including Defence, Education, Finance, Foreign Affairs, Health, Interior, Labour, Universities, Scientific Research and Technology and Social Affairs. It meets as and when required with the primary roles of promoting prevention and drug control policies, proposing measures for co-ordinating national and regional activity and for evaluating the activities and co-ordination functions within the remit of the Prime Minister's Office.
- 8.1.4 Under the new law, the secretariat for the National Co-ordination Committee was transferred to the Department of Social Affairs. Technical support is provided by the OIDT through both the statistics and epidemiology and the demand reduction sectors.
- 8.1.5 To support and advise the OIDT in the development of its work programme and priorities, a Scientific Committee has been established consisting of seven experts from different fields appointed by the Minister for Social Solidarity.
- 8.1.6 The OIDT has now been operating fully from 2000 and has developed its work programme and priorities. The work programme and priorities are discussed in sections [7.3](#) and under the relevant special topic ([section 12](#)).
- 8.1.7 There have been no major new trends in demand reduction during 1999. Rather, there has been encouragement for the development of a full range of responses and innovative approaches aimed at reducing the likelihood of people using drugs and reducing the likelihood that they will experience serious harm as a consequence of the use of drugs.
- 8.1.8 Considerable autonomy is granted to the Regions and the Autonomous Provinces in the implementation of broad national policy. This is intended to encourage the development of strategies which respond to the specific local situation. At this level, there have been continuing developments as the Regions implement the responsibilities envisaged for them in the Regulations approved by

the Permanent Conference for Relations between the State, the Regions and the Autonomous Provinces.

- 8.1.9 The major national strategies may be synthesised as:
- Prevention and information
  - Support towards treatment or other appropriate interventions
  - Treatment and rehabilitation
  - Social and economic reinsertion
  - Evaluation of demand reduction interventions
- 8.1.10 In terms of prevention, this combines both more general health promotion and specific drug prevention. The means used include curriculum based health promotion and drug prevention, a national prevention campaign, youth counselling, internet pages and computer games amongst others. A particular focus has been on the development of personal and group responsibility amongst pupils, involving them directly in the development of the educational environment.
- 8.1.11 Support services include street work with young people, work within youth leisure settings, such as discotheques and major music events, mobile units operated by the Ser.T to reach drug users not currently in treatment, services targeted at specific 'at risk' populations such as street prostitutes and homeless or temporarily housed people and damage limitation services supplying or exchanging injection equipment and providing condoms.
- 8.1.12 Treatment services are provided through National Health Service managed public drug treatment services (Ser.T) and by private treatment services, almost entirely managed by not for profit organisations. The former offer both pharmacological and psycho-social treatment, including short, medium and long term substitute prescribing. The latter may provide additional support services in association with the Ser.T and, more commonly, provide ambulatory, semi-residential and residential rehabilitation programmes. Many public and private treatment services also work in the prison setting with drug dependent prisoners. Penal policy is to guide drug dependent prisoners, wherever possible into treatment as an alternative to continued custody and the active involvement of treatment services is an essential element of the strategy.
- 8.1.13 Social and economic reinsertion is supported by specific employment legislation to maintain a right to return to work for someone who has undertaken drug treatment. It is also supported by relapse programmes, often operated by private treatment services and by the allocation of specific resources by Regional, Provincial and/or Local Authorities to support training for employment for former drug users, drug dependent prisoners on their release from prison and drug users in the later stages of a rehabilitation programme.
- 8.1.14 Evaluation of the impact of demand reduction interventions is a matter for the health and local authorities and for individual organisations. However, through the National Drugs Fund substantial resources have been allocated at the national level to

develop evaluation systems and to improve the available data and integrate it within a central, national data system.

8.1.15 The overall national strategy, therefore, is to prevent drug use, minimise problematic drug use and its associated harms, guide problematic drug users into appropriate treatment intervention and support their full re-insertion into the wider community and to evaluate the impact of the interventions.

8.1.16 Implementation of the strategy, as mentioned above, is the responsibility of the Regions and, to a lesser extent, of the Communes.

## 8.2 *Approaches and New Developments*

### *Re-organisation of treatment services for drug users, misusers and dependents*

8.2.1 The major developments which have occurred in 1999 have arisen from the passing of Law 45/99. These have involved establishing minimum standards for services, delineating the objectives of services and seeking to ensure that the distribution of services corresponds to identified need in both geographical and service delivery terms.

8.2.2 A re-organisation of the Ser.T has begun. This has involved the development of the quality of the service offered through the use of appropriate resources and an adequate range of clinical approaches within a logical programme framework capable of verification. In particular, the need has been identified to develop the capacity of services to respond to new needs, for instance misuse of new synthetic drugs, multi-ethnicity and to work with other services and to develop street work.

8.2.3 Under a regulation approved on 21 January 1999 by the Permanent Conference for Relations between the State, the Regions and the Autonomous Provinces, the basis for the re-organisation of services for drug misusers was established.

8.2.4 The regulation was of considerable importance, dealing with both the organisation and the purpose of the Ser.T and the inter-relationship between public and private organisations active within the sector.

8.2.5 The objectives of public services for people with problems associated with the use, misuse or dependence on substances were defined as:

- Offering a full range of validated therapeutic and support services for drug users
- Prevention of mortality and morbidity associated with drug use, with a particular focus on mortality arising from acute episodes
- Data collection, both basic and specific, in order that epidemiological data on the extent and characteristics of the drug problem might be effectively determined
- Appropriate initial and continuing training of treatment staff
- Periodic evaluation of the treatment interventions of the service and their outcomes
- Collaboration with other organisations involved in the overall drugs strategy.

- 8.2.6 The Regions were assigned responsibility for:
- developing and implementing regional plans for prevention, treatment and rehabilitation
  - the organisational model for achieving the objectives
  - the rules and modalities for establishing the optimum relationship between health agencies, local authorities and private services
  - training programmes for drug services staff in collaboration with training institutes
  - the rules for the control, evaluation and verification of the results of treatment interventions
- 8.2.7 The local health authority, within the framework of the national objectives and based on the Regional plan, is responsible for:
- Defining the local plan and specific intervention programmes
  - Establishing the responsibilities of the programme, with particular reference to co-ordination of services in line with the organisational model established by the Region
  - Undertaking a study of welfare needs on the basis of the epidemiological data
  - Organising the provision of prevention, treatment, healthcare, rehabilitation and social reinsertion interventions identified as a result of the study and establishing a balance between ease of access to services and rationalisation of the interventions available from different organisations
  - Adopting measures which provide the optimal integration of its own activities with those available from other services and defining collaboration protocols with them
  - Verifying the application of operational standards for the sector and controlling the operational units with regard to their participation in the programme of the authority
- 8.2.8 The specific role of specialist drug services was defined as guaranteeing the provision of:
- Client reception and multidisciplinary diagnosis
  - Pharmacological and non-pharmacological therapies, including clinical and laboratory monitoring
  - Prevention of, screening for and participation in the treatment of drug related illnesses and diseases
  - Psychological assessment, support and counselling
  - Rehabilitation
  - Collecting local data for epidemiological studies in the health and social fields
- 8.2.9 The text accompanying the Regulation provides a more detailed analysis of the grounds for the re-organisation and the expectations. Specifically, it notes that specialist drug services should be available for all substance related problems and not focused on heroin or even

solely on the issue of dependence. Moreover, it notes that the public treatment services have a role in all aspects of demand reduction, not solely in the treatment of those who have drug problems.

- 8.2.10 The text also proposes organisational frameworks for the management of the public treatment services which will facilitate effective administrative and financial management and monitoring and evaluation of the services and their outcomes. To support the overall planning and provision of services, it also recommends an internal and external committee structure.
- 8.2.11 A separation has been made between the role of the local health authority and that of the Ser.T. The former has responsibility for planning, co-ordination and for ensuring the application of the standards and procedures operating locally on the basis of regional guidance. The latter has operational responsibility for the delivery of agreed services. The intention has been to free the Ser.T of administrative burdens and to provide a more effective operational focus. For instance, within metropolitan areas it is expected that the Ser.T will provide services to specific at risk populations such as immigrants and ethnic groups.
- 8.2.12 The broad objective of services was defined as protecting the health of clients, with a range of specific objectives ranging from complete rehabilitation to assisting a drug user to move to less risky behaviours. To this end, public drug treatment services should not operate on moral judgements, but rather have a strategy to assist drug users based on recognised professional standards. Specifically, a focus on the development of appropriate interventions in light of the increased use and availability of synthetic drugs was highlighted, along with the need to work on an equal basis with private services and identify ways in which their experience and initiatives might be more effectively utilised whilst moving away from the too high commitment to the provision of residential rehabilitation services.

*Accreditation of and minimum standards for drug treatment services*

- 8.2.13 Under a second regulation approved on 5 August by the Permanent Conference for Relations between the State, the Regions and the Autonomous Provinces, minimum standards were established for the accreditation of private services for drug dependents and for public services. The standards cover the requirement to be registered with the relevant local authority, the physical standards of the accommodation/building, the provision of explicit details about the services offered, ethical issues, staffing levels, qualifications and training, administrative reporting, monitoring, evaluation and data submission.
- 8.2.14 Another strand in these developments has been the integration of health and social services. This has been linked to an understanding of the patterns of drug use among young people, especially associated with music and youth events and connected lifestyles.
- 8.2.15 Through the regulation, integration of the work of the Ser.T with that of other services provided through the local authorities is foreseen, both to facilitate verification and evaluation of treatment programmes and to

link more effectively the range of demand reduction activities: prevention, treatment and rehabilitation.

- 8.2.16 The regulation of 5 August requires private services for drug users to co-operate in the implementation of the objectives of the state and the Region, particularly with regard to the objectives of the National Health Service.
- 8.2.17 The overall aim, therefore, has been to ensure that services are provided in direct relationship to the assessed need, that they are of high quality and have the capacity to respond to changing needs, are effectively co-ordinated and complementary and provide for a range of interventions relevant to demand reduction.
- 8.2.18 In support of these developments, the Decree which allocated resources from the National Drugs Fund to the Regions gave specific guidance on the use of the funds in order that they might be directed towards implementation of the national drugs strategy.

#### *Research*

- 8.2.19 During the year some 75 research papers have been published in a number of areas. [Table 29](#) shows the research published by areas of activity. Most research activity is undertaken independently by universities and research organisations. It is rarely co-ordinated and often is unrelated to operational needs.
- 8.2.20 A number of national research projects have been undertaken and the National Drugs Fund has been used to support research directly relevant to strategic planning and service provision. Specifically the Funds has been used to support the development of systems and research which conforms to European standards as proposed from work commissioned or undertaken by the EMCDDA.
- 8.2.21 The three main research areas which have been supported concern:
- Studies (quantitative and qualitative) aimed at assessing drug use and problematic drug use
  - Research on the effects of substances
  - Evaluations of the effectiveness of interventions
- 8.2.22 Under the first heading, three research projects are of particular interest. The Northern Italy Seronegative Drug Abusers Study ([NISDA](#)), undertaken by the Department of Epidemiology of the National Research Council, which is based in Milan, has been examining the relationship between drug use and HIV infection. The national project on new drugs ([Macchia and Giannotti 2000](#)), undertaken by the National Health Institute and involving all the Regions and the Autonomous Provinces has established an inter-regional technical group on synthetic drugs. Within this project, specific research interests have been identified, for instance, the relationship between use of synthetic drugs and motor accidents, methods and occasions of use and intervention 'best practice'. The Permanent Observatory on Young People and Alcohol has been undertaking a research project on young people and risk behaviour. This is concerned with young people between the ages of 15 and 24 and involves five other European countries. It has been seeking to validate

an instrument for measuring risk behaviour. One important finding has been that within Italy between 1994 and 1997 the number of young people driving whilst drunk or significantly exceeding the legal limit has risen substantially.

- 8.2.23 Under the second heading, an example of a national study which has been initiated is the relationship between acute psychiatric and neurological symptoms and the use of ecstasy and similar drugs ([Macchia and Giannotti 2000](#)).
- 8.2.24 Under the third heading, three national studies have been underway. The VedeTTe study was begun in 1998 involving 122 Ser.T in 12 Regions with a total of some 15,000 clients enrolled in the study. The study is co-ordinated by the Public Health Service of the Lazio Region and the Department of Public Health of the University of Torino and is funded by the National Drugs Fund via the Ministry of Health. It is a prospective study using methodological tools from the USA and the UK and its first major results are expected to be available in 2001. Some preliminary results are already available. These show that around 15% of clients sniff heroin and that this method of consumption is higher among new clients. It also shows that the risk of HIV or Hepatitis infection and the risk of overdose is much greater in clients from the socially disadvantaged population. The prospective nature of the study is of considerable value and allows exploration not only of the effectiveness of treatment but also of issues such as mortality and morbidity. It also allows for follow-up of clients to evaluate subsequent use of drugs and the level of rehabilitation in social, employment and family terms.
- 8.2.25 A second national study has been the evaluation of quality of the Ser.T. This study has been co-ordinated by the Emilia-Romagna Region and is funded by the National Drugs Fund via the Ministry of Health ([emme and erre 2000a](#)). It links together groups in 16 Regions and builds on work which has been on-going in Emilia-Romagna since 1993. The study aimed to examine in detail the regulations applying at the regional level to drug treatment services, to define minimum quality criteria for the Ser.T applicable across the Regions and Provinces and to establish valid national instruments for evaluating quality relating directly to common criteria used throughout the country. The results to date have been the identification of quality criteria relating to input, process, quality and, more generally, to the broad framework of treatment outcomes.
- 8.2.26 The third study, related directly to the second study, is an evaluation of therapeutic communities ([emme and erre 2000b](#)). Some 35 therapeutic communities distributed throughout Italy have been involved in the study and 721 clients have been recruited. The study has aimed to define common concepts for the communities, to measure and evaluate their effectiveness and to relate the impact of treatment to a number of variables such as different client types, different treatment modalities and the like. The results produced so far have been an analysis of retention rates, and analysis of client characteristics at entry into treatment and a review of client changes during the first six months of treatment.

- 8.2.27 In terms of retention rates, the study has found that over one quarter (26.7%) of people left treatment within the first three months and that 38.6% had left within 6 months. The highest percentage of 'drop out' occurred within the first month (11.3%) or in the third month (9.4%). The first main drop out period appears to be related to the client being unready to accept long term abstinence. The second main drop out period appears to be related to the time when the client has to become more committed to the therapeutic activities of the community.
- 8.2.28 The review of clients on admission to the community has produced four profiles. These are shown in [Table 30](#). The review of client changes during the first six months of treatment looked at a number of factors, grouped under the headings attitudes towards drug use and quality of life. It found that the communities had a significant impact in relation to attitudes towards drug use and deviant behaviour in the first six months of treatment. It was not clear, however, whether this was a real change or to what extent it was a desire to conform to group norms or passive acceptance of the situation. In terms of quality of life, there were significant improvements in the first six months and this was assessed as a key measure of the effectiveness of the community.
- 8.2.29 The results of the study are still being developed and it is hoped that additional material will be available for the next report to the EMCDDA.

*Specific events*

- 8.2.30 During the year there have been a number of seminars and conferences concerned with drug misuse and its associated problems. The majority have been at a Regional level. Additionally, there has been continuation of the 1998 anti-drug campaign and a variety of local initiatives. These are considered in the relevant sections of this report.
- 8.2.31 One major national conference held in Bologna in November 1999 was concerned with street work with drug users. From this conference proposals for the development of street work were developed along with a valuable exchange of experience between those involved in this area of work.

*Dissemination of information*

- 8.2.32 Within Italy there are a number of national co-ordinating groups concerned with drug misuse issues. These include the Italian Federation of Therapeutic Communities (FICT), the Federation of Ser.T (FederSer.T), the National Co-ordinating Organisation for Reception Communities (CNCA), ITACA Italia, ERIT Italia, (SIA), (SICAD) and (SITD). Six of these organisations (ERIT, FederSerT, ITACA, SIA, SICAD and SITD) have worked together to develop common platforms on areas of mutual interest as well as to co-ordinate research and training initiatives and to provide technical support at the local, regional and national levels. Together, they have been able to disseminate information on demand reduction and have produced Guidelines on Ethical Behaviour in relation to drug demand reduction activities.
- 8.2.33 In addition to these co-ordinating or umbrella groups, a number of major organisations produce nationally distributed magazines and arrange national and international conferences. Notable amongst these are San Patriagno, ComunitàIncontro and CeIS di Roma.



8.2.34 The use of the internet as a means of disseminating information and research results has also developed considerably. Information about the research on the Ser.T and on the therapeutic communities is available on the internet and can be downloaded. The Bulletin on Drug Dependence and Alcoholism (Bollettino per le Farmacodipendenze e l'Alcoolismo) is available on line containing research and evaluation reports from around Italy. Additionally, the Annual Report of the Central Directorate for Anti-Drug Services and the Report on Activity in the Drug Dependence Sector (Ministry of Health), are also on line and can be downloaded. Many Italian drug services now have their own web site offering information about their work and most, if not all, of these are listed on the links page of the Focal Point web site ([www.puntofocale.it](http://www.puntofocale.it)). A number of sites provide more considerable information, notably that of Gruppo Abele ([www.gruppoablele.it](http://www.gruppoablele.it)) in Torino and of Riccardo Gatti ([www.droga.net](http://www.droga.net)).

## 9. INTERVENTION AREAS

### 9.1 PREVENTION

#### 9.1.1 *Infancy and Family*

- 9.1.1.1 Activities and initiatives to promote effective interaction between the child and parents, parental attachment and effective parenting has been the core of this area of activity. Local organisations, both the Ser.T and social enterprises, have been involved in this area and have undertaken a range of actions at the commune and the elementary school levels.
- 9.1.1.2 On the advice of the Ministry of Education, the focus in elementary schools has been on interpersonal relations, personal hygiene and education on the environment, food and the imagination. Particular attention has been paid to experiential programmes and the use of interactive modules.
- 9.1.1.3 For teachers, courses have been provided to help them deal with over-impulsive behaviour and aggressive behaviour and training support has been offered in the management of mental and behavioural problems in children.
- 9.1.1.4 The form of prevention which is being developed is rooted in helping the children to develop their identity, to stimulate their imagination and to build capacity and confidence in personal relations. Projects have been realised by local organisations and elementary schools looking at the first years of life and the period of pregnancy. A goal has been to promote parental attachment, promoting competencies and affective attitudes. This approach is based on the finding that strong mother-child integration, the ability to defer gratification, to accept frustrations and to avoid boredom all appear to be a protective factors to dependency.
- 9.1.1.5 Opportunities have also been given to parents, with courses held by experts integrating training into the normal preparations for birth. These have sought to develop an understanding of the "internal model" and of the assumptions

and behaviours which had subconsciously been assumed from their parents.

- 9.1.1.6 For families with greater difficulties, networks of parents have been promoted, along with self-help groups, providing the opportunity to meet and exchange feelings and experiences. This approach has been of particular value for isolated mothers by allowing them the chance to interact and have a dialogue with other parents.
- 9.1.1.7 Within the elementary school, training for teachers has sought to develop their diagnostic skills to identify relationship problems and psychopathologies, which in the future might be associated with misuse of alcohol and/or psychoactive substances. Where problems are identified there is close working collaboration with child psychiatry and social services. Experience has shown that where there is slowness in or no response, the child is stigmatised by his/her fellow pupils, is left to his/her own devices as an unpopular child and, moving in to adolescence is fixed in his/her disturbances.
- 9.1.1.8 A variety of methods have been used both to assist child development and to support parents in the development of effective parenting. The underlying objective for all these approaches has been to build and strengthen affiliation to the family, school and local community.
- 9.1.1.9 Of relevance to this area of development is the fund established under Law 285 of 28 August 1997. The law was concerned with promoting rights and opportunities for infants and adolescents and was not specific to drug prevention. However, much of its focus has direct relevance to prevention.
- 9.1.1.10 Specifically, the funds provided were directed towards: developing and supporting parent/child relationships which were damaged as a result of violence; socio-educative pilot projects for first infancy; recreational and educational activities outside school; activities aimed at promoting the rights of children and adolescents, supporting environmental improvements which would benefit children and promoting appreciation of and respect for different cultures and ethnic groups; economic support for families with a handicapped child to improve the quality of life and avoid marginalisation and institutionalisation.
- 9.1.1.11 Arising from the allocation of the funds, considerable activity has been undertaken within the Regions and the communes. Together, these actions have supported specific drug prevention activities by seeking to address some of the underlying circumstances which have been shown to have an impact on the likelihood of someone misusing substances.

9.1.2 *School programmes*

- 9.1.2.1 Schools have continued to provide health education and promotion programmes aimed at the prevention of alcohol and drug misuse and of smoking. The objective has been to integrate this work within the normal schools curriculum, regardless of whether specific funds were available for such programmes.
- 9.1.2.2 Directive n.463 of 26 November 1998 was issued to schools with the aim of creating a coherent framework for health education and drug prevention. It advised on the content of preventive education and promoted the development of programmes which were adapted to meet the needs of the pupils and relevant to their culture and environment.
- 9.1.2.3 Italian schools have been given considerable autonomy in the management and delivery of the curriculum. The intention has been to encourage schools to develop in ways which are appropriate to the needs of the community which they serve and which is relevant to their pupils. As a result of this approach, in drug prevention, new projects have emerged which actively engage the pupils in the curriculum, provide information about the available resources, promote the growth of identity and seek to educate for health. The observed benefits of these programmes are:
- the active involvement of the students, stimulating their commitment
  - a close connection to the lives of the pupils and of the school, promoting an attachment to fellow pupils and the school and a greater openness to face personal and social problems
- 9.1.2.4 It is believed that, with the development of emotional involvement in the programmes, greater self-awareness and appreciation of "self" in the context of the family, culture and environment, there is increased protection from recourse to substance misuse.
- 9.1.2.5 Particular attention has been given to disadvantaged young people aimed at supporting them to realise their potential. For this it has been necessary to identify, down to the individual level, risk conditions and how they might be dealt with. Some projects have focused specifically on the development of critical abilities, such as resistance to peer group pressure and a negative vision of the abuse of alcohol and other drugs.
- 9.1.2.6 A tendency noted in 1998 and which has continued in 1999 is the reduction of the use of experts to work directly with pupils. Rather, experts have been used to train teachers with, for instance, the local health authority (ASL), usually through the Ser.T, assisting and supporting teachers with the provision of material and guidance but not direct interventions. This process has allowed schools to assume

responsibilities for their drug prevention work and to develop the necessary competencies, rather than be dependent on fragmentary external provision.

- 9.1.2.7 The Centres of Information and Consultation (CIC) have continued to promote and support dialogue between teachers and pupils and have given specific attention to the most disadvantaged pupils. The work of these centres varies from Region to Region, depending on local circumstances. Examples of their work include providing access to the Internet, post-diploma orientation, organising the school newsletter, holding meetings and seminars and arranging extra-curricular activities. It is increasingly common for pupils to be directly involved in the management of the centres and thus to promote activities which are most relevant to them. The approaches which have been developed have offered new opportunities for the most problematic pupils and have often been able to bridge the gap between these pupils and the school which, if it had continued to increase, could have led to greater problems including the risk of dependency.
- 9.1.2.8 The potential role of these Centres in drug prevention has increasingly been recognised. A number have now developed specific drug prevention activities. For instance, in Parma, with the support and guidance of the local education authority and the Ser.T, seven higher schools have joined in a mobilisation aimed towards the UNDCP objective of a 21<sup>st</sup> Century free of drugs. The initial activity was within the schools but is now extending to engage young people and others outside the school environment. Some of the pupils participated in the UNDCP sponsored meeting held in Canada and have maintained the international contacts which they made then.
- 9.1.2.9 Given that the age of first use of cannabis, alcohol and tobacco is in some areas as low as 11 or 12, preventive education has also paid attention to this population. A specific project in Verona, for instance, has used animated figures to provide a route into discussing dependencies. This approach has made such discussion less threatening and allowed an exploration of good and bad dependencies and of the real problems experienced by the children.
- 9.1.2.10 Prevention projects have been included in the general curriculum of the middle schools whilst students are attending compulsory schooling. To avoid the problems which can arise from the presentation of unfiltered information, the lessons have been formalised and experts have been used to provide specific technical information.
- 9.1.2.11 Many prevention projects have also focused on work with parents, aiming to assist them in their parenting skills, especially during the teenage years when issues concerning

authority, liberty, autonomy, consumerism and family relationships arise.

9.1.2.12 Since 1998, there have also been initiatives concerned with the new drugs (amphetamine based), supported through the National Drugs Fund. The programmes have evolved from the existing programmes and represent additional elements rather than completely new and centrally proposed actions.

9.1.2.13 In furtherance of the national strategy, the Ministry of Education has obtained funding from the National Drugs Fund for a number of projects focused on prevention and support for students and their families. These include development of the Counselling and Information Centres, projects for students and for families, life skills and peer education projects, continuation of the ESPAD study in 2000, 2001 and 2002, a primary prevention project in disadvantaged areas of three Italian cities and a risk behaviour modification project, targeting adolescents and using new technology which will be implemented in Rome.

### 9.1.3 *Youth programmes outside schools*

9.1.3.1 These types of programmes are largely within the framework of the activities of the Counselling and Information Centres which have been described in the preceding section or of outreach work, which is described below.

9.1.3.2 One particular focus which has developed more fully in the period is close work with sports organisations and associations aimed at both the prevention of drug misuse by those involved in sporting activities but also at promoting sport as an alternative to drug use. To this end, at the national level there has been close working with the National Olympic Committee which culminated in a major conference concerned with the relationship between sport and drug use.

9.1.3.3 In a number of parts of the country, particularly the major urban areas and on the occasion of major youth events, mobile youth consultation centres have been provided. These services are not specifically focused on drug use but include within their work advice on drugs.

9.1.3.4 Similarly, as part of the National AIDS Campaign mobile services have been operating, in particular, a train with a consultation centre. This aimed to raise awareness about HIV and AIDS, to provide advice about how to avoid infection and to promote solidarity with people who were HIV positive or had AIDS related illnesses. Although drug use was not a primary objective of this work, the risks associated with drug use, both from unsafe sexual practices and from drug injection, were an element of the campaign.

9.1.4 *Community programmes*

9.1.4.1 This area of work is largely covered by other sections of this report. There are few specific community programmes focused on drug use which are not within the general ambit of outreach work or of socio-rehabilitative services.

9.1.5 *Telephone help lines*

- 9.1.5.1 Drogatel, the national, free, drugs help line (800-016600) has continued to operate throughout the year. It is available from 09.00 to 21.00 every day and has a team consisting of 12 psychologists, 1 educator, 1 social worker, 1 legal adviser, 1 technician and a co-ordinator from the Department of Social Affairs.
- 9.1.5.2 From 1 January 1999 the service has had the technical characteristics of a 'call centre' with four telephone stations. It is able to provide information on drugs, alcohol and related problems, telephone counselling, referral to appropriate services and to send out material about different drugs.
- 9.1.5.3 To facilitate its work it convenes expert meetings in order that it may be fully informed about new therapies, research results, identify new developments and, in particular, be informed about new drugs and methods of consumption.
- 9.1.5.4 The service is advertised through a variety of media. It is listed in the 'Useful Numbers' section of all telephone directories, makes widely available stickers listing its number, is included in many information and prevention leaflets, participates in radio programmes when invited, provides consultation for articles and information brochures concerned with drugs, especially those for young people.
- 9.1.5.5 Annually there are television and radio spots promoting the service. In 1999 there was a considerable increase in the response to these spots, from 12,536 calls in 1998 to 20,001 in 1999.
- 9.1.5.6 The new system in operation during 1999 allows for on line data entry, collecting information relating to the caller, as well as direct consultation to a computerised archive of services throughout the country. This arrangement has permitted improved capacity to make appropriate referrals and to respond to the specific needs of the caller as well as the development of an improved data base of demand.
- 9.1.5.7 The data available for 1999 is particularly rich as a consequence of the new system and offers much greater information than has been available in earlier years.
- 9.1.5.8 46.2% of all calls came from people who were not in contact with another service. Drogatel was, therefore, able to inform these callers about the range of services available and explore with the callers which service might be most appropriate for them.

- 9.1.5.9 The highest percentage of calls came from the 19 - 25 age group (24%). This contrasts with the predominant age range for those already in contact with services, which is 26 - 35. This situation is of some importance as 72.4% of those who made the call or about whom the call was made were habitual drug users, only 15.2% were occasional users and 12.5% of users were not sufficiently defined for classification.
- 9.1.5.10 The most common request from people not in contact with services was for information about drugs, particularly short term effects and the likelihood of dependence. Most of these calls concerned cannabis, cocaine, ecstasy and LSD. For those already in contact with services the most common requests concerned information about cocaine and cannabis.
- 9.1.5.11 In terms of the drug or drugs used, the 'hidden' population of drug users most often took cannabis (28.7%), heroin (20.1%) and cocaine (19.1%). Those already in contact with services used heroin (44.9%) followed by benzodiazepines (15.2%). There is a difference between age groups, with adolescents most likely to use cannabis whilst for those in their late teens and early twenties use of cannabis and of heroin was at about the same level. This finding appears to reflect the information coming from the ESPAD study and from the Ministry of Defence, which has been discussed fully in section 2.2. The older age ranges appear to show a progressive move on from a predominant use of heroin, to include alcohol and psycho-pharmaceutical drugs, and the oldest age groups predominantly use alcohol and psycho-pharmaceuticals.
- 9.1.5.12 23.6% of calls are made by regular users, followed by 20% of calls from mothers. Partners, friends and people involved with the drug user accounted for 24.4% of the calls whilst only 5.9% of calls came from occasional users. It is interesting to note that female members of a family (mothers and sisters) were much more likely to call than male members.
- 9.1.5.13 The assistance sought appears directly related to the type of caller. Habitual users sought psychological support and advice (50%), information about available services (46%) and about drugs (40%). Their requests differed significantly from those of other callers to Drogatel, being more focused on medical information, on questions about pharmacological substances (benzodiazepines, antidepressants, barbiturates and anti-psychotic drugs) and on psycho-pharmacological therapies.
- 9.1.5.14 Mothers most commonly requested psychological support and advice (78%) and information about services (50%) or about drugs (36%). In particular, they asked about how they should behave towards their child and how to manage crises.

A similar pattern was found for partners, along with a large number of requests for information about drugs and the likelihood of dependence. People involved with the user and friends also sought similar information, although there was also an increase in requests for information about AIDS and sexually transmitted diseases from them.

- 9.1.5.15 Occasional users most commonly sought information about drugs (61%) and about related effects (44%), as well as psychological support and advice. It was also noted that they often asked for information about toxicological analysis, usually before entering military service or before their parents asked for such an analysis.
- 9.1.5.16 The geographical distribution of calls was 36% from the northern Regions, 35% from the southern and island Regions and 25% from the central Regions. This distribution differs somewhat from other indicators of prevalence, such as treatment demand, referrals for unlawful possession, drug law offences and drug related deaths. It may reflect the higher concentration of treatment services in the northern and central regions and supports the need for development of treatment services in terms of both geographical availability and the range of services available.

#### 9.1.6 *Mass media campaigns*

- 9.1.6.1 In 1999, there was no specific national mass media anti-drugs campaign. Rather, material developed for the 1998 campaign was widely distributed and specific media opportunities were taken to promote this material and the anti-drug messages.
- 9.1.6.2 In 2000 a major mass media campaign was conducted focused on the issue of new and synthetic drugs. The primary targets for this campaign were adolescents and young people and to this end over half the funds available for the campaign were specifically dedicated to activities in areas where young people gathered.
- 9.1.6.3 The tender for the campaign was won by Sudler and Hennessey and involved different levels of communication:
- Information  
With brochures about the effects and risks arising from the use of new drugs, from alcohol abuse and from multi-drug use
  - Emotional  
With television and radio spots
  - Internet  
With a constantly updated internet site
  - Games



With an interactive game to involve young people

- Direct

With the aim of creating direct dialogue between drug service staff and thousands of young people

- Institutional

With an announcement of the campaign in all the regional papers

- Night meeting points

With a small leaflet dealing with risks and giving advice where someone has a bad reaction

- For drug service staff

Through magazines for those working with young people or with drug users

- For the media

With a workshop for the Chief Editors of the major daily papers under the title "The style of reporting when dealing with the drug problem".

9.1.6.4 Substantial activity was undertaken through this campaign which had the catchphrase "I won't limit my life" (Io non calo la mia vita). The aim was to create grounds for reflection, primarily amongst young people, but also among all those involved, from the family and teachers to staff of drug services.

9.1.6.5 Full details of the major activities carried out through the campaign will be provided in the next report, as most of the activities were conducted in the second half of the year. An important element of the whole campaign was, however, integration and continuity. Those appearing in the TV spots were developed as individual characters with their own personalities and opinions. Through them, a synthesis of young people was developed. This group was used as the basis for characters in the brochures and in cartoon form in the leaflets and information cards. Through the campaign, therefore, the aim was to develop coherence but also to have characters with whom young people could identify and who were immediately recognisable. An example of this integration is shown in Scans 1 - 3 with the credit card size information booklet ([Scan 1](#)) prepared as part of the campaign and the local information card produced by the Commune of Rome ([Scans 2](#) and [3](#)). The same characters and slogan appear on both cards.

9.1.6.6 There was no specific evaluation of the national prevention activities in 1999 as it was a continuation of the 1998 campaign in terms of distribution of material. The 2000 campaign has been evaluated and the results will be included in the next report.

- 9.1.6.7 There was an evaluation of the campaign undertaken in the Veneto Region in the first half of 2000 ([Rossi, A. et al 2000](#)). The evaluation was undertaken in Verona and aimed to assess the comprehensibility and usefulness of the spot for the target population (young people between 15 and 20), the clarity of the message and the responses to the spot. Young people in two institutions, one commercial and one public, were involved in the evaluation.
- 9.1.6.8 In total, 302 young people participated, 56% male and 44% female, with a mean age of 16.7 years. 51% were 16 or under.
- 9.1.6.9 63% considered the message precise and clear, although young women considered it less clear than young men. [Table 31](#) shows the number and percentage of positive and negative responses to the clarity of the message and agreement with the contents. There was a less satisfactory response to the intelligibility, acceptability and utility of the spot although it achieved its objective with generating unpleasant feelings associated with drug use whilst not engendering fear. Overall, the study concluded that the spot, whilst having achieved some of its objectives, could not affect behaviour modification and that more detailed study of those young people who engaged in a range of interlinked risk behaviours was needed in order that the variable impact of such campaigns could be assessed and appropriate strategies might be developed. It also noted the potential importance of a variety of other factors, which were not evaluated, such as the frequency of transmission, the medium used, the coherence of the message with the signals given by significant adults (parents, teachers, etc).

#### 9.1.7 *Internet*

- 9.1.7.1 As part of the national campaign, an internet site was developed [www.loNonCalo.it](http://www.loNonCalo.it). This is a permanent site which is constantly updated. In a 6 month period there were over 3.5 million hits.
- 9.1.7.2 The site has a very high level of inter-activity using multi-media tools - sound, videos and games. It has been designed to be accessible and easy to use even for those with little experience of using the computer. This is a particular advantage for schools.
- 9.1.7.3 Within the site there are ten main areas, each with a name of one of the characters appearing throughout the campaign:
- Jenny. To drop what  
This provides information on the range of drugs, the names, forms, effects and dangers
  - Ginko. To read  
Containing news, texts, abstracts, reports and bibliographies, classified by theme

- Franky. To contact  
Updated names and addresses of organisations active in the drugs field
  - Tommy. To create  
Creative space on line (designs, songs and poems, comic strips) for schools and internet users
  - Chiara. To be us  
A calendar of activities and events and full reports on the events which have taken place
  - Fede. To ask  
Frequently asked questions and exhaustive replies
  - Alek. To link  
Links to other sites which deal with drug addiction
  - Susi. To tell  
Personal contributions in the form of testimonies
  - Tama. To play  
The interactive game section of the site, with a role play game designed to be played alone or in a group. Answering different questions and tests, requiring a little knowledge and common sense, the players work through different levels with the goal of being able to take part in Chiara's party.
  - Download  
The chance to download the home page and to listen to or watch again the radio and TV spots
- 9.1.7.4 Given the number of hits to the site and linked with the national focus on developing knowledge and use of information technology, it has been a very successful element of the campaign.
- 9.1.7.5 Along with the continuing development of internet sites by individual treatment services and organisations, there have been a number of other developments. The Focal Point now has its own web site ([www.puntofocale.it](http://www.puntofocale.it)) which contains national and European information, downloadable documents in Italian or English and over 400 links worldwide. The OI DT has also commissioned a virtual library ([www.bibliotox.it](http://www.bibliotox.it)) which contains a wide range of literature both from Italy and from other countries.
- 9.1.7.6 Although not internet based, computer based programmes have also been developed to support prevention, notably a number of CD ROMs. For instance, the Guardia di Finanza has produced a CD ROM "Stupefacente - conoscere per prevenire" in collaboration with the L'Espresso group. This is freely available and has been widely distributed.

9.1.7.7 The Veneto Region has invested in the development of an internet system ([Ancona, E. et al 2000a](#)). This is organised at four levels, public, two password protected levels and a level solely for the system managers. For the public, the site offers information on many aspects of drug use and related problems. There is also a section with general information but which more of interest to the services involved in the system. The final section has high security and provides client information for use by treatment staff using ISDN connection to provide rapid transmission of data.

## 9.2 REDUCTION OF DRUG RELATED HARM

### 9.2.1 *Outreach work*

9.2.1.1 Outreach work has been a feature of Italian drug services for over 10 years and is undertaken both by the public health services and by private social organisations. Much of this work has been financed by the National Drugs Fund in the framework of the national drugs strategy.

9.2.1.2 The main objective of the outreach projects has been to limit the spread of HIV infection amongst injecting drug users. This has, however, been extended to deal with both other aspects of health and social care for habitual drug users and the emerging issue of synthetic drugs, the casual use of these substances and the risks associated with their use.

9.2.1.3 Over the last three years, outreach projects have been developed throughout Italy, based on the discussions held at the National Drugs Conference in Napoli in 1997.

9.2.1.4 In the same period, as noted above, the services have developed their role. For example, there has been an increased focus on reducing the risk of overdose, both through training and information and through the distribution of naloxone and greater focus on the range of different needs of drug dependents.

9.2.1.5 A significant development in March 1999 was a national conference for outreach workers held in Bologna in which some 600 people participated. Working groups examined issues such as new needs, evaluating street work, the changing nature of drug misuse and new professionalism in street work. At the end of the conference, the Bologna Charter was adopted. This provides an agreed statement about the purpose and values of street work and seeks to establish a framework for the relationship between outreach work and other services.

9.2.1.6 Within Italy, there are three specific target groups for outreach work: drug users; the general population and; institutions and services with service planning and delivery responsibilities.

9.2.1.7 For habitual drug users, the primary target population is drug users who are not in contact with other services. For

occasional and casual drug users, the primary target population has been young people more generally, especially in settings where young people gather (discotheques, music events and town squares).

- 9.2.1.8 Work with habitual drug users has a number of purposes. For those not in contact with services it is concerned to increase knowledge, provide information about risks and to promote less dangerous patterns of drug use. It is also concerned to contain the development of more acute problems and to facilitate contact with the network of local services. For those who are in treatment, it is part of the integrated treatment programme aiming at improving compliance with the treatment programme and retention rates and dealing with issues which for various reasons it has not been possible to tackle within the programme. A secondary purpose is a form of action research aimed at improving knowledge and understanding of the characteristics of the drug problem in the area.
- 9.2.1.9 The services provide counselling, advice and support and accompany users in their contacts with other services. They also provide or exchange injection equipment and distribute condoms and information about drugs and drug related infectious diseases. This information material is closely inter-related with the national drugs prevention campaign and with the national AIDS campaign and provides both the internet address and the national drugs help line telephone number.
- 9.2.1.10 Outreach services also work particularly with non-Italians, both those who are drug dependent and those who are non-drug users or casual/occasional users. This has proved valuable because this population can have considerable difficulties in accessing services. Moreover, this situation is complicated because many of those who are contacted have entered or remained in Italy without permission. In consequence, they are usually directed towards private social organisations. In these circumstances there is likely to be limited data available on the number of people involved or on their specific problems.
- 9.2.1.11 Work with occasional and casual drug users is more focused on prevention of the development of drug related problems. It includes the provision of information about drugs and related risks, on ways of reducing risk and advice on how to deal with emergencies. Particular attention has been paid also to the risk of contracting sexually transmitted diseases. Again, the material which has been produced is closely inter-linked with the national anti drugs and HIV prevention campaigns, with the same characters appearing in the different leaflets and cards. A more detailed description of this work with examples of different projects is contained in [Section 4](#).

- 9.2.1.12 For the general population outreach work is concerned with meetings aimed at supporting and preserving public health and the maintenance of good relations between drug users and the general population. For instance, issues of public nuisance, abandoned injection equipment, etc, might be dealt with. The interlinked approaches of outreach work, therefore, aim to reduce individual risk behaviour on the part of drug users and to deal with general risk situations.
- 9.2.1.13 Within the epidemiology section of this report, information from the outreach project in Bologna has been given ([Pavarin and Salsi 1999](#)). This is confirmed by other reports. For instance, taking data from Bologna, Milano and Roma, almost 1 in 5 of those contacted were male, over  $\frac{1}{5}$  did not know about the services available from the Ser.T and 11% were non-Italians. Most had low educational attainments, poor social integration, experienced repeated unemployment, had unstable accommodation and frequently experienced legal problems.
- 9.2.1.14 Risk behaviours which were most commonly noticed included sharing of injection equipment, unprotected sex and use of stimulants. There was very little knowledge about the risks of overdose, for instance where drugs were used in combination, or a ways of reducing risk.
- 9.2.1.15 At the national level, it has been noticed that the number of non-Italian drug misusers has been increasing, with about 1 in 7 of those contacted being non-Italian. The majority are from the Magreb countries and from central Africa. However, the number of people from eastern Europe has been rising significantly.
- 9.2.1.16 In terms of the drugs most commonly used by drug dependents contacted, there are some differences between Italian and non-Italian users. For both, heroin is reported most often. However, older Italian drug users tend to administer heroin by injection, whilst newer users and non-Italians tend to inhale. For Italian drug users there has also been an increased use of cocaine, usually administered by injection often with secondary use of alcohol, benzodiazepines, cannabis and methadone, the latter coming from a grey market in this drug. Use of cocaine amongst non-Italian drug users is again by inhaling.
- 9.2.1.17 For casual and occasional drug users, psycho-stimulants are the drugs most used. These include ecstasy, cocaine, ketamine and LSD. There has also been an increasing use of alcohol and use of heroin as a sedative has also been noted. Poly-drug use amongst this population is a cause of particular concern and led to some of the specific focuses for the 2000 national anti-drugs campaign.
- 9.2.1.18 For those responsible for the planning and delivery of services, outreach work offers information which can allow the development of responses to specific local situations.



Given the changes arising from the re-organisation of treatment services and the development of national agreement on minimum standards, this contribution is likely to be of increasing importance.

9.2.1.19 Training for outreach work is undertaken at the Regional and local level. It is generally focused on the specific needs of this type of service, for instance, issues of ethics and confidentiality, avoiding judgemental approaches, orientation towards advice, guidance and support rather than therapeutic interventions, and the like. There is no national data on the number of such courses or on the professional background of staff in outreach services. However, the indications are that the increase in health and social workers and in educators in the Ser.T appears to be linked to the increased activity undertaken outside the premises of the service.

### 9.2.2 *Low threshold services*

9.2.2.1 These services are provided by reception or welcome services (Servizi di accoglienza). They may be provided either by the Ser.T or by private social organisations.

9.2.2.2 Separate national information on these types of service is not maintained, rather the data is included within data for socio-rehabilitative services.

9.2.2.3 The required national standard for this type of service was included in the Regulation approved by the Permanent Conference on 5 August 1999. They may not discriminate in terms of clients and must receive all those who approach them. Pharmacological treatment may be provided by the service for a maximum of 90 days. Drug users should be provided with a health check including diagnosis of drug related infections and be provided with general medical support whilst they are attending the service. Where possible the client should be brought into a therapeutic programme which is most suited to the specific needs of the individual. Even where this is not possible, the service should provide advice, counselling and psychological support. Additionally, the services are expected to work with families to provide advice and support and offer guidance about the support and treatment options available.

9.2.2.4 As with all the standards approved by the Regulation, it is a matter for each Region and Autonomous Province to determine precise specifications and to establish monitoring, reporting and evaluation arrangements.

9.2.2.5 One report published in 1999 discussed the work of a low threshold centre ([Granucci et al 1999](#)). The front office was established by four educators in co-operation with other staff of the Ser.T of Arezzo and aimed to provide reception for new clients and deal with telephone calls from those seeking help. They had observed that the previous arrangements of



the Ser.T seemed to present invisible obstacles to new clients who, as a result, often failed to enter treatment. By establishing a specific 'welcoming' environment in which clients, families and partners has immediate, direct access to staff they were able to retain clients in treatment. Moreover, they were able to observe behaviour and language which allowed them to provide valuable data for therapeutic interventions and to provide information to clients about the range of treatments available within the Ser.T and within other services, including those for non-drug problems.

### 9.2.3 *Prevention of infectious diseases*

- 9.2.3.1 The prevention of drug related infectious diseases has been a major theme in the national strategy for dealing with drug problems over the last 10 years. It has three basic elements: prevention of new infections; care and support for those already infected; treatment and support for those experiencing serious health problems as a result of infection.
- 9.2.3.2 The prevention of new infections has been included as an objective of both the national anti-drugs campaign and the national AIDS campaign. As has been noted elsewhere in this report, there has been an effort to integrate outreach work, work focused on synthetic drugs, work with specific groups and the two national campaigns. Thus local campaigns and information used characters and images from the national campaigns and both campaigns addressed the issues of drug use and risky sex.
- 9.2.3.3 The range of activities described in the last report and directed towards injecting drug users have continued. There are needle and syringe exchange programmes, or machines for dispensing injection equipment throughout the country. These may be provided by a range of organisations, most commonly the Ser.T and private social organisations, but also by Communes, Church organisations and pharmacies. A national registry of needle and syringe exchange schemes has been operating for several years. It has not been possible to determine how often it is updated and the web site for the registry provides no information on when it was last updated ([www.itba.mi.cnr.it/epidemiology/syringe.html](http://www.itba.mi.cnr.it/epidemiology/syringe.html))
- 9.2.3.4 Prevention of infectious diseases amongst injecting drug users is integrated with outreach work and with the use of mobile information and advice centres.
- 9.2.3.5 The main development which has occurred has been integration of work concerned with the use of synthetic drugs and stimulants and advice and information about the risk of sexual transmission of infectious diseases. Although the risk of sexual transmission of infectious diseases has always played a part in work with injecting drug users, the focus has been primarily on reducing the risk of infection or

of transmitting infection through unsafe injection practices. The use of synthetic drugs and stimulants on an irregular basis, often associated with evening and night time leisure activities (discotheques, pop concerts, etc), has led to a clear recognition that sexual transmission of infection needs to be addressed in work with this population. To this end, publicity and publications dealing with 'new' drugs have also contained advice about avoidance of infectious diseases, in particular, HIV.

- 9.2.3.6 Testing for HIV and Hepatitis B and C is standardly offered to clients attending for treatment at the Ser.T. The total number of tests undertaken for each of these infections varies from year to year ([Table 25](#) and [Figure 28](#)). This may reflect different treatment practices over time and the number of clients who have already undertaken a test for whom a further test is not required.
- 9.2.3.7 As can be seen from this table, the percentage of people testing positive for HIV infection has continued to decline annually. This is true both for new clients of the Ser.T and for those already in treatment ([Figure 29](#)). The percentage of new clients testing positive for HIV infection appears to have declined more rapidly than the percentage of clients already in treatment with the Ser.T. However, as [Tables 19 and 20](#) show, for the last two years data has not been available on test results for one quarter of male and one fifth of female new clients of the Ser.T and it may be too early to draw firm conclusions. On the other hand, it may reflect the ageing population within the Ser.T as well as changed patterns of drug use amongst new clients of the Ser.T. This appears to be supported by the fact that over the last three years the percentage of clients not undertaking a test because, amongst other reasons, they have had a negative test result recently has increased annually from 26.7% (1997) to 31.9% (1999). It is also supported by reports that new clients are less likely to use drugs by injection. What is more noticeable is that female clients are more likely to test positive for HIV infection than male clients ([Figure 29](#)) whether they are new clients or already in treatment with the Ser.T. This may reflect a greater likelihood of female drug users sharing injection equipment with their partner and/or sexual transmission.
- 9.2.3.8 In terms of Hepatitis B infection the situation has remained fairly stable with around 44% of clients testing positive ([Table 25](#)). It is noticeable, however, that the number of new clients who have not been tested or about whom data is not available has exceeded 50% for both males and females in each of the last two years ([Tables 21 - 22](#)). Thus, whilst the percentage of new clients testing positive has declined annually, so has the percentage of new clients testing negative. A similar situation applies to existing clients of the

Ser.T ([Tables 21 - 22](#)) although the percentage not tested or where data is not known is lower.

- 9.2.3.9 Over the last three years the percentage of clients of the Ser.T vaccinated for Hepatitis B has increased with the exception of new male clients ([Tables 21 - 22](#)). There is little information available about the vaccination policies and practice of the Ser.T. However, there may be some relationship between the increasing percentage of people not tested and the increasing percentage who have been vaccinated. Further exploration of this question would be necessary to offer a more concrete explanation.
- 9.2.3.10 As with Hepatitis B, the percentage of clients of the Ser.T testing positive for Hepatitis C has remained broadly stable over the last three years ([Table 25](#)). There remain substantial regional variations and these may reflect the level of testing in the Region as much as the possible impact of education and harm reduction initiatives. This appears to be supported by the fact that there has been only a small decrease in the percentage of existing male clients testing positive and a continuing increase in the percentage of existing female clients testing positive (as a percentage of all clients of the Ser.T), although there has been larger decreases in positive test results for new male and female clients ([Tables 23 and 24](#)). This latter fact may not, however, be significant because the percentage of new clients not tested remains at between 20% and 25%, around one third are not tested and negative test results for new female clients have been declining and remained almost static for new male clients ([Tables 23 and 24](#)).
- 9.2.3.11 Treatment of clients testing positive for HIV or for Hepatitis B or C is a matter of clinical judgement for the medical staff at an individual Ser.T, in consultation with specialist doctors where appropriate. Clients testing positive are commonly provided with specific information and advice on how to care for their own health and on how to avoid transmitting infection to others. Where they become ill, appropriate medical treatment is provided, including hospitalisation if this is required. For clients who develop AIDS related illnesses some Regions have accommodation specifically designed to meet the needs of people with AIDS. This is not, however, a widespread provision in Italy.
- 9.2.3.12 Reference has already been made to the major study which has been undertaken in north Italy ([NISDA 1999](#)). This has identified a continuing decline in the prevalence of HIV infection amongst injecting drug users from 5.2 per 100 in 1987 to 0.9 in 1996 among male drug users and from 4.2 to 2.3 in female drug users over the same period. The frequency of needle and syringe exchange also declined in both male and female drug users. There was only a small improvement towards safer sexual behaviour and women were more sexually exposed than men, whilst the proportion

of sexually active women increased more than the proportion of sexually active men. The latest report from the study suggested that the pattern of reduction in HIV infection might reflect a reduction in transmission through injecting drug use and an increase in heterosexual transmission. The study is continuing to produce information to guide responses. It was through this study that the national register of needle and syringe exchange programmes was developed.

9.2.3.13 Training of staff is now standardly incorporated into the normal training programmes for new staff and for skills development amongst existing staff. It is relatively uncommon to have training courses now which are specifically focused on drug related infectious diseases.

### 9.3 TREATMENT

#### 9.3.1 *Treatments and health care at National level*

##### *Treatment services*

- 9.3.1.1 Within Italy treatment services are provided either by the National Health Service managed drug treatment programmes (Ser.T) or by private, not for profit organisations. In 1999 there were 555 Ser.T spread throughout Italy and 1,375 socio-rehabilitative structures. The regional distribution of the Ser.T and the social-rehabilitative services is shown in [Maps 6](#) and [7](#).
- 9.3.1.2 Information about the staffing, clients and treatment typology of the Ser.T is collected by the Ministry of Health ([Health 2000](#)) using a series of standard reporting forms. A recent development has been the production of an electronic system for recording and submitting the data from the Ser.T. The aim is that this should allow the collection of data in line with European standards and that it should link with a national system referred to earlier. It is expected that this electronic system will become operational throughout Italy in the next 12 months.
- 9.3.1.3 The general trend in the staffing of the Ser.T through the 1990s has been for a higher level of full time staff and a reduction in the number of part time staff. This reduction has been further strengthened by the introduction from 1997 of professional staff with whom the Ser.T established an agreement for the provision of specified services. [Maps 8 and 9](#) compare the percentage of full time staff in the Ser.T in 1991 and 1999.
- 9.3.1.4 Over the period, the total number of active Ser.T rose from 518 to 555. Based on data from 506 Ser.T in 1999, the absolute number of medical staff rose from 1,247 (1991) to 1,636 (1999) but full time medical staff fell as a percentage of all full time staff, the number of part time medical staff fell substantially whilst agreement for specified services with medical staff has been rising significantly over the last three

years. A similar situation applies to psychologists, whilst there has been only a small change in the number of administrative staff.

- 9.3.1.5 The major development in the staffing of the Ser.T has been the increase in health and social workers. In 1991, 43.8% of full time staff were health or social workers, rising to 48.4% in 1999.
- 9.3.1.6 [Table 32](#) shows the average staffing and client numbers for the Ser.T in 1991 and 1999. The increased staffing levels reflect not only the increase in the number of clients but also the diversification of the activities of the Ser.T. In 1991 staff were primarily active within the Ser.T. By 1999 they were also likely to be involved with a mobile unit, outreach work, prison work or a range of other activities.
- 9.3.1.7 For the socio- rehabilitative services, provided by both public and private services, no national data is available on their staffing levels. Data is only available on the type of service and the number of clients.
- 9.3.1.8 The Ministry of the Interior, through the Central Directorate for Documentation ([DCD 1999](#)), undertakes a census of these services. The data for 1999 shows that of the 1,375 operating in 1999, 857 were residential, 252 were semi-residential and 266 were ambulatory.
- 9.3.1.9 Private services for drug dependents are required to be registered with the Region in which they operate. Minimum standards have been established for the services, enshrined in the regulation approved by the Permanent Conference between the State, the Regions and the Autonomous Provinces on 5 August 1999.

*Objectives of drug treatment*

- 9.3.1.10 As discussed above, a primary objective during 1999 has been to develop and improve co-ordination between different types of service and to establish a better distribution of services in relation to assessed need. The objectives of services is largely determined by the type of programme. The Ser.T provide substitution treatment, psycho-social counselling and support or co-ordinate other types of treatment intervention. At the national level, the objective is to assist the individual drug user away from the most damaging forms of drug misuse and ultimately to achieve abstinence. Semi-residential and residential services are focused on achieving long term abstinence and social/economic re-insertion into the wider community. Ambulatory services in general are concerned to provide support to those not currently receiving treatment and to guide people towards treatment services and/or to provide information and counselling to people at risk to drug dependence but who do not yet require specific treatment interventions.

*Criteria for admission*

- 9.3.1.11 The regulations deal with criteria and processes for admission into drug treatment services. For the Ser.T there must be no discrimination in accepting potential clients, a health check, including for drug related infectious diseases is required, a multi-disciplinary assessment is expected and allocation to the most appropriate treatment either within the service or through referral to a specialist service. For socio-rehabilitative services, potential clients should be accepted where they meet explicitly stated criteria and are drug free. A multi-disciplinary assessment is expected and the development of a treatment programme which takes account of individual needs - therapeutic, health and psychological.

*Involvement of non-drug specialist public health services*

- 9.3.1.12 There is little information available at the national level about the involvement of non-drug specialist public health services and general medical practitioners in the provision of drug treatment. In general, those requiring treatment appear to be referred to specialist drug services. A study, related to development of the infectious diseases indicator in Italy, has information on drug dependents attending STD clinics since 1991. This shows a very substantial decline in the number of drug dependents attending STD clinics from a peak of 688 in 1992 to 36 in 1999. It is not clear whether this reflects less attendance at STD clinics, less observation of drug dependents, improved sexual health amongst the drug dependent population or greater reliance on specialist drug treatment services. It does seem to reflect, however, the relatively low involvement of generic rather than specialist treatment services in the care of drug dependents.
- 9.3.1.13 In some Regions the Ser.T have developed a team to work with drug users who have been admitted to hospital. These admissions may be the result of an overdose or for other health problems. The purpose of this intervention is to provide support to the drug user and to bring him or her into contact with treatment services. It is, therefore, an aspect of outreach work from the treatment service. More detailed data is unfortunately not available about this aspect of the work of the Ser.T.

*Co-ordination of services*

- 9.3.1.14 As already indicated, one of the purposes of the re-organisation of drug treatment services has been to improve co-ordination between services and rationalise the provision of services. To this end, the regulation provides for the accreditation of networks of treatment programmes and of territorially based action plans. This aims to ensure integrated service provision and improvement in the range of services available in the geographical area, in particular, contact with drug users not currently in treatment, social and



health care support for people with serious conditions, self-help programmes for clients and their families, training and skills programmes to assist social re-insertion and educational/rehabilitation programmes.

- 9.3.1.15 Rather than the development of new special services, the focus in 1999 has been to place many of the past developments into the mainstream of treatment provision. This has included making services responsive to nationally identified needs such as the use of synthetic drugs, contacting drug users not already in treatment and making provision for groups who have not accessed services fully, for instance, women drug users and drug users within the ethnic communities.

*Funding of treatment services*

- 9.3.1.16 The financing of drug treatment services comes from a variety of sources. For the Ser.T funding is through the health care system. For the socio-rehabilitative services funding may be on the basis of contracts with the Ser.T, project funds from the Commune, Province and or Region in which they operate, projects financed through the National Drugs Fund and private donations.

*Statistics and evaluation*

- 9.3.1.17 During 1999 some 142, 651 people were in treatment with the Ser.T. Of these, 123, 225 attended the Ser.T and 19,426 were in socio-rehabilitative services. Since 1991 there has been a continuing increase in the number of people treated by both types of service, but the growth rate for treatment within the Ser.T has been considerably higher than that for treatment in the rehabilitation services.
- 9.3.1.18 Statistics on the work of the Ser.T, given that they have had a particular focus on pharmacological interventions, are dealt with in the section concerned with substitution and maintenance programmes.
- 9.3.1.19 In terms of socio-rehabilitative services, the census conducted by the Central Directorate for Documentation of the Ministry of the Interior ([DCD 1999](#)) provides data as at 31 March 1999. This identified 1,375 such services of which 857 were residential, 252 semi-residential and 266 ambulatory. The residential services had a total capacity of 19,044 places and the semi-residential services had a capacity of 5,015 places.
- 9.3.1.20 A large number of services have agreements for the provision of services with the Ministry of Justice, the Region, the Province, the Commune, the local Health Authority and/or with other bodies. Over 70% of residential services have agreements with the local health authority and 62.3% of semi-residential services have such an agreement. Over one quarter of residential services also have an agreement with the Ministry of Justice, reflecting the use of diversion



and alternative to custody provisions, as well as the reception of drug dependent prisoners on their release. For ambulatory services, there are significantly fewer agreements with public authorities for the provision of services, and where these exist they are most commonly with local health authorities (37.2% of all ambulatory services) and with the local commune (16.9%).

- 9.3.1.21 Occupancy levels show a marked difference between services provided directly by public authorities and those provided by private (not for profit) organisations. At 31 March 1999 the occupancy rate for residential rehabilitation services operated by public authorities was 80.8% compared with 73.4% for private residential services. There is an even more marked difference for semi-residential services, with an occupancy rate of 74.3% in publicly operated services and only 46.3% in private services. The reasons for these differences is not entirely clear. In part it may reflect a natural inclination to keep clients within the same treatment system. It may also reflect unease with or retention problems for semi-residential services. In either case, it supports the rationale for re-organisation of the treatment system in order that services can more fully reflect the assessed needs.
- 9.3.1.22 The male to female ratio for public residential services is 5.9 to 1 and for private residential services it is 6.2 to 1. This slight difference probably reflects the much higher number of such private services and that historically a significant number have been single sex. Only relatively recently have they become mixed services and are still adjusting to the specific needs of female drug users. There is a larger difference in the male to female ratio between public and private semi-residential services, with a ratio of 4.8:1 and 5.8:1 respectively, probably for the same reasons as already mentioned. By contrast, the male female ratio for ambulatory services, whether provided by public or private organisations, is 3.8 to 1. This may reflect different drug using patterns amongst women and difficulties for them to access or use residential and semi-residential services.
- 9.3.1.23 There has been a substantial increase in the number of evaluations published during the year. A specific focus of many of the reports which have been published has been on the quality of the service provided (eg. [Sorio and Bimbo 1999](#)). Many of the studies have developed from the national projects reported above and focus on individual services or geographical areas. The Regions of Abruzzo ([Frattoni 2000](#)) and of Emilia-Romagna ([Ugolini \(ed\) 2000](#)) have both published reports concerned with quality and with the development of the treatment system within their Region. In most reports the focus has been either on customer satisfaction surveys or on forms of Total Quality Management (TQM). A common finding has been the

importance of regular and specific information sharing and staff team development and of regular training to develop both motivation to change and to ensure that service provision utilises the most effective treatment methodologies. A list of the published reports is contained within the bibliography.

### *Training*

9.3.1.24 Training is most commonly provided within a Region or within a specific local health authority. There is no single national list of the training events in Italy. However, the national regulations already referred to cover the qualifications and training of staff and volunteers and requires the Regions to develop a permanent training system aimed at improving skills and knowledge, developing new treatment approaches and qualifying or re-qualifying staff who have not obtained the level of qualification expected for the provision of services.

### 9.3.2 *Substitution and maintenance programmes*

#### *Organisation and delivery*

9.3.2.1 Substitution and maintenance programmes are exclusively provided by the national health service managed drug treatment services (Ser.T). The Regulation approved by the Permanent Conference for Relations between the State, the Regions and the Autonomous Provinces on 5 August 1999 establishes the expected standards for these services.

9.3.2.2 These standards require that there should be no discrimination in terms of potential clients and that all those who approach the Ser.T should be assessed by a multidisciplinary team to determine their specific needs and the most appropriate treatment modality. It is for each Region to establish its own quality standards for treatment services, for the local health authority to establish appropriate management and operational arrangements and for the Ser.T to provide a service which meets the required standards.

9.3.2.3 Given the devolved nature of responsibility, there are no specific national guidelines for substitution and maintenance programmes. Rather, the national guidance covers the issues which should be included in quality standards, including staff training, the range of services offered, the staff client ratio, availability of the service and the maximum number of clients who can be accepted for treatment by the service. National guidance on the provision of substitute or maintenance prescribing is covered by the general provisions for prescribing and should be evidence based from the scientific literature.

#### *Objectives*

9.3.2.4 The objectives of these programmes are within the framework of the national objectives for all specialist drug services. The

overall objective is to improve the physical and mental health of the client and to assist them to become drug free. The Regulation of 21 January 1999 specifically states in the text that the concept that drug dependence is incurable is inappropriate. Treatment should, therefore, always have the aim of guiding a drug misuser towards abstinence, at least from the more risky drugs and modes of use. To this end, treatment services are expected to provide individual treatment based on assessed needs and to have at their disposal a full range of treatment options including short term detoxification, medium and long term prescribing, psycho-social therapies and drug free treatments and rehabilitation.

*Substitute Prescribing*

- 9.3.2.5 Over the last 10 years there has been a clear national trend in the type of treatment offered within the Ser.T. Pharmacological treatment, especially with methadone, has increased whilst non-pharmacological treatments have declined over the same period. [Figure 39](#) shows the percentage of clients of the Ser.T receiving different treatment interventions by year.
- 9.3.2.6 The data collection method changed slightly in 1997 and it is not possible to make a direct comparison between the duration of methadone treatment before 1997 and from 1997 onwards. What is noticeable, however, is that the use of other pharmacological treatments has declined, as has the short term (under 30 days) use of methadone, whilst long term (over 6 months) use of methadone and, to a lesser extent, medium (30 days to 6 months) term use has continued to increase.
- 9.3.2.7 Within this national picture there are significant Regional variations. [Maps 10, 11 and 12](#) show the percentage of clients of the Ser.T receiving methadone treatment by Region for 1997 - 1999. In five Regions (Campania, Lazio, Sardegna, Toscana and Valle d'Aosta) over half of the clients in treatment with the Ser.T have received methadone treatment for each of the three years. In four Regions (Emilia Romagna, Lombardia, Piemonte and Trentino) there has been an annual increase in the percentage of Ser.T clients receiving methadone treatment. In the remaining Regions, there has been a general consistency in the percentage of clients receiving methadone treatment.
- 9.3.2.8 There are also large differences between Regions in terms of the length of time for which methadone is prescribed. For instance, of the five Regions with over half the clients of the Ser.T receiving methadone treatment, Valle d'Aosta and Campania have relatively high levels of short and medium term prescribing, whilst Lazio, Toscana and Sardegna have relatively high levels of long term prescribing. Of the four Regions with an increasing percent of clients receiving methadone, Lombardia and Emilia Romagna have higher

than average use of long term prescribing whilst Piemonte and Trentino have higher use of medium and short term prescribing respectively.

- 9.3.2.9 The difference in prescribing practices between Regions, and almost certainly within Regions, appears to reflect different treatment approaches, either short or medium term detoxification or long term maintenance and risk reduction. They may also reflect treatment preferences and/or assessment of both individual clients and of the extent and characteristics of the drug problem in the Region.
- 9.3.2.10 The use of other drugs in the treatment of drug dependence shows similar variations. A number of Regions have a relatively high percentage of clients of the Ser.T receiving naltrexone, clonidine or other pharmaceuticals. In each of the last three years, of those clients receiving a pharmacological intervention, over one fifth received one or other of these drugs in four Regions (Emilia Romagna, Friuli V.G., Sicilia and Veneto), whilst this has been the case for the last two years in Liguria. It is also clear that in some Regions a clinical decision has been taken to use these drugs more widely. For instance, the percentage of clients receiving non-methadone pharmacological intervention rose from 15.9% in 1997 to 33.8% in 1998 in Liguria. In Friuli V.G. over the same period the percentage rose from 23.2% to 39.7%, in Molise from 8% to 16.8% and in Basilicata from 5.8% to 17.7%.
- 9.3.2.11 Not all these developments in prescribing practice were sustained. For instance, in Piemonte the percentage fell from a high of 17.2% in 1997 to 11.9% in 1998 and in Molise from 16.8% in 1998 to 10.3% in 1999. This suggests that after an experimental period with the use of these drugs, a more settled pattern based on clinical assessment and experience has developed.
- 9.3.2.12 By contrast, in a small number of Regions the use of non-methadone pharmacological interventions is around half the national average. This has been the case over the last three years in Abruzzo, Calabria, Lazio, Toscana and the Autonomous Province of Trento.
- 9.3.2.13 Clinical monitoring of clients and laboratory analysis of urine samples is expected and is included in the national quality standards. It is for individual Regions, however, to determine the specific standards for their Region and to monitor their application.

#### *Psycho-social treatment*

- 9.3.2.14 In terms of psycho-social treatment, the picture is less clear. All clients of the Ser.T receive support and appropriate interventions from the multidisciplinary team. However, more detailed information about the nature of this support is only available for those clients who are not in receipt of a pharmacological intervention.

- 9.3.2.15 [Maps 13, 14 and 15](#) show the percentage of clients of the Ser.T receiving psycho-social and/or rehabilitative treatment over the last three years. The national average percentage for clients of the Ser.T exclusively receiving such treatment has been declining annually ([Figure 39](#)) and now stands at 35.5% of all clients.
- 9.3.2.16 There are substantial Regional variations in the use of such treatments. In four Regions, less than one quarter of clients are exclusively allocated to these types of treatment (Friuli V.G., Lazio, Sardegna and Valle d'Aosta), whilst in seven Regions (Abruzzo, Calabria, Lombardia, Marche, Molise, Puglia and Trentino A.A.) 40% or more of all clients are allocated exclusively to these forms of treatment. As with the choice of drug for treatment, there is no clear explanation for these wide variations. It may reflect the characteristics of drug problems being presented and/or the treatment approaches preferred by Ser.T staff.
- 9.3.2.17 No Regional breakdown is available for the type of psycho-social or rehabilitative treatment provided, only national data. Treatment typology is classified as psychological support, psychotherapy and social work intervention and is shown by the location in which the treatment is provided. [Table 33](#) shows the type of treatment by location for the last three years. From this, it can be seen that the type of treatment provided in rehabilitative services and in prisons has changed very little whilst there has been a decline in both psychological support and psychotherapy within the Ser.T and an increase in the percentage of clients receiving social work interventions. This development appears to reflect the change in staffing of the Ser.T noted earlier, with a marked increase in the percentage of full time health and social work staff and a decrease in the percentage of full time psychologists in favour of part time staff and, in particular, staff contracted to provide specific services.

*Diversion of substitute drugs*

- 9.3.2.18 It is normal practice for methadone and other substitution drugs or drugs used in the treatment of dependence to be dispensed and consumed on the premises. There is little evidence of any significant diversion of drugs prescribed in the course of drug treatment. One indirect indicator of this is the number of people attending for treatment at the Ser.T whose primary or secondary drug use is methadone. In 1999, in nine Regions no clients were reported as having methadone as a primary drug of misuse and in 4 Regions there was no report of methadone as a secondary drug. In a majority of Regions clients using methadone either as a primary or a secondary drug represented less than 1% of all clients. In two Regions, Campania and Puglia, the percentage of clients with methadone as a primary or a secondary drug has significantly exceeded the national average for each of the last three years and in a further two Regions (Marche and Abruzzo)

secondary use has exceeded the national average. However, the percentage remains very small and this may well be accounted for by different prescribing practices in these Regions which, with the exception of Campania, are the less populated and more rural Regions.

### *Statistics*

- 9.3.2.19 As noted earlier, in 1999 there were 142,651 people attending the Ser.T for treatment. Of these, 123,225 were treated within the Ser.T and 19,426 in socio-rehabilitation services. The figure for clients of socio-rehabilitative services provided through the census of such services undertaken by the Central Directorate for Documentation of the Ministry of the Interior is slightly higher at 20,404. However, this census relates to clients on 31 March 1999 and the difference, therefore, appears to reflect the different reporting period and clients who were attending private ambulatory services and who were not in contact with the Ser.T. In fact, it is likely that the number of clients of ambulatory services will be higher than that reported given the limited record keeping within these services and the fact that many ambulatory services work with a wide range of clients (homeless people, people with mental health problems, problem drinkers, etc) and are not specifically focused on drug use and problems.
- 9.3.2.20 There has been a continuing increase in all treatment demands and in new treatment demands, although the mean age of both existing and new clients has also continued to increase. This suggests an aging population in treatment. However, there are also some indications that the demand for treatment is greater than the number of places available within the Ser.T. One element in the gradual aging of the treatment population may, therefore, be people remaining in treatment for longer, limiting the capacity to admit new clients. A second element may be the focus on heroin dependence, especially injecting heroin, when patterns of drug use appear to be changing, resulting in new clients of the Ser.T being older than the drug using population which might be in need of treatment. [Figure 40](#) shows the percentage of clients of the Ser.T by existing and new clients and by sex and year.
- 9.3.2.21 There has been a slow upward trend in the male to female ratio over the years rising from 5.2:1 in 1991 to 6.2:1 in 1999 for all treatment demands. There has been a similar rise in the male to female ratio for new treatment demands from 5.6:1 in 1991 to 6.3:1 in 1999. It is not clear if this represents the actual situation, that is, a significantly lower level of drug dependence amongst women. Given that the male to female ratio for ambulatory services is significantly lower than that for the Ser.T, it may indicate that female drug users have a different pattern of drug use and/or that at present they feel that the Ser.T do not sufficiently meet their needs. There may also be cultural factors at work in which women are dissuaded from attending treatment services.

*Research and Evaluation*

- 9.3.2.22 As reported earlier, two major national research and evaluation projects are underway concerned with the work of the Ser.T. Only preliminary results are available to date but it is expected that more substantial will be published shortly.
- 9.3.2.23 At the Regional and local level there has continued to be research and evaluation of the work of the Ser.T. Many have been concerned with evaluation of quality and the development of standards ([Di Carlo et al 1999](#), [Di Fini et al 1999](#), [Ghirardello and Quaresima 2000](#), [Giannelli et al 1999a](#), [Nizzoli et al 1999](#),). Other reports have focused on the effectiveness of treatment ([Filippone et al 1999](#), [Giannelli et al 1999b](#), [Maremmanni et al 1999](#), [Mollica 2000](#), [Poloni and Arcelloni 1999](#), [Ugolini 2000](#), [Zucchi and Ferrari 1999](#)). Together, these reports have continued to provide a basis for monitoring and evaluation and for the improvement of service efficacy.
- 9.3.2.24 An interesting development has been the use of information technology to create different programmes for the management of individual clients, for monitoring and evaluation and for administrative and reporting purposes. In addition to the CD ROM and on-line system for submitting data from the Ser.T to the Ministry of Health, a number of Regions have used part of their allocation from the National Drugs Fund to develop improved mechanisms for data collection and submission and to establish evaluation systems. The Veneto Region appears to be most advanced in this area, and has published several papers concerned with the development of information technology for use within drug treatment services ([Ancona et al 2000a](#), [Ancona and Serpelloni 2000b](#), [Serpelloni 1999](#), [Serpelloni 2000](#)). The Ministry of Health has also received support from the National Drugs Fund to pilot a client monitoring and management system developed by CelS Roma at the national level for socio-rehabilitative services.

9.4 AFTER-CARE AND RE-INTEGRATION

9.4.1 *Education and training*

- 9.4.1.1 From the data reported earlier, it is clear that a substantial number of people with problems arising from drug misuse and dependence have poor educational attainments, come from poor family situations and have little experience in the employment sector. They are thus at a severe disadvantage in the employment market.
- 9.4.1.2 At the Regional, Provincial and Commune levels there has been particular attention paid to measures to promote social inclusion. These have been within the general framework of national policy aimed at combating social exclusion and include education, training and support into employment projects.



- 9.4.1.3 Given that these projects are concerned with social inclusion, it is not appropriate to separate them into those concerned with education and training and those concerned with employment. Rather, this section will deal with drug users not in employment and the next section will be concerned with employees who develop problems whilst in employment.
- 9.4.1.4 Under the National Drugs Fund, from the three Regions (Autonomous Province of Bolzano, Lombardia and Toscana) which have provided details of the projects which they have funded almost 20% (105) of the projects are concerned with social inclusion and employment. The Veneto Region has also funded projects in this area but the number of projects has not been provided. In total, some 20,423 million lire (10,547,599 euro) has been allocated to such types of project in the four Regions which have provided data. This represents 14.3% of the total funds allocated to these Regions.
- 9.4.1.5 Unfortunately, data is not available at the national level on the number of projects concerned with social inclusion but funded from sources other than the National Drugs Fund. It is not possible, therefore, to provide an adequate description of the range of programmes which are being offered or to furnish statistical and other data on these programmes.
- 9.4.1.6 The picture is further complicated because programmes for social inclusion may be funded by the Regions, Provinces or Communes through funds from different budget headings, including funds from the European Social Fund. An example of a social inclusion project, which has been undertaken by CeIS Roma is training of former drug dependents, prisoners and residents in the later stages of rehabilitation to qualify as pizza makers and as ice-cream producers. These projects were carried out in collaboration with the relevant trade association and involved direct teaching, practical work and placements in pizzeria and gelateria. The collaboration with the trade associations was of particular importance. It ensured that the training was directly relevant to the requirements of the employer and resulted in almost 80% of participants securing employment, with a significant number being employed before completion of the course.
- 9.4.1.7 In other areas of the country, there has also been a focus on improving educational attainments and facilitating entry into further education as well as on providing training for employment skills.

#### 9.4.2 *Employment*

- 9.4.2.1 As reported last year ([OIDT 2000](#)), legislation in the employment field provides for employees with drug or dependence related problems to receive treatment and to return to work within a three year period. Unfortunately



there is no updated national data on the actual operation of the legislative provisions and it is not, therefore, possible to provide an analysis of the impact and effectiveness of the legislative measures.

#### 9.4.3 *Housing*

9.4.3.1 It is not common practice to provide special arrangements for the housing of drug dependents when they have completed treatment. Many are in a position to return to live with their family. Others will seek to rent accommodation whilst they are in the re-entry phase of a treatment programme.

9.4.3.2 A number of Regions have accommodation specifically established for people with AIDS. Drug users who have developed AIDS and who require more intensive social and medical support may be placed in such accommodation.

### 9.5 INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

9.5.1 Work with drug users involved in the criminal justice system may occur at several different points. People referred to the Prefect for possession of a listed drug may request a therapeutic programme. Those charged with a criminal offence who are drug misusers may be offered the opportunity to participate in a treatment programme as an alternative to custody. Drug misusing prisoners may be offered the opportunity to participate in a treatment programme as an alternative to continued imprisonment or may participate in such a programme whilst serving their prison sentence. Finally, drug misusing prisoners may be offered a treatment or support programme on their release from prison.

9.5.2 In 1999, 6,444 people who were referred to the Prefect for possession of a listed drug requested a therapeutic programme. There is very limited national data about the types of intervention offered or about the outcomes of such interventions. This in part reflects the problem of different and incompatible data bases operating which do not allow a correlation to be made between requests for treatment as a result of a law enforcement intervention and outcome as a result of a treatment intervention.

9.5.3 The grounds for offering alternatives to custody or to continued detention were discussed fully in the 1999 report to the EMCDDA ([OIDD 2000](#)). The decline in the use of community sanctions and alternatives to continued detention noted in that report has continued in 1999. This may reflect a situation in which drug dependent offenders, because of repeated offending, are no longer eligible for such sanctions or alternatives. At the same time, it is noticeable that in 1999 there was a significant reduction in the number of people who were charged with breaching the terms of a community sanction or alternative measure involving a therapeutic programme. In 1998, 133 people were reported for breaching these terms whilst in 1999 only 48 people were reported.

9.5.4 Work with drug dependent prisoners has been a major area of development in recent years and has been further encouraged by the two Regulations approved by the Permanent Conference for Relations between the State, the Regions and the Autonomous Provinces.

- 9.5.5 In 1999 there were 15,097 people assessed as drug dependent held within the prison system. Of these, 48.9% were charged with drug law offences and 51.1% with other offences.
- 9.5.6 Data from the Ser.T shows that in 1999, 7.5% of all their clients were in prison. This compares with 6.8% for both 1998 and 1997. Increased activity within the prison system is confirmed by the fact that the Ser.T were in contact with 70.9% of all drug dependent prisoners in 1999 compared to 69% in 1998, and this despite the fact that the drug dependent prisoner population rose by 1,530 between 1998 and 1999. Work with drug dependent prisoners therefore increased by 14.3% in 1999 whilst the drug dependent prisoner population only increased by 11.3%.
- 9.5.7 A gradual change has occurred in the type of treatment offered. Over the last three years the percentage of drug dependents given psycho-social and/or rehabilitative treatment has declined whilst the percentage receiving a pharmacological intervention has increased. The major change has been an increased use of non-methadone pharmacological interventions and in medium term (30 days - 6 months) methadone treatment. [Figure 41](#) shows the type of treatment offered to drug dependent prisoners over the last three years.
- 9.5.8 A significant number of projects proposed for funding through the National Drugs Fund have been concerned to develop work in relation to drug users involved in the criminal justice system. These range from the provision of direct treatment services through joint training of treatment and criminal justice staff to the development of self help groups. Although many of these developments are only just becoming operational, it is likely that they will result in an increase in the number of drug using prisoners having contact with treatment services. This is likely to be of particular value if, as appears to be the case, many drug dependent prisoners are not eligible for community sanctions or alternative measures.
- 9.5.9 As noted earlier, around one quarter of rehabilitation services have an agreement with the Ministry of Justice to provide services ([DCD 1999](#)). Most offer residential therapy as part of a community sanction or as an alternative measure to continued imprisonment. Unfortunately there are no recent reports or evaluations on the impact of these programmes.
- 9.5.10 The only recent report on work with drug dependent prisoners concerns a self help group in Pinerolo Prison in the Province of Torino ([Galletto 1999](#)). The report covers the period 1992 to 1997, when the prison was closed. In summary, the report found that those drug users who participated in the self help group had an increased willingness to undergo treatment and were more likely to take up continued treatment on their release.
- 9.5.11 Following the allocation of funds from the National Drugs Fund at the Regional level, it is anticipated that there will be increased training for work with drug dependent prisoners. The new element in this approach is likely to be the increased involvement of treatment and prison staff in joint training in order that they are working together for

common goals with a shared understanding of the objectives of the intervention.

## 9.6 SPECIFIC TARGETS AND SETTINGS

- 9.6.1 There have been no major new developments in the course of 1999. Rather, there has been a broad trend towards the creation of interventions which reflect the overall drug situation not just a focus on the most serious drug problems. The description of interventions aimed at children and parents of drug users, of self-help groups, of alternatives to prison and of gender specific interventions given in the last report ([OIDT 2000](#)) remains accurate.
- 9.6.2 There have been three areas of specific development, all related to the issue of the use of synthetic drugs.
- 9.6.3 The first has been concerned with prevention and harm limitation work associated with youth leisure locations. A protocol has been agreed between the Government and the Union of Local Dance Hall Operators aimed at reducing the presence and use of drugs at discotheques, providing information about the risks of drug use and at reducing the risks arising from drug use. This protocol provides for the training of discotheque staff, for the provision of advice and information facilities, for improvements to the physical environment and facilities, for support from the Regions for this work and for resources to be used from the National Drugs Fund to support implementation of the protocol.
- 9.6.4 In essence, this has provided a governmental and organisational framework for activities which have been undertaken on a more ad hoc basis by local drug services in various parts of the country.
- 9.6.5 A second development has been work with driving schools, focused on training about the risks associated with the use of drugs and alcohol in relation to driving. Again, this project, which is in the development stage, builds on work which has been done at the local level in some parts of the country.
- 9.6.6 The third development has been concerned with training for young workers. In particular, courses designed to assist young people enter into the world of work have been a target for information about drugs and for drug prevention. Most commonly these courses have used small groups to explore the themes and have provided an opportunity to focus on key issues relevant to the participants. Building from this experience, work is now planned to extend this approach to programmes for apprentices.
- 9.6.7 These developments are relatively recent and therefore no specific evaluation results are available and detailed descriptions of local programmes have not yet been published. It is anticipated that fuller information will be available for the next report.

## 10. QUALITY ASSURANCE

### 10.1 *Quality assurance procedures*

- 10.1.1 Procedures for quality assurance have already been described in relation to the Regulation approved by the Permanent Conference for Relations between the State, the Regions and the Autonomous

Provinces. This establishes the minimum standards expected of services for people with drug problems and proposes measures which are appropriate to the different types of service (residential, reception, specialist, etc.).

10.1.2 In all Regions regulations have been or are being prepared to establish the specific quality standards required and to create the structures and systems necessary. It is anticipated that for the next report to the EMCDDA all Regions will have established their systems and procedures and it will be possible to offer an analysis of these.

## 10.2 *Treatment and prevention evaluation*

10.2.1 As has been noted earlier, there have been a substantial number of papers published concerned with evaluation of the quality of drug misuse services. These have concerned both the quality of the services offered from different perspectives and the impact of specific interventions.

10.2.2 One particular focus of evaluation has been the perception of the quality of the services offered ([Di Carlo et al 1999](#), [Giannelli et al 1999a](#), [Nizzoli et al 1999](#), [Sorio and Bimbo 1999](#),). These studies have reflected the increasing concern with improving the effectiveness of services and most pre-date the Regulation approved between the State, the Regions and the Autonomous Provinces. A second focus has been on the outcome of interventions ([Filippone et al 1999](#), [Fogaroli et al 1999](#), [Nardini et al 1999](#), [Poloni and Arcelloni 1999](#), [Ugoli \(ed\) 2000](#)).

10.2.3 The decree allocating the resources of the National Drugs Fund and the agreements between the State, the Regions and the Autonomous Provinces all gave evaluation of interventions a high priority. Funding of services was specifically linked to the furnishing of information in a format established by the relevant Region and to adequate evaluation of the service provided.

10.2.4 The priorities established by the Agreements and by the National Drugs Fund arose from previous evaluations and the need to focus on the development of intervention services to meet the broad range of needs, not just heroin dependence and to utilise validated interventions. It is anticipated that the results of this approach will start to show benefits throughout the country over the coming years.

## 10.3 *Research*

10.3.1 It remains the case that research is undertaken at several different levels. At one level, individual organisations and research institutes may undertake research which is relevant to the demand reduction sector. This research largely reflects the interests and research agendas of the individual organisations and institutions involved.

10.3.2 A second level is research undertaken at the local or Regional level, usually as part of the Regional strategy. This may be conducted by the Regional Drugs Observatory or be commissioned by the Region from public or private organisations. In general, this research aims to provide the tools for more effective implementation of the strategy and to provide a basis of validated methodologies for interventions. It is

also usual for Regional Observatories to review research findings and to draw on these to inform the development of Regional strategy.

10.3.3 The third level is research commissioned or undertaken at the national level. Reference has already been made to a number of major national research projects, namely the evaluations of the Ser.T and of therapeutic communities and the VedeTTe study. A range of other research projects have been commissioned by Ministries which together are designed to provide a vastly improved data base upon which to base national policy and strategy. In particular, the bids from Ministries for money from the National Drugs Fund have been evaluated against national priorities for information on the epidemiology of drug use, the socio-demographic characteristics of drug users and people with drug problems and the effectiveness of interventions. Central to this has been the OI DT and its priorities and work programme. In particular, in relation to developing the application of European standards within Italy, some 16 projects have been financed through the National Drugs Fund ([Social Affairs 2000](#) pp. 96 - 102).

#### 10.4 *Training for professionals*

10.4.1 Training in quality assurance and evaluation is a matter for initial professional training and is generally part of such training courses. Within the Regions, which have the responsibility for ensuring that relevant training is available, increasingly there has been a focus on quality assurance and evaluation modalities. A number of publications have been developed to assist in the implementation of quality assurance and evaluation procedures.

10.4.2 The agreements between the State, the Regions and the Autonomous Provinces of January and August 1999, which require continuous training programmes for staff of treatment services to be made available and which require monitoring and evaluation of intervention activities is likely to lead to a further and more specific focus on quality assurance and evaluation training in order that the standards and requirements adopted by individual Regions can be effectively implemented.

### 11. CONCLUSIONS: FUTURE TRENDS

11.1 The main trend which can be foreseen arising from developments in the last year is for an increased focus on an improved balance of interventions and services and on quality standards and evaluation.

11.2 In terms of an improved balance, there is likely to be specific attention paid to the development of a collaborative network between public and private services and between drug specific and generic services. The aim of such networks will be to provide appropriate interventions at different levels from those related to primary prevention through to those aimed at economic and social re-integration of those who have had drug problems.

11.3 It is likely that Regional variations in the focus and pattern of service provision will become greater but that these variations will more accurately reflect the specific needs of the Region.

- 11.4 The results of the two major national evaluation studies on the Ser.T and on therapeutic communities, along with results emerging from the VedeTTe study, are likely to have an impact on the work of treatment interventions. The increasing use of information technology to provide client management and monitoring systems is also likely to have an impact as comparative data sets become available.
- 11.5 The relatively low occupancy rates of residential services for drug misusers may lead to a review of these services with the aim of improving occupancy and retention rates.
- 11.6 The national focus on synthetic drugs is likely to continue. As importantly, the initiatives which have been engendered by this focus are as relevant for other drug use as they are for synthetic drug use. Thus, the projects directed at young workers, at drug use and driving, at work with discotheques and in the further development of outreach work and alternative leisure activities are likely to be expanded. The projects proposed for funding through the Regional element of the National Drugs Fund clearly indicate an extension of these areas of activity.
- 11.7 A further area of development is likely to be in work with drug users within the criminal justice and prison systems. The transfer of responsibility for prisoner health care to local health authorities from 2000 is likely to accelerate the trend for increased activity by the Ser.T within local prisons.
- 11.8 The allocation of specific responsibilities for data collection, analysis, strategic planning and service delivery should begin to provide more substantial local data on drug misuse. The need for this data to be collected in a common form in order that national, regional and local trends can be identified is an issue being addressed by the OI DT.
- 11.9 1999 was a year of significant change in drugs misuse field at national and regional levels. It is anticipated that in the next few years the impact of these structural and organisational changes will start to have a positive impact on responses to drug use and drug related problems in Italy.

## PART 4 KEY ISSUES

### 12. DRUG STRATEGIES IN EUROPEAN UNION MEMBER STATES

#### 12.1 *National policies and strategies*

- 12.1.1 At the national level the new legislation, which was described in detail in the last report (OIDT 2000), confirms the role and functions of the National Co-ordination Committee. The Prime Minister chairs the Committee and may delegate this role to the Minister for Social Solidarity. Membership is drawn from the Ministers of Foreign Affairs, of the Interior, of Health, of Labour, of Finance, of Education, of Defence, of Labour, of Universities, Scientific Research and Technology and of Social Solidarity and the relevant Under-Secretary of State to the Prime Minister. Other Ministers may attend where issues relevant to their responsibilities are being discussed.
- 12.1.1 The formal responsibilities of the Committee are:
- To address and promote general policies for prevention and for supply reduction (production and trafficking) at the national and international levels
  - To formulate proposals to the Government for exercising its functions of addressing and co-ordinating activities which are in the competence of the Regions
  - To express its opinion on the actions and measures, within the competence of the Prime Minister (or the Minister for Social Solidarity where delegated) concerning the co-ordination of prevention and treatment activities.
- 12.1.2 The Committee meets as and when required convened by the Committee President or at the request of another Minister. The Secretariat is provided by the Ministry of Social Affairs.
- 12.1.3 A second tier is the Conference of Director Generals whose membership is drawn from all the Ministries and Departments represented in the National Co-ordinating Committee. The function of the Conference is to define the criteria and the modalities for implementing the decisions made by the Co-ordinating Committee. This structural arrangement is intended to provide a clear link between policy and broad strategy and effective implementation across the range of Ministries, rather than leave implementation to individual Ministries operating in isolation.
- 12.1.4 National strategy is concerned with development of a fully integrated system for the prevention of drug use and drug misuse, to reduce the likelihood of drug problems developing and to reduce the risks arising from drug use, to provide appropriate treatment, rehabilitation and social re-insertion programmes for those who have drug problems and to reduce the availability of listed drugs. It also specifically includes the need to evaluate the interventions in order that a basis for future developments can be established.
- 12.1.5 To this end, a specific focus of work during 1999 and into 2000 has been to review the present situation and to identify priority areas for



activity in order that the strategy might be implemented effectively. Law 45/99, the Regulations agreed between the State, the Regions and the Autonomous Provinces and the Decrees establishing arrangements for the allocation and use of the National Drugs Fund together seek to provide the basis for creating this integration.

## 12.2 *Application of national strategies and policies*

- 12.2.1 The National Drugs Observatory (Osservatorio Italiano per la verifica dell'Andamento del Fenomeno delle Droghe e delle Tossicodipendenze - OI DT) has now been established within the Department of Social Affairs. The OI DT is advised by a Scientific Committee of seven people appointed by the Minister for Social Affairs and by an inter-ministerial group established to optimise the flow of information between Ministries and the Regions. The Observatory has initially been concerned to develop its structure, work programme and priority tasks.
- 12.2.2 The OI DT is organised in three sectors:
- Statistical /epidemiological sector
  - Demand reduction sector
  - National Reitox Focal Point
- 12.2.3 For each sector the Department of Social Affairs has utilised leading experts in the relevant field to develop priority work in order that an as complete as possible information base is established from which national policy and guidelines can be developed, the general situation can be monitored and the impact of interventions can be evaluated.
- 12.2.4 The work programme of the OI DT has focused on improving the information base for both the development of policy and strategy and to support drug services in developing their work.
- 12.2.5 The Epidemiology and Statistics Sector has been focused on a new definition of the protocol for data collection from Ministerial, Regional and other relevant sources. The aim has been to create a situation in which aggregated data can be related to individual data. A starting point has been to establish a minimum data set for each individual within the confines of the laws concerned with privacy. The aim is to create a system which will allow cross reference between data on clients in treatment with the Ser.T or with accredited services, data in drug users in prison or subject to an alternative measure, data on arrests for drug law offences and referrals for drug possession, data on drug use in the armed forces, data on social re-insertion and data on drugs seized.
- 12.2.6 To develop this new arrangement, a working group has been established with representatives from the Ministries of Health, Labour, Education, the Interior, Defence and Justice and with a representative of the Regions. Its first task has been to develop Guide Lines for the rationalisation of the flow of data and the identification of new arrangements for this data flow.
- 12.2.7 A second area of activity has been the development of procedures for estimating the prevalence of drug use within the general



population. The first task has been to review data on problematic drug use at the provincial level and to provide a picture of the relative levels of problematic drug use throughout Italy. The results of this are referred to in the epidemiology section of this report. The second task which is now underway is a national population survey, undertaken in collaboration with the National Research Council and using the guidelines and protocols proposed by the EMCDDA.

- 12.2.8 A third area of development has been a pilot project, in conjunction with the Regions, for the creation of Provincial Observatories in order that the collection of data might be further improved.
- 12.2.9 For the Demand Reduction Sector, the focus has been on the creation of a Virtual Library offering ready access to data from a range of sources and covering a number of different fields. This is now on line at [www.bibliotox.it](http://www.bibliotox.it).
- 12.2.10 A second objective has been the creation, within the Virtual Library, of a data bank containing highly specialised material specifically dedicated to the needs of those working in the drugs field. The service will allow them to receive up-dates and material for training and in-depth understanding of specialised issues.
- 12.2.11 The third area of development will be the creation of a data base concerned with the availability of treatment, prevention initiatives and groups active in the drug prevention field and a map of treatment and prevention services based on the EDDRA questionnaire.
- 12.2.12 At the level of individual Ministries, the resources available to them from the National Drugs Fund have primarily been used to develop improved capacity to collect and analyse data and to develop national pilot projects aimed at advancing national strategy. These projects have come from the Ministries of Defence, Education, Health, the Interior, Justice and Labour. Together, they aim to pilot prevention programmes, improve data collection and analysis, build effective links with European initiatives (particularly the EMCDDA and the European Action Plan), develop information and sensibilisation initiatives, develop the competencies of staff working in the drugs field by building specific competencies, carry out health education programmes and improve information sharing and data transmission between central and local administrations.
- 12.2.13 The core of the initiatives at the central government level has been projects to identify and understand new problems arising from drug use, evaluation of new practices and methodologies, the definition of performance standards and strengthening of the evaluation of institutional interventions.
- 12.2.14 Whilst central government has the responsibility for developing strategy and for implementation of the strategy in so far as this concerns establishing the most effective framework and the broad standards and guidelines for interventions, it is for the Regions, local health authorities and the communes to develop specific programmes and interventions which best meet their local situation.
- 12.2.15 As referred to earlier in this report, the Regulations approved by the Permanent Conference for Relations between the State, the Regions

and the Autonomous Provinces established the new basis for planning and implementation of the agreed national strategies at the Regional level.

- 12.2.16 Responsibility within the Regions is usually located within the Health Department or the Social Policy Department. Each Regional Department is headed by a member of the Regional Council and by a Director. Within the relevant Department there is Director for Drug Services who has responsibility for the development and implementation of Regional strategy and its implementation.
- 12.2.17 Under the new Regulation, Regions are responsible for developing and implementing Regional plans for prevention, treatment and rehabilitation and for establishing arrangements which provide the optimum situation for the delivery of interventions. They also have responsibility for accrediting services, ensuring the availability of training and for establishing the rules for control, verification and evaluation of interventions.
- 12.2.18 The local health authority, drawing on national objectives and based on the Regional plan, is responsible for developing a local plan and its implementation, including gathering and analysing epidemiological data, effective co-ordination of all interventions and ensuring the minimum quality standards are met.
- 12.2.19 By allocating the responsibilities for policy and planning with the Region and for implementation, data collection and control with the health authority, the aim has been to ensure that interventions are relevant to local needs and that they are part of an overall, integrated response.
- 12.2.20 To support planning and implementation, many Regions have developed their own observatory which acts as the scientific reference point for the Region. [Frattoni \(2000\)](#) and [Ugolini \(2000\)](#) are examples of the kind of documentation which can be provided through these observatories whilst [Macchia and Giannotti \(2000\)](#) contain reports from many Regional Drug Dependence Offices about the epidemiology of and interventions on synthetic drugs.
- 12.2.21 Regional advisory committees have also operated, for instance, to assess proposals submitted to the Region for financing through the National Drugs Fund allocation to the Region. Local health authorities have also established committees, both internal and external, to advise and assist in local planning, co-ordination and implementation.
- 12.2.22 Communes and, to a much lesser degree, Provinces have also been involved in providing or supporting interventions. In particular, they have supported prevention initiatives at primary and secondary levels, youth service provision, outreach work with disadvantaged people and social re-integration projects. In a number of Communes, local advisory committees have been established to advise on and support the implementation of local initiatives.
- 12.2.23 The new structure and responsibilities, which are still being put into place, seek to overcome some of the problems which have arisen from an earlier lack of clarity or from planning and delivery

responsibilities being placed within the same organisation. Those Regions which had an observatory or which had already established a basis for quality standards have been able to make more rapid progress. However, for all Regions, the need to consult, to develop the Regional objectives and strategies and for local health authorities the need to develop integrated implementation plans has taken time. From reports submitted for inclusion in the Annual Report to Parliament ([Social Affairs 2000](#)) it is clear that Regional planning has been focused on establishing the essential information frameworks and promoting specific services and interventions aimed at improving the balance of responses to cover prevention, treatment and rehabilitation and social re-insertion.

### 12.3 *Evaluation of national strategies*

12.3.1 Given that the new arrangements are only now becoming fully operational, it is too early for any evaluation to be undertaken. However, within the competence of the OI DT is analysis and interpretation of data and analysis of policies in the drugs field. It will, therefore, fall to the OI DT to establish the methodologies for evaluation and the priority to be attached to overall or specific evaluations.

## 13. COCAINE AND BASE/CRACK COCAINE

### 13.3 *Different patterns and users groups*

13.1.1 There is limited information available about the different patterns of use and different user groups of cocaine in Italy. A search of the bibliographic data base of Gruppo Abele found only one report with a specific focus on cocaine or crack use in Italy entered in 1999. The majority of information, therefore, is drawn from published reports concerned with other aspects of the drug problem but where cocaine or crack is mentioned.

13.1.2 The ESPAD Study found that whilst there had been an increase in the number of students who had tried cocaine or crack at least once in their life, it still represented a relatively small population. More surprising is the fact that a larger percentage reported lifetime cocaine use than reported lifetime use of ecstasy or amphetamines ([Table 5](#)). Age of first use of cocaine appears to be later than for licit drugs ([Table 6](#)). The data from the Ministry of Defence on drug use in the armed forces also shows cocaine to be more frequently reported than amphetamine or its analogues ([Table 7](#)).

13.1.3 Both these data sets are concerned with general populations and appear to reflect a broad pattern of casual or occasional drug use in which cocaine is as likely to be used as amphetamine or ecstasy.

13.1.4 A study commissioned by the Italian Federation of services to the public (bars, pubs, etc) (FIPE) and the Union of Dance Hall Operators (SILB) and carried out by CIRM looked at 615 people between the ages of 15 and 40. This found that men were more likely to use drugs than women. Cannabis and cocaine were the preferred drugs for the older groups whilst synthetic drugs were preferred by the younger age groups.

- 13.1.5 Project AMR (Multi-risk approach), a collaboration between the National Institute of Health and the Ministry of Public Works has been concerned with the epidemiology and prevention of road accidents. It began in 1998 and has based its work on students in the middle and upper schools with the aim of understanding risk behaviours and their relationship to road accidents. It has now encompassed six Regions and 51 schools in nine distinct areas.
- 13.1.6 Of the 7,125 young people in the study, 52.3% were male and 47.7% female. The mean age was 16.3. 25% of the young people said that they were using or had used drugs and of these, 20% (5.1% of the total) used cocaine. This was higher than the percentage declaring use of ecstasy (4.1% of the total). The study has also found that 85% of those using drugs did so in combination with the use of alcohol ([Macchia 2000](#) p.29).
- 13.1.7 A special study of calls for help or advice to Drogatel, undertaken in the context of the national project concerned with synthetic drugs, found that 123 callers (44.6%) had used cocaine at least once, second only to cannabis, with 135 callers (48.9%). Even more interesting was the finding that the drug most commonly used was cocaine (37.3%), which was higher than use of cannabis (35.1%) or ecstasy (15.9%) ([Macchia 2000](#) p.11).
- 13.1.8 A study in the Lazio Region ([Macchia 2000](#) p.120-4), also in the context of a project concerned with the use of synthetic drugs, confirmed data from other sources. Some 10 projects participated in a study undertaken in the second half of 1999 and data was recorded for 3,016 adolescents contacted by the projects. Two groups were identified, 1,674 contacted through street work and 1,342 contacted within schools. The 'street' contacts were slightly older (mean age 18 compared to 16 for the 'school' contacts) and more likely to be male (59.1% to 52.4%). There was little difference between the 'street' and 'school' groups in the educational qualifications of the parents.
- 13.1.9 There were more significant differences between the two groups in terms of smoking and drinking alcohol. The 'school' group was much more likely to not smoke and to not drink and where they did smoke and drink alcohol, consumption was occasional or moderate. These differences were also reflected in use of drugs. 29.5% of the 'street' contacts has tried cocaine at least once and 23.1% had used it in the last three months. By contrast, only 6% of the 'school' contacts had tried cocaine and only 5.4% had tried it in the last three months. What is noticeable from this study, supporting findings from different studies around the country, is that cocaine use was more prevalent than use of any drug other than cannabis.
- 13.1.10 Taken together, the data suggests that cocaine use may be more prevalent in Italy than use of synthetic drugs both in terms of lifetime use and in terms of more regular use. In general, cocaine use appears to be more prevalent amongst young people in the over 20 years age group but even amongst younger age groups, cocaine use is more prevalent than use of any drug other than cannabis.
- 13.1.11 Although there is some reference to crack cocaine in the reports, there appears to be little evidence that crack has gained any

popularity. However, since there have been few, if any studies focused on cocaine use, a fuller picture of prevalence, frequency of use and user groups is difficult to provide.

### 13.2 *Problems and needs for services*

13.2.1 As for the previous section, there is limited published data available about problems related to the use of cocaine and the need for services. What data is available arises from general epidemiological reports rather than specific studies with regard to cocaine.

13.2.2 [Maps 16 - 18](#) show the percentage of clients of the Ser.T reporting primary use of cocaine in 1997, 1998 and 1999, whilst [Maps 19 - 21](#) show secondary use of cocaine for the same period.

13.2.3 What is noticeable from these maps is an increase throughout Italy in primary use of cocaine amongst clients attending the Ser.T. In particular, Lombardia, Molise and Puglia show a very rapid increase in primary cocaine use as well as rapid increase in secondary cocaine use. There may be a correlation between supply routes and the level of primary cocaine use.

13.2.4 In terms of mode of use, for those whose primary drug is cocaine there has been a marked reduction in the percentage who take the drug by injection. In 1997, 21.2% of primary cocaine users in treatment with the Ser.T injected, but this had fallen to 14.5% in 1999.

13.2.5 This trend is not necessarily reflected in the experience reported by outreach projects. In these reports, Italian drug users contacted by street projects were increasingly found to be using cocaine and usually by injection. By contrast, non-Italian drug users whilst using cocaine rarely injected, apparently for cultural and/or religious reasons ([Social Affairs 2000, p 138](#)). [Secchi](#) et al (2000), reporting on the work of the street project in Brescia, noted that of 441 drug dependents contacted during 1999, 160 (36.2%) used cocaine but for only 22 people (5%) was cocaine their unique drug.

13.2.6 The difference between the prevalence of cocaine use found in various studies and the prevalence of problematic drug use in relation to treatment demand at the Ser.T appears to be greater than might be expected. This is particularly so given that in the study of drug related deaths by the Forensic Toxicologists Group of the Italian Society of Legal Medicine found that 35 (5.8%) of the deaths they identified were caused solely by cocaine and that it was associated with 130 (32.4%) of 401 deaths where drugs were an associated factor ([Figures 24 and 26](#)) ([Social Affairs 2000 pp. 122 - 124](#)).

13.2.7 The picture which emerges, therefore, is of an increasing prevalence of cocaine use, indications of an increasing prevalence of problematic use but a slower increase in the number of people receiving treatment at the Ser.T where cocaine was their primary drug. This suggests that the concentration on heroin misuse, along with substitute prescribing, may have acted as a deterrent to cocaine users. The re-organisation of treatment provision and the requirement for a wider range of intervention options is expected to result in changes which could well lead to a higher number of people with cocaine related problems seeking help from the Ser.T.



### 13.3 Market

- 13.3.1 There is no current information published about local cocaine markets or about local supply systems. Information has been taken from data prepared by the Ministry of the Interior ([DCSA 2000](#)) or from the Department for Social Affairs ([Social Affairs 2000](#)).
- 13.3.2 The number of people referred to the Prefect for possession of cocaine has increased each year. Between 1997 and 1998 there was a 5.8% rise (2,302 to 2,436) and between 1998 and 1999 there was a 15.6% rise (2,436 to 2,815). It is the only drug which has shown a consistent increase in possession referrals over this period and supports all other evidence which suggests that cocaine use has become established throughout Italy.
- 13.3.3 There has also been a continuing increase in the number of referrals to the Judicial Authorities for drug law offences involving cocaine. [Maps 22 and 23](#) show the referral rate per 10,000 population for the Regions of Italy in 1998 and 1999. Lazio and Liguria have the highest prevalence rates followed by Toscana and Emilia Romagna. In general, the northern and central Regions have considerably higher prevalence rates than the southern and island Regions. This is a little surprising given the percentage of clients of the Ser.T reporting primary use of cocaine in Molise and Puglia and a general rise in all the southern and island Regions (except Sardegna) in primary cocaine use ([Maps 16 - 18](#)). This would suggest that there are established local supply systems for cocaine which at present have not been disrupted as a result of law enforcement activity.
- 13.3.4 Data is only available on the upper and lower price levels for cocaine at street level. No information is readily available on purity at street level. The price levels are generated from data recorded by police forces in 12 Italian cities (Palermo, Reggio Calabria, Napoli, Bologna, Venezia, Firenze, Torino, Trieste, Roma, Genova, Milano, Verona) during the year and averaged to create upper and lower limits. In 1999, the price for a gram of cocaine was between 92.96 and 134.8 Euro (180,000 - 261,000 lire). No comparative figures for previous years is available. However, it may not be unreasonable to assume that the price has remained stable or fallen in real terms given the various indicators which suggest increasing availability and levels of use.
- 13.3.5 Since 1993, the quantity of cocaine seized has always been substantially greater than the quantity of heroin seized. What is less clear is whether this is due to a larger market for cocaine, seizure of drugs in transit and not necessarily destined for the Italian market or more successful policing of cocaine supply than of heroin.
- 13.3.6 The location of cocaine seizures changed between 1998 and 1999. In 1998 67% of seizures occurred within Italy and 29% at airports. In 1999, only 30% of seizures occurred within Italy and 18% at airports whilst half of all seizures occurred at sea frontiers. In 1998 the most significant seizures occurred in Lazio whilst in 1999 they occurred in Lombardia.

13.3.7 Trafficking routes are predominantly direct from South American countries to Italy, with Colombia, Venezuela, Brazil and Ecuador being the main ones. Spain and, to a lesser degree, The Netherlands are the main transit countries within Europe.

#### 13.4 *Intervention projects*

13.4.1 There are no reports on projects which have a focus specifically on cocaine. Rather, projects have been focused on synthetic drugs (which have often included cocaine within their broad remit) or on casual/ occasional use of drugs in recreational settings. Cocaine misuse has not generally been recognised as a major issue and is only now being acknowledged as requiring attention.

### 14. INFECTIOUS DISEASES

#### 14.1 *Prevalence and incidence of HCV, HBV and HIV among drug users*

14.1.1 At the national level, the prevalence and incidence of HIV infection amongst drug users in treatment with the Ser.T has been declining over the last five years. The prevalence of Hepatitis B infection has remained broadly stable over the same period. The prevalence of Hepatitis C infection has also remained broadly stable for the three years in which data has been collected.

14.1.2 [Tables 19 to 24](#) show male and female clients of the Ser.T with regard to drug related infectious diseases over the last three years. The percentage of clients testing positive for an infection has declined annually for both new and existing clients. However, there has also been a decline in the percentage of clients with negative test results and an increase in the percentage of people not tested. For existing clients this is likely to reflect the fact that they had already been tested. For new clients it may reflect a lower percentage who inject drugs and who are, therefore, considered to be less at risk to infection.

14.1.3 For all drug related infections, new clients of the Ser.T are less likely to have a positive test result than existing clients and female drug users, both new and existing clients, are more likely to test positive than their male counterparts. The [NISDA \(1999\)](#) study suggests that this may be an indication of sexual transmission based on the fact that women were more sexually exposed than men and a higher proportion of women in the study were sexually active than the proportion of sexually active men.

14.1.4 There are substantial regional variations in the percentage of clients of the Ser.T who test positive for a drug related infection. [Table 25](#) shows the total number of tests conducted for each of the last five years and the percentage of clients of the Ser.T testing positive by Region. [Maps 24 - 32](#) provide a graphic representation of the patterns of infection over the last three years. For all infections, the southern Regions have a lower percentage of clients of the Ser.T testing positive compared to the northern and west central Regions. The exception is Sardegna, where there has been an increase in the percentage of clients testing positive for all infections for over the last



three years. This seems to suggest a situation in 1996 which resulted in an increase in infections.

- 14.1.5 For some other Regions, there are substantial fluctuations in the percentage of clients testing positive for Hepatitis B and C from year to year. This may suggest changes in testing policy and in the number of tests carried out rather than true changes in the level of infection. Another possibility is that the through flow of clients may differ significantly between Regions and from year to year. Given that there appears to be a lower level of infection amongst new clients, a large influx of new clients in any one year could have an impact on the percentage of clients testing positive.
- 14.1.6 A second source of information about HIV infection in drug dependents is data from the Ministry of Justice on prisoners. In 1999, out of a total prison population of 51,604, 1,638 (3.17%) were HIV positive, with 1,089 asymptomatic, 386 symptomatic and 163 with AIDS related illnesses. 84.37% (1,382) of those identified as HIV positive were drug dependent at entry into prison, representing 9.15% of the drug dependent prison population. What cannot be assessed from the current data is how many of the drug dependent prisoners were in treatment when they were sentenced.
- 14.1.7 Looking at data reported by street projects ([Social Affairs 2000 pp. 137-138](#)), 21% of those contacted were not currently in treatment and they had significant problems, including frequent imprisonment. It may well be, therefore, that levels of infection may be higher in this population than in those already in treatment or prepared to enter treatment.

## 14.2 *Determinants and consequences*

- 14.2.1 The [NISDA](#) (1999) study suggests that the focus on risk reduction during the early part of the 1990s had an important impact on the incidence of HIV infection amongst injecting drug users. It noted, however, that exchange of injecting equipment was declining and that there appeared to be increased sexual transmission of infection especially amongst sexually active women drug users.
- 14.2.2 For those in treatment with the Ser.T or with private socio-rehabilitative services, the evidence suggests that risk behaviours in terms of injecting practices have been substantially modified over the years. The incidence of HIV infection, and its prevalence, have been declining amongst the population of those in treatment and in new clients of the Ser.T. This is also true for Hepatitis B and C infection, but the rate of decline has been considerably slower. This might suggest that the spread of infection, whilst initially related to injecting practices, is now also related to sexual behaviour and general living circumstances.
- 14.2.3 For those outside treatment, even if they have previously received treatment, risk behaviours remain a serious concern. The data from street projects ([Social Affairs 2000](#)) suggest that sharing injection equipment and high risk sexual behaviour continue, along with multiple drug use and high risk of overdose. Moreover, around one in seven of those contacted are non-Italians, primarily from the maghreb

countries and central Africa, who may have problems in using existing treatment services either because of their illegal status or because of linguistic and/or cultural difficulties.

- 14.2.4 The evidence from these projects is particularly important because of the gap between first use of heroin and first approach for treatment. This is around five years and in this period the 'inexperienced' user is most exposed to the risk of infection, accidental overdose and other risk behaviours. There is evidence that the contact through street projects can reduce risk behaviour as well as reduce the gap between first use and first treatment and help retain people within treatment ([Pavarin and Salsi 1999](#)).
- 14.2.5 [Secchi](#) et al (2000) reported on data for 268 people contacted through the street project in Brescia. One fifth engaged in unsafe sex, 8.9% shared injection equipment and 3.7% had unsafe sex and shared injection equipment. However, the report also noted an increasing percentage of contacts for whom self-declared information on risk behaviour was not available. The limited data available from new contacts found that they were more likely to share injecting equipment.
- 14.2.6 In the reports published on risk behaviour or on the work of street projects, the focus has been consistently on HIV transmission. Hepatitis B or C infection is rarely mentioned. Whilst much of the risk behaviour associated with the transmission of HIV infection is equally relevant to the transmission of Hepatitis infection, there are additional considerations which might need to be addressed, given the much higher levels of Hepatitis infection.

### 14.3 *New developments and uptake of prevention, harm reduction, care*

- 14.3.1 The main new developments with a potential impact on the spread of drug related infectious diseases have been activities focused on synthetic drugs, in particular, the use of these drugs on an occasional or casual basis. Otherwise, widely recognised harm reduction approaches have been in operation, for instance, provision of sterile injecting equipment, advice and information on how to avoid becoming infected or transmitting infection, etc.
- 14.3.2 The national project on synthetic drugs ([Macchia and Giannotti 2000](#)) and services involved with the Coordinamento Nazionale Nuove Droghe ([CNND 2000](#)) have paid particular attention to the risks associated with drug experimentation and with unsafe sex especially when under the influence of drugs and/or alcohol. The national anti-drugs campaign, focused on synthetic drugs, includes advice on safe sex and warns of the danger of unprotected sex for the transmission of HIV and Hepatitis. This has been echoed in local campaigns, for example [Tedici et al](#) (1999), who report on prevention work at a large discotheque attended by around 1,200 young people each Saturday night. Advice about safe sex and the provision of condoms was one of the elements of the activities carried out by the project.
- 14.3.3 The protocol agreed between the Government and the Union of Dance Hall Operators (Sindacato Imprenditori dei Locali da Ballo - SLIB) in December 1999 strengthened the general approach to prevention of

both drug use and the development of drug related problems, including infectious diseases, within the context of the discotheque. It has resulted in an ever-increasing number of projects focused on youth leisure settings, especially discotheques.

- 14.3.4 There is no national data readily available on the uptake at the local level of prevention and intervention services aimed at containing and reducing the spread of drug related infectious diseases. Both [Pavarin and Salsi](#) (1999) and [Secchi et al](#) (2000) report on the work of street projects. In Bologna during the first half of 1998, 11,102 syringes were distributed and 2,972 condoms. In Brescia in 1999, 103,754 syringes were distributed and 78,558 were collected, an exchange rate of 76%. In the same period, 14,001 condoms were distributed. The data from Brescia also reports on a continued reduction in the number of used syringes abandoned in public places from 14,693 in 1997 to 11,837 in 1999.
- 14.3.5 The data from the two cities, Bologna and Brescia, show different approaches in that the former had a focus on distribution and exchange of injection equipment was relatively rare whilst in the latter, the focus was on exchange of equipment with a relatively high level of exchange. The concern with the risks to the wider population from abandoned injection equipment is an important development and is indicative of increased awareness about the wider social consequences of drug misuse in addition to the specific consequences for individual drug misusers.
- 14.3.6 Within the Ser.T there has been a gradual increase in the number of clients vaccinated against Hepatitis B ([Tables 21 and 22](#)). However, there is no information available about the basis for selecting clients for vaccination.
- 14.3.7 Overall, there have been few new developments or strategies in responding to the prevention or treatment of drug related infectious diseases. HIV has remained the major focus and little literature has been published concerning infection with Hepatitis B or C amongst drug users. The main initiatives have been to include the issue of the transmission of infectious diseases within the framework of prevention activity concerned with synthetic drug use.

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| Comunità "Massimo"  | <a href="http://www.monasterolanuvio.it/inter.htm">http://www.monasterolanuvio.it/inter.htm</a>   |
| Fondazione Villa Maraini  | <a href="http://www.villamaraini.it">http://www.villamaraini.it</a>   |
| La Promessa - onlus   | <a href="http://www.lapromessa.org">http://www.lapromessa.org</a>   |
| <b>Liguria</b>  | <a href="http://www.regione.liguria.it">http://www.regione.liguria.it</a>   |
| Centro di Crescita Comunitaria, La<br>Spezia  | <a href="http://www.infinito.it/utenti/ceislaspezia">http://www.infinito.it/utenti/ceislaspezia</a>   |
| <b>Lombardia</b>  | <a href="http://www.regione.lombardia.it">http://www.regione.lombardia.it</a>   |
| Centro "Gulliver"   | <a href="http://www.gulliver-va.it">http://www.gulliver-va.it</a>   |
| Centro Terapeutico Riabilitativo<br>Territoriale                                    | <a href="http://www.geocities.com/MadisonAvenue/Boardroom/3307/asl.html">http://www.geocities.com/MadisonAvenue/Boardroom/3307/asl.html</a> |
| La comunità Casa del Giovane  | <a href="http://www.cdg.it">http://www.cdg.it</a>   |
| CREST   | <a href="http://www.crest.it">http://www.crest.it</a>   |

|   |   |
|---|---|
| ECCAS   | <a href="http://www.asl.bergamo.it/web/intsert.nsf/pages/Homepage">http://www.asl.bergamo.it/web/intsert.nsf/pages/Homepage</a> |
| EXODUS  | <a href="http://www.exodus.it">http://www.exodus.it</a>   |
| Associazione Comunità "IL GABBIANO" onlus                               | <a href="http://space.tin.it/associazioni/ropoten">http://space.tin.it/associazioni/ropoten</a>                                 |
| inSERT  | <a href="http://www.droga.net">http://www.droga.net</a>   |
| Tetto Fraternalo a.r.l.   | <a href="http://www.pegacity.it/informa/case/4375/index.htm">http://www.pegacity.it/informa/case/4375/index.htm</a>             |
| <b>Marche</b>   | <a href="http://www.regione.marche.it">http://www.regione.marche.it</a>   |
| AVAPA   | <a href="http://www.studiofabbri.com/avapa">http://www.studiofabbri.com/avapa</a>   |
| Il Ponte, Cooperativa di Solidarietà Sociale                            | <a href="http://www.advcom.it/ilponte/default.htm">http://www.advcom.it/ilponte/default.htm</a>                                 |
| <b>Molise</b>   | <a href="http://www.molisedati.it">http://www.molisedati.it</a>   |
| <b>Piemonte</b>   | <a href="http://www.regione.piemonte.it">http://www.regione.piemonte.it</a>   |
| Comunità Terapeutica Saint Jacques                                      | <a href="http://www.freeweb.org/associazioni/saintjacques">http://www.freeweb.org/associazioni/saintjacques</a>                 |
| Cyber Pupazza   | <a href="http://space.tin.it/associazioni/ileoncin">http://space.tin.it/associazioni/ileoncin</a>                               |
| Associazione Fides  | <a href="http://web.tiscalinet.it/Fides">http://web.tiscalinet.it/Fides</a>   |
| Gruppo Abele  | <a href="http://www.gruppoabele.it">http://www.gruppoabele.it</a>   |
| Gruppo "Arco"   | <a href="http://www.arpnet.it/arco">http://www.arpnet.it/arco</a>   |
| Dr. Franco MORETTI  | <a href="http://users.iol.it/fm_psy">http://users.iol.it/fm_psy</a>   |
| Sert ASL 14 Verbano Cusio Ossola  | <a href="http://www.asl14piemonte.it/Sert/index.htm">http://www.asl14piemonte.it/Sert/index.htm</a>                             |
| <b>Puglia</b>   | <a href="http://www.regione.puglia.it">http://www.regione.puglia.it</a>   |
| Cooperativa Sociale C.A.P.S.  | <a href="http://caps.freeweb.org">http://caps.freeweb.org</a>   |
| F.A.C.T.  | <a href="http://digilander.iol.it/Arpi">http://digilander.iol.it/Arpi</a>   |
| Gruppo SIMS SAVA (TA)   | <a href="http://www.geocities.com/simssava">http://www.geocities.com/simssava</a>   |
| <b>Sardegna</b>   | <a href="http://www.regione.sardegna.it">http://www.regione.sardegna.it</a>   |
| Associazione di Volontariato - Centro di Accoglienza "Don Vito Sguotti" | <a href="http://AssociazioneDiVolont.freeweb.org">http://AssociazioneDiVolont.freeweb.org</a>                                   |
| Associazione Mondo X - Sardegna   | <a href="http://web.tiscalinet.it/mondoxsardegna">http://web.tiscalinet.it/mondoxsardegna</a>                                   |
| Univerità di Cagliari, Dipartimento di Neuroscienze                     | <a href="http://vaxca1.unica.it/~saramu/new">http://vaxca1.unica.it/~saramu/new</a>   |
| <b>Sicilia</b>  | <a href="http://www.regione.sicilia.it">http://www.regione.sicilia.it</a>   |
| <b>Toscana</b>  | <a href="http://www.regione.toscana.it">http://www.regione.toscana.it</a>   |
| Associazione Genitori Comunità Incontro                                 | <a href="http://www.zen.it/agci">http://www.zen.it/agci</a>   |
| Associazione Insieme  | <a href="http://www.odissea.it/coorATanas/insieme.htm">http://www.odissea.it/coorATanas/insieme.htm</a>                         |
| Centro di Solidarietà di Prato  | <a href="http://www.comune.prato.it/associa/centsol">http://www.comune.prato.it/associa/centsol</a>                             |
| Fides Associazione  | <a href="http://web.tiscalinet.it/Fides">http://web.tiscalinet.it/Fides</a>   |
| Il Gabbiano   | <a href="http://space.tin.it/associazioni/ropoten">http://space.tin.it/associazioni/ropoten</a>                                 |
| Gruppo SIMS   | <a href="http://www.sims.it">http://www.sims.it</a>   |
| <b>Trentino Alto Adige</b>  | <a href="http://www.regione.taa.it">http://www.regione.taa.it</a>   |
| CSDPA   | <a href="http://www.irsrs.tn.it/csdpa">http://www.irsrs.tn.it/csdpa</a>   |
| <b>Umbria</b>   | <a href="http://www.regione.umbria.it">http://www.regione.umbria.it</a>   |
| C.A.S.T.  | <a href="http://www.freeweb.org/freeweb/cast">http://www.freeweb.org/freeweb/cast</a>   |
| <b>Valle D'Aosta</b>  | <a href="http://www.regione.vda.it">http://www.regione.vda.it</a>   |

|                                  |   |
|----------------------------------|---|
| <b>Veneto</b>                    | <a href="http://www.regione.veneto.it">http://www.regione.veneto.it</a> |
| ASL Vicenza, Piani di Zona       | <a href="http://www.pianodizonavi.org">http://www.pianodizonavi.org</a> |
| CBFT                             | <a href="http://apf.cbft.unipd.it">http://apf.cbft.unipd.it</a>         |
| Centro "Don Lorenzo Milani"      | <a href="http://www.ceisdonmilani.com">http://www.ceisdonmilani.com</a> |
| Centro di Solidarietà di Belluno | <a href="http://www.sunrise.it/ceis">http://www.sunrise.it/ceis</a>     |
| Evelink                          | <a href="http://www.evelink.org">http://www.evelink.org</a>             |
| Temerari                         | <a href="http://www.temerari.it">http://www.temerari.it</a>             |
| Progetto Teseo                   | <a href="http://www.sert2-pd-it.com">http://www.sert2-pd-it.com</a>     |

## ANNEXES

### ➤ **Drug monitoring systems and sources of information**

Italian Observatory for Drugs and Drug Dependence

Ministry of Health, Health Information System

Ministry of the Interior, Central Directorate for Anti-Drug Services

Ministry of the Interior, Central Directorate for Documentation

National Institute of Health (ISS)

National Statistics Institute (ISTAT)

Ministry of Education

Ministry of Justice

Ministry of Defence

Regional Councils

Health Authorities

Research Institutes

Universities

Private Social Organisations

## Tables

**Distribution (%) by Region of the resident population and of the number of drug dependents in treatment with the Ser.T, the average for each element and allocation of the National Drugs Fund for the years 1997, 1998 and 1999**

| REGION  | 1                       | 2   | 3             |                        |
|---|-------------------------|---|---------------|------------------------|
|   | RESIDENT POPULATION (1) | N. OF DRUG DEPENDENTS IN TREATMENT WITH SER.T (2) | MEDIA (3)     | TOTAL                  |
|   | %                       | %   | %             | V.A.                   |
| PIEMONTE  | 7,46                    | 10,41   | 8,93          | <b>42.525.441.000</b>  |
| VALLE D'AOSTA   | 0,21                    | 0,26  | 0,23          | <b>1.095.290.000</b>   |
| LIGURIA   | 2,85                    | 2,00  | 2,42          | <b>11.524.251.000</b>  |
| LOMBARDIA   | 15,62                   | 14,81   | 15,22         | <b>72.478.971.000</b>  |
| PROV. AUT. TRENTO   | 0,81                    | 0,39  | 0,60          | <b>2.857.252.000</b>   |
| PROV. AUT. BOLZANO  | 0,79                    | 0,26  | 0,53          | <b>2.523.906.000</b>   |
| VENETO  | 7,76                    | 7,55  | 7,66          | <b>36.477.590.000</b>  |
| FRIULI V.G.   | 2,06                    | 1,84  | 1,95          | <b>9.286.070.000</b>   |
| EMILIA ROMAGNA  | 6,86                    | 6,67  | 6,76          | <b>32.191.711.000</b>  |
| MARCHE  | 2,52                    | 2,52  | 2,52          | <b>12.000.460.000</b>  |
| TOSCANA   | 6,13                    | 7,02  | 6,57          | <b>31.286.914.000</b>  |
| UMBRIA  | 1,44                    | 2,36  | 1,90          | <b>9.047.966.000</b>   |
| LAZIO   | 9,11                    | 8,73  | 8,92          | <b>42.477.820.000</b>  |
| CAMPANIA  | 10,07                   | 9,08  | 9,58          | <b>45.620.798.000</b>  |
| ABRUZZO   | 2,22                    | 2,53  | 2,37          | <b>11.286.147.000</b>  |
| MOLISE  | 0,57                    | 0,42  | 0,50          | <b>2.381.043.000</b>   |
| PUGLIA  | 7,11                    | 10,05   | 8,58          | <b>40.858.710.000</b>  |
| BASILICATA  | 1,06                    | 0,70  | 0,88          | <b>4.190.637.000</b>   |
| CALABRIA  | 3,60                    | 2,52  | 3,06          | <b>14.571.987.000</b>  |
| SICILIA   | 8,87                    | 5,93  | 7,40          | <b>35.239.447.000</b>  |
| SARDEGNA  | 2,89                    | 3,95  | 3,42          | <b>16.286.339.000</b>  |
| <b>TOTAL ITALY</b>  | <b>100,00</b>           | <b>100,00</b>                                     | <b>100,00</b> | <b>476.208.750.000</b> |
| 1) SOURCE: DATA FROM ISTAT AT THE 31 DECEMBER 1997                          |                         |   |               |                        |
| 2) SOURCE: DATA FROM THE NATIONAL DRUGS OBSERVATORY AT THE 31 DECEMBER 1997 |                         |   |               |                        |
| 3) WEIGHTING: 50% FOR EACH OF THE TWO ELEMENTS                              |                         |   |               |                        |

TABLE 1



## Projects Proposed by Ministries

| Ministry  | Total Funds Allocated | Average per project | Type of Project |                  |                              |                         |           |   | TOTAL     |
|---|-----------------------|---------------------|-----------------|------------------|------------------------------|-------------------------|-----------|---|-----------|
|   |                       |                     | Prevention      | Health Education | Data collection & evaluation | Information & awareness | Training  | Data transfer between central/local administrations |           |
| Labour  | 10.725.100            | 119.168             | 9               |                  |                              |                         |           |   | 9         |
| Interior  | 4.851.000             | 97.020              |                 |                  | 2                            | 1                       | 2         |   | 5         |
| Interior  | 1.161.600             | 14.520              | 1               |                  | 4                            | 1                       | 2         |   | 8         |
| Defence   | 681.000               | 34.050              | 1               |                  |                              | 1                       |           |   | 2         |
| Defence   | 4.662.210             | 233.111             |                 | 1                |                              | 1                       |           |   | 2         |
| Education                                       | 47.086.000            | 588.575             | 2               | 4                |                              |                         | 2         |   | 8         |
| Health  | 16.585.000            | 61.426              | 1               | 3                | 17                           | 1                       | 4         | 1   | 27        |
| Health  | 11.750.000            | 90.385              | 3               | 1                | 8                            |                         | 1         |   | 13        |
| Justice   | 34.202.292            | 310.930             | 1               |                  | 2                            | 2                       | 6         |   | 11        |
| Justice   | 2.011.600             | 50.290              | 1               | 1                | 2                            |                         |           |   | 4         |
| <b>TOTAL</b>                                    | <b>133.715.802</b>    | <b>150.242</b>      | <b>19</b>       | <b>10</b>        | <b>35</b>                    | <b>7</b>                | <b>17</b> | <b>1</b>  | <b>89</b> |
| Projects as a percentage of all projects funded |                       |                     | 21,3            | 11,2             | 39,3                         | 7,9                     | 19,1      | 1,1   | 100,0     |
| Source: Department of Social Affairs            |                       |                     |                 |                  |                              |                         |           |   |           |

TABLE 2

## Allocation of National Drugs Fund by Type of Applicant

|                              | Proposed   |            | Funded     |            | Rejected   |            | Amount                 |            | Av. / project      |
|------------------------------|------------|------------|------------|------------|------------|------------|------------------------|------------|--------------------|
|                              | No         | %          | No         | %          | No         | %          | Lire                   | %          | Lire               |
| Local Authorities            | 237        | 24,3       | 201        | 24,1       | 36         | 25,9       | 30.859.000.000         | 24         | 153.527.360        |
| Local Health Authorities     | 383        | 39,3       | 346        | 41,4       | 37         | 26,6       | 47.255.000.000         | 37         | 136.575.140        |
| Private Social Organisations | 354        | 36,3       | 288        | 34,5       | 66         | 47,5       | 48.110.000.000         | 38         | 167.048.610        |
| <b>Total</b>                 | <b>974</b> | <b>100</b> | <b>835</b> | <b>100</b> | <b>139</b> | <b>100</b> | <b>126.224.000.000</b> | <b>100</b> | <b>151.160.470</b> |

Source: Department of Social Affairs

TABLE 3

## The Spread of Drug Use: Comparative Analysis

|  | ESPAD 1995 % | ESPAD 1999 % |
|--|--------------|--------------|
| Consumption of alcohol in the last 12 months | 83           | 86           |
| Being drunk in the last 12 months            | 35           | 39           |
| Smoked cigarettes - ever                     | 64           | 70           |
| Smoked cigarettes in the last 30 days        | 36           | 45           |
| Used cannabis - ever                         | 19           | 33           |
| Used other illicit drugs - ever              | 8            | 10           |
| Used tranquillisers / sedatives - ever       | 11           | 8            |
| Used alcohol and pills - ever                | 6            | 4            |

Source: ESPAD Project, Italian data

TABLE 4

## Percentage of people reporting use in their life of:

|                              |      |                              |     |
|------------------------------|------|------------------------------|-----|
| Alcohol                      | 86.5 | LSD                          | 3.4 |
| Tobacco                      | 70.4 | Amphetamine                  | 3.1 |
| Been intoxicated             | 52.7 | Ecstasy                      | 3.1 |
| Cannabis                     | 33.3 | Heroin (smoked)              | 3.1 |
| Alcohol and cannabis         | 22.3 | Hallucinogenic mushrooms     | 1.6 |
| Sedatives and tranquillisers | 7.4  | Heroin other than by smoking | 0.8 |
| Inhalants                    | 6.4  | Anabolic steroids            | 0.7 |
| Cocaine                      | 4.8  | Crack                        | 0.7 |
| Alcohol together with pills  | 3.9  | Drugs by injection           | 0.2 |

Source: ESPAD Project, Italian data

TABLE 5

**Age of First Use**

|                                   | 11 or less | 12  | 13  | 14  | 15  | 16 or more |
|-----------------------------------|------------|-----|-----|-----|-----|------------|
| Drank beer                        | 18         | 14  | 16  | 17  | 10  | 8          |
| Drank wine                        | 23         | 11  | 12  | 12  | 8   | 7          |
| Drank spirits                     | 5          | 7   | 10  | 15  | 14  | 14         |
| Being drunk                       | 1          | 2   | 5   | 12  | 14  | 18         |
| Smoked first cigarette            | 7          | 11  | 13  | 17  | 12  | 10         |
| Smoked cigarettes daily           | 0.5        | 2   | 4   | 10  | 9   | 12         |
| Tried amphetamines                | 0.1        | 0   | 0.1 | 0.6 | 1   | 2          |
| Tried sedatives or tranquillisers | 0.3        | 0.3 | 0.6 | 0.9 | 1   | 2          |
| Tried cannabis                    | 0.1        | 0.6 | 2   | 7   | 9   | 12         |
| Tried LSD or other hallucinogens  | 0          | 0   | 0.1 | 0.5 | 0.7 | 2          |
| Tried crack                       | 0          | 0   | 0   | 0.2 | 0.1 | 0.3        |
| Tried cocaine                     | 0          | 0   | 0   | 0.4 | 0.8 | 3          |
| Tried ecstasy                     | 0          | 0   | 0.2 | 0.3 | 0.4 | 2          |
| Tried heroin                      | 0          | 0   | 0   | 0.3 | 0.3 | 0.5        |
| Tried alcohol together with pills | 0          | 0.1 | 0.1 | 0.7 | 0.8 | 2          |

Source: ESPAD Project, Italian data

TABLE 6

**Drugs most used within the armed services**

| Type of Drug          | 1995          |            | 1996          |            | 1998          |            | 1999          |            |
|-----------------------|---------------|------------|---------------|------------|---------------|------------|---------------|------------|
|                       | No. of People | % of total | No. of People | % of total | No. of People | % of total | No. of People | % of total |
| Heroin                | 15            | 3.2        | 100           | 5.3        | 198           | 6.9        | 133           | 5.3        |
| Morphine              |               |            |               |            | 4             | 0.1        | 10            | 0.4        |
| Opium and derivatives | 7             | 1.5        | 12            | 0.6        | 69            | 2.4        | 30            | 1.2        |
| Methadone (licit)     | 9             | 1.9        |               |            | 12            | 0.4        | 8             | 0.3        |
| Methadone (illicit)   | 2             | 0.4        |               |            | 1             | 0.0        | 2             | 0.1        |
| Other opiates         | 4             | 0.9        |               |            | 4             | 0.1        | 2             | 0.1        |
| Alcohol               | 41            | 8.8        | 2             | 0.1        | 61            | 2.1        | 63            | 2.5        |
| Barbiturates          | 1             | 0.2        |               |            | 1             | 0.0        | 0             | 0.0        |
| Hypnotic sedatives    | 10            | 2.1        |               |            | 7             | 0.2        | 2             | 0.1        |
| Amphetamine           | 26            | 5.6        | 5             | 0.3        | 53            | 1.9        | 21            | 0.8        |
| Ecstasy               |               |            |               |            | 36            | 1.3        | 28            | 1.1        |
| Cocaine               | 67            | 14.3       | 13            | 0.7        | 205           | 7.2        | 220           | 8.8        |
| Marijuana/Hashish     | 228           | 48.8       | 1,749         | 92.8       | 2,093         | 73.4       | 1,959         | 78.3       |
| Hashish oil           | 15            | 3.2        |               |            | 4             | 0.1        | 9             | 0.4        |
| Hallucinogens         | 31            | 6.6        | 1             | 0.05       | 20            | 0.7        | 12            | 0.5        |
| Crack                 |               |            |               |            | 1             | 0.0        | 1             | 0.0        |
| Inhalants             | 4             | 0.9        | 1             | 0.05       | 1             | 0.0        | 0             | 0.0        |
| Other drugs           | 7             | 1.5        |               |            | 82            | 2.9        | 3             | 0.1        |
| <b>TOTAL</b>          | <b>467</b>    | <b>100</b> | <b>1,884</b>  | <b>100</b> | <b>2,852</b>  | <b>100</b> | <b>2,503</b>  | <b>100</b> |

Source: Ministry of Defence

TABLE 7

**Distribution of drug users in the Armed Forces by Marital Status**

| <i>MARITAL STATUS</i> | <i>NUMBER</i> |              | <i>FREQUENCY. %</i> |              |
|-----------------------|---------------|--------------|---------------------|--------------|
|                       | 1998          | 1999         | 1998                | 1999         |
| Single                | 2,786         | 2,949        | 98.2                | 98.6         |
| Married               | 26            | 16           | 0.9                 | 0.5          |
| Widowed               | 1             | 0            | 0.0                 | 0.0          |
| Separated             | 3             | 6            | 0.1                 | 0.2          |
| Living together       | 12            | 8            | 0.4                 | 0.3          |
| Not Known             | 10            | 11           | 0.4                 | 0.4          |
| <b>TOTAL</b>          | <b>2,838</b>  | <b>2,990</b> | <b>100.0</b>        | <b>100.0</b> |

Source: Ministry of Defence

TABLE 8

**Distribution of drug users in the Armed Forces by educational qualification**

| <i>Educational Level</i> | <i>Number</i> |              | <i>%</i>     |              |
|--------------------------|---------------|--------------|--------------|--------------|
|                          | 1998          | 1999         | 1998         | 1999         |
| None                     | 17            | 7            | 0.6          | 0.2          |
| Elementary               | 307           | 249          | 10.8         | 8.3          |
| Lower Secondary          | 1,909         | 2,062        | 67.3         | 69.0         |
| Upper Secondary          | 582           | 651          | 20.5         | 21.8         |
| Short Degree (3 yrs)     | 4             | 3            | 0.1          | 0.1          |
| Degree (5 yrs)           | 9             | 5            | 0.3          | 0.2          |
| Not known                | 10            | 13           | 0.4          | 0.4          |
| <b>TOTAL</b>             | <b>2,838</b>  | <b>2,990</b> | <b>100.0</b> | <b>100.0</b> |

Source: Ministry of Defence

TABLE 9

**Distribution of drug users in the Armed Forces by employment before enlistment**

| <i>Employment</i> | <i>Number</i> |              | <i>%</i>     |              |
|-------------------|---------------|--------------|--------------|--------------|
|                   | 1998          | 1999         | 1998         | 1999         |
| Student           | 425           | 589          | 15.0         | 19.7         |
| Manual worker     | 1,020         | 1,113        | 35.9         | 37.2         |
| Office worker     | 71            | 85           | 2.5          | 2.9          |
| Self-employed     | 193           | 106          | 6.8          | 3.5          |
| Professional      | 56            | 33           | 2.0          | 1.1          |
| Manager           | 2             | 0            | 0.1          | 0.0          |
| Entrepreneur      | 10            | 7            | 0.4          | 0.2          |
| Unemployed        | 852           | 816          | 30.0         | 27.3         |
| Other             | 198           | 241          | 7.0          | 8.1          |
| Not known         | 11            | 0            | 0.4          | 0.0          |
| <b>TOTAL</b>      | <b>2,838</b>  | <b>2,990</b> | <b>100.0</b> | <b>100.0</b> |

Source: Ministry of Defence

TABLE 10

**Distribution of users by frequency of use**

| <i>Frequency of use</i> | <i>Number</i> |              | <i>%</i>     |              |
|-------------------------|---------------|--------------|--------------|--------------|
|                         | 1998          | 1999         | 1998         | 1999         |
| Several times a year    | 537           | 520          | 18.9         | 17.4         |
| Several times a month   | 735           | 741          | 25.9         | 24.8         |
| Several times a week    | 647           | 640          | 22.8         | 21.4         |
| Daily                   | 298           | 266          | 10.5         | 8.9          |
| Not known               | 621           | 825          | 21.9         | 27.5         |
| <b>TOTAL</b>            | <b>2,838</b>  | <b>2,990</b> | <b>100.0</b> | <b>100.0</b> |

Source: Ministry of Defence

TABLE 11

**Distribution of users by period of first use**

| <i>Period</i>     | <i>Number</i> |              | <i>%</i>     |              |
|-------------------|---------------|--------------|--------------|--------------|
|                   | 1998          | 1999         | 1998         | 1999         |
| Before enlistment | 402           | 432          | 14.2         | 14.4         |
| After enlistment  | 2,003         | 2,257        | 70.6         | 75.5         |
| Not known         | 433           | 301          | 15.3         | 10.1         |
| <b>TOTAL</b>      | <b>2,838</b>  | <b>2,990</b> | <b>100.0</b> | <b>100.0</b> |

Source: Ministry of Defence

TABLE 12

**Distribution of users by motivation for use**

| <i>Motivo</i>           | <i>Number</i> |            | <i>%</i>     |              |
|-------------------------|---------------|------------|--------------|--------------|
|                         | 1998          | 1999       | 1998         | 1999         |
| Group pressure          | 121           | 123        | 30.1         | 28.4         |
| Psychological pressures | 14            | 19         | 3.5          | 4.4          |
| Curiosity               | 164           | 213        | 40.8         | 49.4         |
| Meeting a dealer        | 5             | 2          | 1.2          | 0.5          |
| Personal problems       | 66            | 55         | 16.4         | 12.7         |
| Other                   | 32            | 20         | 8.0          | 4.6          |
| Not known               | 0             | 0          | 0.0          | 0.0          |
| <b>TOTAL</b>            | <b>402</b>    | <b>432</b> | <b>100.0</b> | <b>100.0</b> |

Source: Ministry of Defence

TABLE 13

**Resident Population of Italy in 1997 and 2000 by sex**

|        | 15 - 24   |           | 25 - 34   |           | 35 - 44   |           | 45 - 54   |           |
|--------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
|        | 01/01/97  | 01/01/00  | 01/01/97  | 01/01/00  | 01/01/97  | 01/01/00  | 01/01/97  | 01/01/00  |
| Male   | 3,897,126 | 3,483,627 | 4,719,204 | 4,651,765 | 3,970,745 | 4,307,555 | 3,645,015 | 3,775,032 |
| Female | 3,743,482 | 3,337,778 | 4,625,326 | 4,533,493 | 3,982,569 | 4,258,734 | 3,732,032 | 3,831,562 |
| Total  | 7,640,608 | 6,821,405 | 9,344,530 | 9,185,258 | 7,953,314 | 8,566,289 | 7,377,047 | 7,606,594 |

TABLE 14

SOURCE: ISTAT

**Prevalence by Region for four indicators**

| Region         | In treatment with the Ser.T |             | Drug law offences |             | Unlawful possession |             | In treatment with private services |            |
|----------------|-----------------------------|-------------|-------------------|-------------|---------------------|-------------|------------------------------------|------------|
|                | Number                      | Rate*       | Number            | Rate*       | Number              | Rate*       | Number                             | Rate*      |
| Piemonte       | 14801                       | 63.5        | 3056              | 12.9        | 2709                | 11.6        | 1899                               | 8          |
| Valle d'Aosta  | 375                         | 55.5        | 41                | 6           | 144                 | 21.3        | 17                                 | 2.5        |
| Lombardia      | 22034                       | 42.9        | 4966              | 9.6         | 4144                | 8.1         | 3257                               | 6.3        |
| Trentino       | 1720                        | 32.7        | 442               | 8.4         | 338                 | 6.4         | 343                                | 6.5        |
| Veneto         | 11747                       | 45.9        | 2341              | 9.1         | 1267                | 4.9         | 1390                               | 5.4        |
| Friuli V.G.    | 2626                        | 41.0        | 736               | 11.3        | 626                 | 9.8         | 233                                | 3.6        |
| Liguria        | 5684                        | 68.7        | 1685              | 19.7        | 1616                | 19.5        | 494                                | 5.8        |
| Emilia Romagna | 9422                        | 44.0        | 2727              | 12.8        | 2593                | 12.1        | 2943                               | 13.8       |
| Toscana        | 10229                       | 54.0        | 2751              | 14.4        | 3572                | 18.9        | 1375                               | 7.2        |
| Umbria         | 2198                        | 49.7        | 417               | 9.4         | 384                 | 8.7         | 632                                | 14.3       |
| Marche         | 4116                        | 52.6        | 762               | 9.8         | 1108                | 14.2        | 903                                | 11.6       |
| Lazio          | 11345                       | 38.1        | 3373              | 11.3        | 4529                | 15.2        | 4233                               | 14.2       |
| Abruzzo        | 2732                        | 39.1        | 724               | 10.4        | 768                 | 11.0        | 443                                | 6.4        |
| Molise         | 579                         | 32.6        | 87                | 4.9         | 120                 | 6.8         | 83                                 | 4.7        |
| Campania       | 12828                       | 38.5        | 2463              | 7.4         | 1351                | 4.1         | 829                                | 2.5        |
| Puglia         | 12400                       | 52.9        | 2205              | 9.4         | 1674                | 7.1         | 1331                               | 5.7        |
| Basilicata     | 927                         | 27.5        | 309               | 9.3         | 346                 | 10.2        | 289                                | 8.7        |
| Calabria       | 3646                        | 31.6        | 1226              | 10.6        | 1068                | 9.2         | 536                                | 4.6        |
| Sicilia        | 8597                        | 30.4        | 2807              | 9.9         | 2393                | 8.5         | 1225                               | 4.3        |
| Sardegna       | 5365                        | 54.9        | 1166              | 11.8        | 2074                | 21.2        | 511                                | 5.2        |
| <b>Italy</b>   | <b>142651</b>               | <b>44.3</b> | <b>34284</b>      | <b>10.4</b> | <b>32824</b>        | <b>10.2</b> | <b>22966</b>                       | <b>7.1</b> |

TABLE 15

\* per 10,000 residents in the age range 15-54

Source: Ministry of Health, Ministry of the Interior and ISTAT

**Estimates of Injecting heroin use in Italy for 1996**

| METHOD  | PREVALENT CASES | PREVALENCE RATE x1000 (15-54 YEARS) |
|---|-----------------|-------------------------------------|
| Multivariate indicators                         | 250,000         | 7.7                                 |
| Multiplier (deaths from Police)                 | 172,000         | 5.3                                 |
| Multiplier (treatment services data)            | 299,000         | 9.2                                 |
| Back calculation                                | 267,000         | 8.2                                 |
| Capture-recapture clients in treatment services | 299,000         | 9.2                                 |
| Demographic multiplier method                   | 240,000         | 7.4                                 |
| <b>1996 average estimation</b>                  | <b>254,000</b>  | <b>7.8</b>                          |
| <b>1996 median estimation</b>                   | <b>259,000</b>  | <b>8.0</b>                          |

Source: Drug Use Prevalence: Country Report Italy

TABLE 16

**People in Treatment with the Ser.T. Rates per 10,000 population**

|                   | 1997 | 1999 |
|-------------------|------|------|
| 15 - 24 age group | 38.5 | 40.3 |
| 25 - 34 age group | 83.9 | 82.0 |
| 35 - 54 age group | 19.8 | 24.6 |

Source: Ministry of Health. Health Information System, Department of Prevention and ISTAT

TABLE 17

**Primary and Secondary Drug Use of Clients of the Ser.T 1997 - 1999**

|                     | Primary Use % |      |      | Secondary Use % |      |      |
|---------------------|---------------|------|------|-----------------|------|------|
|                     | 1997          | 1998 | 1999 | 1997            | 1998 | 1999 |
| Hallucinogens       | 0.2           | 0.2  | 0.2  | 0.8             | 0.8  | 0.7  |
| Amphetamine         | 0.2           | 0.2  | 0.3  | 2.3             | 1.7  | 1.6  |
| Ecstasy & analogues | 0.4           | 0.7  | 0.8  | 2.4             | 2.3  | 2.3  |
| Barbiturates        | 0.0           | 0.1  | 0.2  | 0.6             | 0.5  | 0.5  |
| Benzodiazepines     | 0.4           | 0.5  | 0.6  | 16.2            | 14.8 | 13.7 |
| Cannabinoids        | 6.9           | 7.6  | 8.0  | 40.1            | 39.2 | 34.8 |
| Cocaine             | 2.3           | 3.2  | 4.3  | 15.0            | 18.4 | 21.3 |
| Crack               | 0.0           | 0.0  | 0.0  | 0.1             | 0.2  | 0.1  |
| Heroin              | 87.5          | 85.6 | 83.6 | 2.1             | 1.9  | 2.2  |
| Methadone           | 0.6           | 0.7  | 0.4  | 2.4             | 2.4  | 1.8  |
| Morphine            | 0.1           | 0.0  | 0.0  | 0.2             | 0.1  | 0.1  |
| Other opiates       | 0.1           | 0.1  | 0.4  | 0.4             | 0.6  | 0.5  |
| Inhalants           | 0.0           | 0.1  | 0.1  | 0.1             | 0.1  | 0.1  |
| Other               | 1.3           | 1.0  | 1.0  | 2.8             | 1.4  | 6.8  |
| Alcohol *           |               |      |      | 14.4            | 15.6 | 13.5 |

TABLE 18

Source: Ministry of Health, Health Information System, Department of Prevention

**Primary Drug Use of Clients of the Ser.T by Region**

| PIEMONTE            |      |      |      | VALLE D'AOSTA       |      |      |      |
|---------------------|------|------|------|---------------------|------|------|------|
|                     | 1997 | 1998 | 1999 |                     | 1997 | 1998 | 1999 |
| Hallucinogens       | 0.3  | 0.2  | 0.1  | Hallucinogens       | 0.0  | 0.0  | 0.0  |
| Amphetamine         | 0.3  | 0.2  | 0.2  | Amphetamine         | 0.0  | 0.0  | 0.0  |
| Ecstasy & analogues | 0.4  | 0.5  | 0.5  | Ecstasy & analogues | 0.0  | 0.0  | 0.0  |
| Barbiturates        | 0.0  | 0.0  | 0.0  | Barbiturates        | 0.0  | 0.0  | 0.0  |
| Benzodiazepines     | 0.4  | 0.4  | 0.4  | Benzodiazepines     | 1.2  | 0.9  | 0.5  |
| Cannabinoids        | 2.1  | 2.7  | 3.8  | Cannabinoids        | 0.6  | 0.6  | 0.5  |
| Cocaine             | 1.4  | 2.1  | 2.9  | Cocaine             | 0.9  | 1.2  | 0.8  |
| Crack               | 0.0  | 0.0  | 0.0  | Crack               | 0.0  | 0.0  | 0.0  |
| Heroin              | 92.3 | 92.9 | 91.5 | Heroin              | 97.3 | 97.3 | 98.1 |
| Methadone           | 0.0  | 0.1  | 0.0  | Methadone           | 0.0  | 0.0  | 0.0  |
| Morphine            | 0.0  | 0.0  | 0.0  | Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.0  | 0.1  | 0.0  | Other opiates       | 0.0  | 0.0  | 0.0  |
| Inhalants           | 0.0  | 0.0  | 0.0  | Inhalants           | 0.0  | 0.0  | 0.0  |
| Other               | 2.7  | 0.6  | 0.4  | Other               | 0.0  | 0.0  | 0.0  |

TABLE 18 (A)

TABLE 18 (B)



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**LOMBARDIA**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.2  | 0.2  | 0.1  |
| Amphetamine         | 0.2  | 0.3  | 0.2  |
| Ecstasy & analogues | 0.8  | 1.0  | 1.0  |
| Barbiturates        | 0.0  | 0.0  | 0.0  |
| Benzodiazepines     | 0.3  | 0.4  | 0.4  |
| Cannabinoids        | 4.5  | 4.8  | 7.7  |
| Cocaine             | 3.7  | 5.8  | 7.3  |
| Crack               | 0.0  | 0.0  | 0.1  |
| Heroin              | 89.8 | 86.8 | 82.4 |
| Methadone           | 0.0  | 0.0  | 0.0  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.0  | 0.0  | 0.0  |
| Inhalants           | 0.1  | 0.0  | 0.0  |
| Other               | 0.5  | 0.6  | 0.7  |

TABLE 18 (C)

**PROV. AUT. BOLZANO**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.0  | 0.1  | 0.1  |
| Amphetamine         | 0.0  | 0.0  | 0.2  |
| Ecstasy & analogues | 0.6  | 0.1  | 0.7  |
| Barbiturates        | 0.0  | 0.0  | 0.1  |
| Benzodiazepines     | 2.0  | 1.1  | 1.2  |
| Cannabinoids        | 18.1 | 17.7 | 17.3 |
| Cocaine             | 0.6  | 0.9  | 1.8  |
| Crack               | 0.0  | 0.0  | 0.0  |
| Heroin              | 77.9 | 79.8 | 76.1 |
| Methadone           | 0.0  | 0.1  | 0.8  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.9  | 0.1  | 1.6  |
| Inhalants           | 0.0  | 0.0  | 0.1  |
| Other               | 0.0  | 0.1  | 0.1  |

TABLE 18 (D)

**PROV. AUT. TRENTO**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.0  | 0.2  | 0.3  |
| Amphetamine         | 0.6  | 0.0  | 0.0  |
| Ecstasy & analogues | N/A  | 0.4  | 0.4  |
| Barbiturates        | 0.0  | 0.0  | 0.1  |
| Benzodiazepines     | 1.5  | 1.1  | 0.9  |
| Cannabinoids        | 1.7  | 2.9  | 3.4  |
| Cocaine             | 1.5  | 2.1  | 3.1  |
| Crack               | 0.0  | 0.0  | 0.1  |
| Heroin              | 94.7 | 92.8 | 91.1 |
| Methadone           | 0.0  | 0.0  | 0.1  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | N/A  | 0.5  | 0.3  |
| Inhalants           | N/A  | 0.0  | 0.0  |
| Other               | 0.0  | 0.0  | 0.0  |

TABLE 18 (E)

**VENETO**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.1  | 0.2  | 0.1  |
| Amphetamine         | 0.1  | 0.1  | 0.1  |
| Ecstasy & analogues | 0.7  | 1.3  | 1.7  |
| Barbiturates        | 0.0  | 0.0  | 0.0  |
| Benzodiazepines     | 0.6  | 0.8  | 1.3  |
| Cannabinoids        | 9.8  | 10.3 | 9.8  |
| Cocaine             | 2.5  | 3.2  | 4.1  |
| Crack               | 0.0  | 0.0  | 0.0  |
| Heroin              | 81.7 | 79.6 | 79.1 |
| Methadone           | 0.0  | 0.2  | 0.2  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.8  | 0.9  | 2.1  |
| Inhalants           | 0.0  | 0.1  | 0.1  |
| Other               | 3.5  | 3.4  | 1.3  |

TABLE 18 (F)

**FRULI V.G.**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 1.3  | 1.4  | 1.3  |
| Amphetamine         | 0.8  | 0.7  | 0.7  |
| Ecstasy & analogues | 1.9  | 3.3  | 4.5  |
| Barbiturates        | 0.3  | 0.3  | 0.3  |
| Benzodiazepines     | 0.8  | 0.5  | 0.8  |
| Cannabinoids        | 11.0 | 12.1 | 10.2 |
| Cocaine             | 1.2  | 1.9  | 2.7  |
| Crack               | 0.0  | 0.0  | 0.0  |
| Heroin              | 81.1 | 77.9 | 77.6 |
| Methadone           | 0.3  | 0.3  | 0.4  |
| Morphine            | 0.0  | 0.1  | 0.0  |
| Other opiates       | 0.6  | 0.1  | 0.3  |
| Inhalants           | 0.0  | 0.3  | 0.1  |
| Other               | 0.7  | 1.0  | 1.1  |

TABLE 18 (G)

**LIGURIA**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.1  | 0.1  | 0.1  |
| Amphetamine         | 0.7  | 0.4  | 0.2  |
| Ecstasy & analogues | 0.1  | 1.0  | 0.7  |
| Barbiturates        | 0.3  | 0.1  | 0.3  |
| Benzodiazepines     | 0.2  | 0.1  | 0.1  |
| Cannabinoids        | 5.8  | 9.7  | 6.9  |
| Cocaine             | 2.2  | 3.9  | 3.4  |
| Crack               | 0.1  | 0.1  | 0.1  |
| Heroin              | 89.8 | 83.8 | 87.8 |
| Methadone           | 0.0  | 0.0  | 0.0  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.0  | 0.0  | 0.0  |
| Inhalants           | 0.0  | 0.0  | 0.0  |
| Other               | 0.9  | 0.8  | 0.5  |

TABLE 18 (H)

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**EMILIA ROMAGNA**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.1  | 0.1  | 0.2  |
| Amphetamine         | 0.7  | 0.3  | 0.2  |
| Ecstasy & analogues | N/A  | 1.3  | 1.1  |
| Barbiturates        | 0.0  | 0.1  | 0.0  |
| Benzodiazepines     | 0.7  | 0.8  | 0.8  |
| Cannabinoids        | 6.1  | 6.3  | 6.9  |
| Cocaine             | 2.8  | 3.5  | 5.4  |
| Crack               | 0.1  | 0.0  | 0.0  |
| Heroin              | 85.2 | 85.8 | 81.8 |
| Methadone           | 0.4  | 0.4  | 0.5  |
| Morphine            | 0.5  | 0.1  | 0.1  |
| Other opiates       | N/A  | 0.3  | 0.3  |
| Inhalants           | N/A  | 0.0  | 0.0  |
| Other               | 3.5  | 0.8  | 2.7  |

TABLE 18 (I)

**TOSCANA**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.2  | 0.1  | 0.2  |
| Amphetamine         | 0.3  | 0.2  | 0.4  |
| Ecstasy & analogues | 0.8  | 0.8  | 1.2  |
| Barbiturates        | 0.0  | 0.0  | 0.0  |
| Benzodiazepines     | 0.2  | 0.1  | 0.2  |
| Cannabinoids        | 7.5  | 9.5  | 9.5  |
| Cocaine             | 2.6  | 2.2  | 3.8  |
| Crack               | 0.0  | 0.0  | 0.0  |
| Heroin              | 88.1 | 86.5 | 84.5 |
| Methadone           | 0.0  | 0.0  | 0.0  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.0  | 0.0  | 0.0  |
| Inhalants           | 0.0  | 0.0  | 0.0  |
| Other               | 0.2  | 0.4  | 0.2  |

TABLE 18 (J)

**UMBRIA**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.0  | 0.0  | 0.0  |
| Amphetamine         | 0.4  | 0.4  | 0.5  |
| Ecstasy & analogues | 0.2  | 0.1  | 1.2  |
| Barbiturates        | 0.0  | 0.0  | 0.0  |
| Benzodiazepines     | 0.3  | 0.9  | 1.1  |
| Cannabinoids        | 8.1  | 7.1  | 13.1 |
| Cocaine             | 1.2  | 1.4  | 2.6  |
| Crack               | 0.0  | 0.0  | 0.0  |
| Heroin              | 88.8 | 88.7 | 79.4 |
| Methadone           | 0.0  | 0.0  | 0.1  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.1  | 0.0  | 0.0  |
| Inhalants           | 0.0  | 0.0  | 0.0  |
| Other               | 0.8  | 1.5  | 1.9  |

TABLE 18 (K)

**MARCHE**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.2  | 0.3  | 0.4  |
| Amphetamine         | 0.3  | 0.6  | 0.8  |
| Ecstasy & analogues | 0.8  | 0.6  | 1.3  |
| Barbiturates        | 0.0  | 0.0  | 0.0  |
| Benzodiazepines     | 0.4  | 0.3  | 0.7  |
| Cannabinoids        | 15.9 | 16.1 | 17.3 |
| Cocaine             | 1.9  | 2.7  | 3.8  |
| Crack               | 0.0  | 0.1  | 0.1  |
| Heroin              | 78.6 | 76.0 | 71.7 |
| Methadone           | 0.4  | 0.5  | 0.1  |
| Morphine            | 0.2  | 0.2  | 0.6  |
| Other opiates       | 0.0  | 0.0  | 0.0  |
| Inhalants           | 0.1  | 0.1  | 0.1  |
| Other               | 1.3  | 2.6  | 3.3  |

TABLE 18 (L)

**LAZIO**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.0  | 0.1  | 0.0  |
| Amphetamine         | 0.1  | 0.1  | 0.1  |
| Ecstasy & analogues | 0.3  | 0.5  | 0.3  |
| Barbiturates        | 0.0  | 0.0  | 0.0  |
| Benzodiazepines     | 0.1  | 0.1  | 0.2  |
| Cannabinoids        | 4.4  | 4.9  | 4.7  |
| Cocaine             | 2.3  | 3.1  | 3.5  |
| Crack               | 0.0  | 0.0  | 0.0  |
| Heroin              | 92.5 | 91.0 | 91.0 |
| Methadone           | 0.0  | 0.0  | 0.0  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.1  | 0.1  | 0.1  |
| Inhalants           | 0.0  | 0.0  | 0.0  |
| Other               | 0.1  | 0.1  | 0.1  |

TABLE 18 (M)

**ABRUZZO**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.4  | 0.5  | 0.4  |
| Amphetamine         | 0.2  | 0.3  | 0.3  |
| Ecstasy & analogues | 1.6  | 1.2  | 1.3  |
| Barbiturates        | 0.1  | 0.0  | 0.0  |
| Benzodiazepines     | 0.3  | 0.4  | 0.3  |
| Cannabinoids        | 7.6  | 9.2  | 8.8  |
| Cocaine             | 3.1  | 2.9  | 3.5  |
| Crack               | 0.0  | 0.0  | 0.0  |
| Heroin              | 77.5 | 75.2 | 75.5 |
| Methadone           | 0.0  | 3.1  | 0.0  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.0  | 0.0  | 0.0  |
| Inhalants           | 0.0  | 0.0  | 0.0  |
| Other               | 9.1  | 7.1  | 9.9  |

TABLE 18 (N)

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**MOLISE**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.0  | 0.0  | 0.0  |
| Amphetamine         | 0.0  | 0.0  | 0.0  |
| Ecstasy & analogues | 0.0  | 0.2  | 0.0  |
| Barbiturates        | 0.2  | 0.0  | 0.0  |
| Benzodiazepines     | 1.3  | 2.1  | 2.0  |
| Cannabinoids        | 7.8  | 13.2 | 14.1 |
| Cocaine             | 2.7  | 3.3  | 6.8  |
| Crack               | 0.0  | 0.0  | 0.0  |
| Heroin              | 88.0 | 80.5 | 76.5 |
| Methadone           | 0.0  | 0.7  | 0.7  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.0  | 0.0  | 0.0  |
| Inhalants           | 0.0  | 0.0  | 0.0  |
| Other               | 0.0  | 0.0  | 0.0  |

TABLE 18 (O)

**CAMPANIA**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.1  | 0.1  | 0.7  |
| Amphetamine         | 0.2  | 0.2  | 0.4  |
| Ecstasy & analogues | 0.3  | 0.4  | 0.8  |
| Barbiturates        | 0.1  | 0.1  | 0.3  |
| Benzodiazepines     | 0.3  | 0.5  | 1.1  |
| Cannabinoids        | 11.0 | 12.7 | 10.4 |
| Cocaine             | 2.2  | 2.1  | 3.0  |
| Crack               | 0.0  | 0.1  | 0.1  |
| Heroin              | 82.7 | 81.2 | 79.6 |
| Methadone           | 2.7  | 2.4  | 1.9  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.0  | 0.1  | 1.7  |
| Inhalants           | 0.0  | 0.0  | 0.0  |
| Other               | 0.4  | 0.1  | 0.1  |

TABLE 18 (P)

**PUGLIA**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.1  | 0.4  | 0.5  |
| Amphetamine         | 0.0  | 0.4  | 0.5  |
| Ecstasy & analogues | 0.1  | 0.1  | 0.4  |
| Barbiturates        | 0.1  | 1.1  | 1.0  |
| Benzodiazepines     | 0.2  | 0.2  | 0.3  |
| Cannabinoids        | 6.9  | 8.4  | 8.1  |
| Cocaine             | 2.8  | 4.8  | 6.8  |
| Crack               | 0.1  | 0.0  | 0.0  |
| Heroin              | 87.7 | 80.3 | 79.4 |
| Methadone           | 1.4  | 3.1  | 1.2  |
| Morphine            | 0.1  | 0.0  | 0.0  |
| Other opiates       | 0.0  | 0.0  | 0.0  |
| Inhalants           | 0.0  | 0.8  | 1.0  |
| Other               | 0.5  | 0.4  | 0.8  |

TABLE 18 (Q)

**BASILICATA**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.0  | 0.0  | 0.1  |
| Amphetamine         | 0.0  | 0.0  | 0.0  |
| Ecstasy & analogues | 0.0  | 0.1  | 0.0  |
| Barbiturates        | 0.1  | 0.0  | 0.0  |
| Benzodiazepines     | 0.0  | 0.1  | 0.1  |
| Cannabinoids        | 5.9  | 7.2  | 9.3  |
| Cocaine             | 0.9  | 1.2  | 2.0  |
| Crack               | 0.0  | 0.0  | 0.0  |
| Heroin              | 93.1 | 91.4 | 88.5 |
| Methadone           | 0.0  | 0.0  | 0.0  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.0  | 0.0  | 0.0  |
| Inhalants           | 0.0  | 0.0  | 0.0  |
| Other               | 0.1  | 0.0  | 0.0  |

TABLE 18 (R)

**CALABRIA**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.1  | 0.1  | 0.0  |
| Amphetamine         | 1.1  | 0.2  | 0.2  |
| Ecstasy & analogues | 0.3  | 0.0  | 0.3  |
| Barbiturates        | 0.1  | 0.1  | 0.1  |
| Benzodiazepines     | 1.8  | 1.1  | 1.0  |
| Cannabinoids        | 19.4 | 14.0 | 13.4 |
| Cocaine             | 2.4  | 1.7  | 2.6  |
| Crack               | 0.0  | 0.0  | 0.1  |
| Heroin              | 74.6 | 81.1 | 81.2 |
| Methadone           | 0.0  | 0.8  | 0.8  |
| Morphine            | 0.1  | 0.0  | 0.0  |
| Other opiates       | 0.0  | 0.2  | 0.3  |
| Inhalants           | 0.0  | 0.0  | 0.0  |
| Other               | 0.2  | 0.7  | 0.1  |

TABLE 18 (S)

**SICILIA**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.1  | 0.1  | 0.1  |
| Amphetamine         | 0.1  | 0.0  | 0.1  |
| Ecstasy & analogues | 0.0  | 0.0  | 0.1  |
| Barbiturates        | 0.0  | 0.0  | 0.0  |
| Benzodiazepines     | 0.6  | 0.9  | 1.0  |
| Cannabinoids        | 6.8  | 7.0  | 8.7  |
| Cocaine             | 1.1  | 1.6  | 3.0  |
| Crack               | 0.0  | 0.1  | 0.0  |
| Heroin              | 87.9 | 89.4 | 84.6 |
| Methadone           | 2.2  | 0.2  | 0.8  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.0  | 0.0  | 0.0  |
| Inhalants           | 0.0  | 0.0  | 0.0  |
| Other               | 1.2  | 0.6  | 1.5  |

TABLE 18 (T)

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**SARDEGNA**

|                     | 1997 | 1998 | 1999 |
|---------------------|------|------|------|
| Hallucinogens       | 0.0  | 0.0  | 0.0  |
| Amphetamine         | 0.0  | 0.0  | 0.0  |
| Ecstasy & analogues | 0.0  | 0.1  | 0.2  |
| Barbiturates        | 0.0  | 0.0  | 0.0  |
| Benzodiazepines     | 0.3  | 0.2  | 0.4  |
| Cannabinoids        | 2.0  | 2.1  | 1.8  |
| Cocaine             | 0.5  | 0.3  | 0.8  |
| Crack               | 0.0  | 0.1  | 0.1  |
| Heroin              | 97.0 | 96.9 | 95.9 |
| Methadone           | 0.1  | 0.1  | 0.0  |
| Morphine            | 0.0  | 0.0  | 0.0  |
| Other opiates       | 0.0  | 0.0  | 0.0  |
| Inhalants           | 0.0  | 0.0  | 0.0  |
| Other               | 0.1  | 0.3  | 0.8  |

TABLE 18 (U)

Source for tables 18(a)-(u): Ministry of Health, Health Information System, Department of Prevention

**Male clients of the Ser.T with regard to HIV infection (%)**

|                                       | New Clients |      |      | Existing Clients |      |      |
|---------------------------------------|-------------|------|------|------------------|------|------|
|                                       | 1997        | 1998 | 1999 | 1997             | 1998 | 1999 |
| People with positive test results (a) | 3.0         | 2.6  | 2.3  | 10.3             | 9.7  | 8.8  |
| People with negative test results (a) | 45.9        | 40.0 | 38.8 | 51.9             | 47.5 | 46.2 |
| People not tested (b)                 | 31.2        | 32.1 | 33.1 | 25.8             | 30.4 | 31.8 |
| Data not available                    | 19.9        | 25.3 | 25.9 | 12.0             | 12.4 | 13.2 |

TABLE 19

**Female clients of the Ser.T with regard to HIV infection (%)**

|                                       | New Clients |      |      | Existing Clients |      |      |
|---------------------------------------|-------------|------|------|------------------|------|------|
|                                       | 1997        | 1998 | 1999 | 1997             | 1998 | 1999 |
| People with positive test results (a) | 5.4         | 5.0  | 3.8  | 16.7             | 15.2 | 14.8 |
| People with negative test results (a) | 51.0        | 46.0 | 44.3 | 48.6             | 42.8 | 44.2 |
| People not tested (b)                 | 26.6        | 28.2 | 31.2 | 23.7             | 28.6 | 29.9 |
| Data not available                    | 17.0        | 20.8 | 20.8 | 11.0             | 13.4 | 11.0 |

TABLE 20

**Male clients of the Ser.T with regard to Hepatitis B infection (%)**

|                                       | New Clients |      |      | Existing Clients |      |      |
|---------------------------------------|-------------|------|------|------------------|------|------|
|                                       | 1997        | 1998 | 1999 | 1997             | 1998 | 1999 |
| People with positive test results (a) | 12.8        | 10.7 | 9.7  | 26.6             | 25.4 | 23.8 |
| People with negative test results (a) | 30.9        | 26.5 | 26.4 | 30.0             | 26.8 | 25.7 |
| People vaccinated                     | 4.4         | 5.1  | 5.0  | 5.7              | 6.8  | 7.4  |
| People not tested (b)                 | 30.5        | 31.4 | 32.4 | 24.8             | 26.9 | 27.6 |
| Data not available                    | 21.4        | 26.4 | 26.5 | 12.9             | 14.1 | 15.4 |

TABLE 21

**Female clients of the Ser.T with regard to Hepatitis B infection (%)**

|                                       | New Clients |      |      | Existing Clients |      |      |
|---------------------------------------|-------------|------|------|------------------|------|------|
|                                       | 1997        | 1998 | 1999 | 1997             | 1998 | 1999 |
| People with positive test results (a) | 12.2        | 11.5 | 10.6 | 27.7             | 25.1 | 24.9 |
| People with negative test results (a) | 36.9        | 31.3 | 30.4 | 30.0             | 24.7 | 26.2 |
| People vaccinated                     | 6.6         | 6.4  | 8.7  | 6.0              | 7.6  | 8.7  |
| People not tested (b)                 | 25.3        | 26.9 | 30.3 | 23.6             | 26.7 | 26.9 |
| Data not available                    | 19.1        | 24.0 | 20.0 | 12.7             | 16.0 | 13.4 |

TABLE 22

**Male clients of the Ser.T with regard to Hepatitis C infection (%)**

|                                       | New Clients |      |      | Existing Clients |      |      |
|---------------------------------------|-------------|------|------|------------------|------|------|
|                                       | 1997        | 1998 | 1999 | 1997             | 1998 | 1999 |
| People with positive test results (a) | 22.6        | 19.4 | 17.2 | 45.9             | 42.9 | 42.3 |
| People with negative test results (a) | 25.5        | 22.9 | 23.8 | 17.9             | 16.8 | 16.8 |
| People not tested (b)                 | 28.0        | 32.3 | 33.2 | 21.9             | 26.0 | 27.1 |
| Data not available                    | 23.8        | 25.5 | 25.8 | 14.3             | 14.3 | 13.8 |

TABLE 23

**Female clients of the Ser.T with regard to Hepatitis C infection (%)**

|                                       | New Clients |      |      | Existing Clients |      |      |
|---------------------------------------|-------------|------|------|------------------|------|------|
|                                       | 1997        | 1998 | 1999 | 1997             | 1998 | 1999 |
| People with positive test results (a) | 24.7        | 21.9 | 19.8 | 47.5             | 44.0 | 46.8 |
| People with negative test results (a) | 30.4        | 28.4 | 26.5 | 16.9             | 14.9 | 15.5 |
| People not tested (b)                 | 22.4        | 27.2 | 32.3 | 20.9             | 25.1 | 25.3 |
| Data not available                    | 22.5        | 22.5 | 21.4 | 14.7             | 16.0 | 12.3 |

TABLE 24

- (a) as a percentage of all clients of the Ser.T
- (b) includes people who have not undertaken a test and people who, having previously had a negative test result, did not take a test in the relevant year

**Distribution by Region and by percent of positive results from tests for drug related infectious diseases carried out on clients in treatment with the Ser.T.**

| REGION   | HIV<br>percent of positive results out of the total<br>number of tests conducted |                   |                   |                   |                   | HEPATITIS B<br>percent of positive results out of the total<br>number of tests conducted |                   |                   |                   |                   | HEPATITIS C (*)   |                   |                   |
|--|--|-------------------|-------------------|-------------------|-------------------|--|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|
|  | 1995   | 1996              | 1997              | 1998              | 1999              | 1995   | 1996              | 1997              | 1998              | 1999              | 1997              | 1998              | 1999              |
|  | (69941<br>tested)  | (73513<br>tested) | (76096<br>tested) | (71759<br>tested) | (69474<br>tested) | (62955<br>tested)  | (69092<br>tested) | (68062<br>tested) | (64629<br>tested) | (63493<br>tested) | (66467<br>tested) | (72336<br>tested) | (73512<br>tested) |
| PIEMONTE   | 15.1   | 14.5              | 12.9              | 11.6              | 12.0              | 52.5   | 50.9              | 52.5              | 51.6              | 48.0              | 66.8              | 68.5              | 67.7              |
| VALLE D'AOSTA  | 3.1  | 11.2              | 1.2               | 0.6               | 1.7               | 7.4  | 29.8              | 43.6              | 62.2              | 39.3              | 69.7              | 86.9              | 43.0              |
| LOMBARDIA  | 32.2   | 29.7              | 28.2              | 27.7              | 26.0              | 56.1   | 53.6              | 54.0              | 54.0              | 51.9              | 73.5              | 71.4              | 70.6              |
| PROV.AUT.BOLZANO   | 6.6  | 7.3               | 7.3               | 21.2              | 15.5              | 39.6   | 60.2              | 43.1              | 73.5              | 68.1              | 86.2              | 93.0              | 90.9              |
| PROV.AUT.TRENTO  | 23.4   | 21.9              | 20.7              | 16.2              | 17.4              | 5.8  | 4.8               | 38.7              | 35.2              | 47.0              | N.R.              | 74.8              | 85.2              |
| VENETO   | 14.2   | 13.1              | 14.6              | 12.1              | 14.1              | 42.8   | 49.2              | 49.9              | 47.7              | 50.3              | 73.9              | 70.5              | 72.5              |
| FRIULI V.GIULIA  | 12.2   | 11.5              | 8.6               | 8.4               | 9.9               | 51.4   | 54.3              | 56.7              | 59.6              | 62.9              | 78.7              | 79.9              | 77.8              |
| LIGURIA  | 21.0   | 34.0              | 23.4              | 16.5              | 15.5              | 61.8   | 47.3              | 37.3              | 22.8              | 30.7              | 91.0              | 77.4              | 84.9              |
| EMILIA ROMAGNA   | 26.6   | 23.2              | 22.0              | 28.2              | 27.3              | 52.7   | 47.5              | 50.0              | 62.0              | 61.5              | N.R.              | 79.8              | 82.1              |
| TOSCANA  | 13.7   | 9.8               | 11.8              | 12.2              | 12.2              | 37.5   | 32.3              | 43.6              | 45.9              | 43.1              | 71.9              | 73.5              | 70.3              |
| UMBRIA   | 12.0   | 10.4              | 9.6               | 6.0               | 5.2               | 28.3   | 25.2              | 27.7              | 19.1              | 20.6              | 77.6              | 74.5              | 64.0              |
| MARCHE   | 21.3   | 16.6              | 13.8              | 13.6              | 14.3              | 33.4   | 33.7              | 25.8              | 24.8              | 28.7              | 66.8              | 65.4              | 67.8              |
| LAZIO  | 28.3   | 24.7              | 22.5              | 21.6              | 20.3              | 15.1   | 25.0              | 40.6              | 43.3              | 41.1              | 66.0              | 65.2              | 65.0              |
| ABRUZZO  | 7.2  | 7.0               | 5.8               | 4.7               | 5.3               | 35.8   | 32.2              | 27.4              | 33.6              | 32.1              | 59.5              | 53.4              | 50.6              |
| MOLISE   | 3.4  | 3.0               | 4.0               | 4.0               | 6.3               | 23.4   | 32.9              | 28.6              | 38.1              | 33.5              | 58.5              | 69.2              | 66.5              |
| CAMPANIA   | 4.4  | 3.3               | 3.4               | 3.8               | 1.8               | 39.1   | 44.4              | 35.7              | 34.5              | 31.4              | 45.8              | 51.5              | 42.3              |
| PUGLIA   | 11.2   | 9.2               | 8.0               | 13.4              | 8.3               | 41.0   | 37.3              | 36.2              | 42.0              | 43.7              | 61.2              | 60.3              | 63.8              |
| BASILICATA   | 13.1   | 14.5              | 10.7              | 13.7              | 10.9              | 32.1   | 33.8              | 39.2              | 39.2              | 26.3              | 70.0              | 66.0              | 67.4              |
| CALABRIA   | 10.5   | 8.4               | 9.0               | 6.2               | 6.0               | 36.9   | 48.9              | 30.6              | 33.8              | 36.6              | 50.9              | 58.6              | 61.2              |
| SICILIA  | 11.3   | 6.5               | 7.8               | 7.1               | 9.4               | 38.8   | 29.0              | 25.5              | 33.1              | 28.7              | 67.9              | 65.0              | 60.9              |
| SARDEGNA   | 22.2   | 20.9              | 20.1              | 21.7              | 23.7              | 46.5   | 41.2              | 49.8              | 49.2              | 59.6              | 80.5              | 72.0              | 83.2              |
| ITALIA   | 19.4   | 16.9              | 15.7              | 16.2              | 15.2              | 44.1   | 43.8              | 43.6              | 45.3              | 44.4              | 67.3              | 67.6              | 66.9              |
| (*)=percent of positive results out of the total number of tests conducted |  |                   |                   |                   |                   |  |                   |                   |                   |                   |                   |                   |                   |

**TABLE 25**

Source: Ministry of Health, Health Information System, Department of Prevention

**Referrals for unlawful possession of listed drugs: rates per 10,000 population**

|                | Rates per 10,000 people aged 15-54 |             |               | Rates per 10,000 people aged 10-17 |             |               |
|----------------|------------------------------------|-------------|---------------|------------------------------------|-------------|---------------|
|                | <i>Total</i>                       | <i>Male</i> | <i>Female</i> | <i>Total</i>                       | <i>Male</i> | <i>Female</i> |
| Piemonte       | 11.6                               | 20.3        | 1.8           | 9.2                                | 16.2        | 1.8           |
| Valle d'Aosta  | 21.3                               | 38.7        | 2.8           | 13.8                               | 24.1        | 2.6           |
| Lombardia      | 8.1                                | 15.0        | 0.9           | 7.0                                | 12.3        | 1.4           |
| Trentino A.A.  | 6.4                                | 11.5        | 1.1           | 5.6                                | 9.4         | 1.6           |
| Veneto         | 4.9                                | 9.1         | 0.6           | 4.7                                | 8.5         | 0.8           |
| Friuli V.G.    | 9.8                                | 18.3        | 0.9           | 5.4                                | 8.7         | 2.0           |
| Liguria        | 19.5                               | 35.2        | 3.6           | 18.9                               | 32.3        | 4.5           |
| Emilia Romagna | 12.1                               | 22.2        | 1.7           | 10.0                               | 17.8        | 1.6           |
| Toscana        | 18.9                               | 33.5        | 4.0           | 15.5                               | 27.0        | 3.5           |
| Umbria         | 8.7                                | 16.0        | 1.2           | 7.6                                | 12.5        | 2.4           |
| Marche         | 14.2                               | 25.5        | 2.5           | 10.1                               | 17.7        | 2.1           |
| Lazio          | 15.2                               | 28.7        | 1.8           | 9.0                                | 16.9        | 0.6           |
| Abruzzo        | 11.0                               | 20.5        | 1.4           | 5.5                                | 10.3        | 0.6           |
| Molise         | 6.8                                | 12.9        | 0.5           | 3.8                                | 7.4         | n.a.          |
| Campania       | 4.1                                | 8.0         | 0.1           | 2.4                                | 4.6         | 0.1           |
| Puglia         | 7.1                                | 14.0        | 0.4           | 5.7                                | 10.7        | 0.4           |
| Basilicata     | 10.2                               | 19.8        | 0.5           | 6.9                                | 13.0        | 0.3           |
| Calabria       | 9.2                                | 17.8        | 0.6           | 5.8                                | 11.4        | n.a.          |
| Sicilia        | 8.5                                | 16.4        | 0.6           | 7.1                                | 13.2        | 0.6           |
| Sardegna       | 21.2                               | 39.5        | 2.5           | 10.5                               | 19.5        | 1.1           |
| <b>Italy</b>   | <b>10.2</b>                        | <b>19.0</b> | <b>1.3</b>    | <b>7.3</b>                         | <b>13.1</b> | <b>1.1</b>    |

Source: Ministry of the Interior and ISTAT ([www.demo.istat.it/stima2000](http://www.demo.istat.it/stima2000))

TABLE 26

**Referrals to the Judicial Authorities by Drug Law Offence**

| Offence                    | 1998          |          | 1999          |          |
|----------------------------|---------------|----------|---------------|----------|
|                            | <i>Number</i> | <i>%</i> | <i>Number</i> | <i>%</i> |
| Production and trafficking | 3,428         | 10.3     | 3,901         | 11.4     |
| Selling drugs              | 26,550        | 80       | 27,860        | 81.2     |
| Involved in trafficking    | 2,855         | 8.6      | 2,258         | 6.6      |
| Involved in selling        | 336           | 1        | 240           | 0.7      |
| Other drug law offences    | 10            | 0.0      | 38            | 0.1      |
| Total                      | 33,179        | 100      | 34,297        | 100      |

Source: Ministry of the Interior

TABLE 27



|                    | RETAIL PRICES (PER GRAM) |         |         |         | WHOLESALE PRICES (PER KILOGRAM) |            |          |            |
|--------------------|--------------------------|---------|---------|---------|---------------------------------|------------|----------|------------|
|                    | MINIMUM                  |         | MAXIMUM |         | MINIMUM                         |            | MAXIMUM  |            |
|                    | EURO                     | LIRE    | EURO    | LIRE    | EURO                            | LIRE       | EURO     | LIRE       |
| CANNABIS RESIN     | 7.08                     | 13,700  | 8.78    | 17,000  | 1755.95                         | 3,400,000  | 2582.28  | 5,000,000  |
| CANNABIS LEAVES    | 5.06                     | 9,800   | 6.46    | 12,500  | 1032.91                         | 2,000,000  | 1394.43  | 2,700,000  |
| HEROIN BROWN       | 63.52                    | 123,000 | 77.47   | 150,000 | 29438.04                        | 57,000,000 | 33311.47 | 64,500,000 |
| HEROIN WHITE       | 81.60                    | 158,000 | 92.96   | 180,000 | 40283.64                        | 78,000,000 | 44931.75 | 87,000,000 |
| COCAINE POWDER     | 92.96                    | 180,000 | 134.80  | 261,000 | 39250.72                        | 76,000,000 | 47514.03 | 92,000,000 |
| AMPHETAMINE POWDER | 19.42                    | 37,600  | 20.66   | 40,000  | 6817.23                         | 13,200,000 | 7075.46  | 13,700,000 |
| 'ECSTASY'          | 19.88                    | 38,500  | 25.05   | 48,500  | 5939.25                         | 11,500,000 | 6455.71  | 12,500,000 |
| LSA                | 24.27                    | 47,000  | 24.79   | 48,000  | 9038.00                         | 17,500,000 |          |            |

TABLE 28

**Number of Italian research papers published in international journals by topic area**

| Topic Area                                      | Number    |
|---|-----------|
| Treatment of substance abuse                    | 7         |
| Genetics of drug dependence and alcoholism      | 4         |
| Drugs and behaviour                             | 6         |
| Toxicological diagnosis                         | 6         |
| Drug dependence and internal medicine           | 11        |
| Diagnosis of drug dependence and alcoholism     | 3         |
| Endocrinology and metabolism of drug dependence | 7         |
| Neuro-physiology and drug dependence            | 12        |
| Pharmacology and drug dependence                | 8         |
| Drug dependence and infectious diseases         | 8         |
| Prevention                                      | 3         |
| <b>TOTAL</b>                                    | <b>75</b> |

TABLE 29

Source: Annual Report to Parliament on the State of the Drug Problem in Italy, 1999

**Typology of Clients of Therapeutic Communities participating in the Research**

|                         |   |
|-------------------------|---|
| <b>Typology 1</b>       | ▪ Drug use in the week before entering the community  |
|                         | ▪ Most likely to have been treated for heroin dependence  |
|                         | ▪ Signs of depression, sadness, mobility problems   |
|                         | ▪ Isolated, difficulty in managing emotions, sleep problems   |
|                         | ▪ Poor decisional and risk management skills  |
|                         | ▪ Low self esteem and a tendency to deviancy  |
| <b>Typology 2</b>       | ▪ The majority did not use heroin for at least a month before entering the community and had dealt with the problem of abstinence |
|                         | ▪ No problems of sadness, mobility, emotional reactions   |
|                         | ▪ Patterns of sleep, social isolation and energy match those of the general population  |
|                         | ▪ Detoxification is primarily without use of methadone  |
|                         | ▪ Good decision making skills, risk management and self esteem  |
|                         | ▪ Good educational level (degree or upper school leaving certificate)   |
| ▪ Came to drug use late |   |

|                   |   |
|-------------------|---|
| <b>Typology 3</b> | <ul style="list-style-type: none"> <li>Used heroin up to a month before entering the community or had used drugs other than heroin in the week before admission</li> </ul>  |
|                   | <ul style="list-style-type: none"> <li>Non-critical psycho-social problems but a range of difficulties, most clearly in dealing with emotions, but also with sleep, sadness, mobility, social isolation and lack of energy</li> </ul> |
|                   | <ul style="list-style-type: none"> <li>The majority were detoxified with antagonists</li> </ul>   |
|                   | <ul style="list-style-type: none"> <li>Had positive signs: a desire to get help, and had a job.</li> </ul>  |
|                   | <ul style="list-style-type: none"> <li>Most were married</li> </ul>   |
|                   | <ul style="list-style-type: none"> <li>Were in the age range 25 - 29 and began drug use between the age of 16 and 18</li> </ul>   |
| <b>Typology 4</b> | <ul style="list-style-type: none"> <li>Had used drugs other than heroin in the last month but not in the last week</li> </ul>   |
|                   | <ul style="list-style-type: none"> <li>Had problems particularly in relation to dealing with emotions and with sleep</li> </ul>   |
|                   | <ul style="list-style-type: none"> <li>Contrasting signs: good decision making and poor risk management skills</li> </ul>   |
|                   | <ul style="list-style-type: none"> <li>Young and single</li> </ul>  |
|                   | <ul style="list-style-type: none"> <li>Lower school leaving certificate</li> </ul>  |
|                   | <ul style="list-style-type: none"> <li>Few legal problems</li> </ul>  |
|                   | <ul style="list-style-type: none"> <li>First approach to a community</li> </ul>   |

Source: emme e erre. Project for the Evaluation of the quality of therapeutic communities

TABLE 30

**Number and percentage of positive and negative replies concerning the clarity of the message and agreement with the contents.**

|                     | <b>Clarity of the message</b> |           |                   |           | <b>Agreement with the contents</b> |           |                   |           |
|---------------------|-------------------------------|-----------|-------------------|-----------|------------------------------------|-----------|-------------------|-----------|
|                     | <b>Number</b>                 |           | <b>Percentage</b> |           | <b>Number</b>                      |           | <b>Percentage</b> |           |
|                     | <b>Yes</b>                    | <b>No</b> | <b>Yes</b>        | <b>No</b> | <b>Yes</b>                         | <b>No</b> | <b>Yes</b>        | <b>No</b> |
| Male students       | 114                           | 56        | 67                | 33        | 140                                | 30        | 82                | 18        |
| Female students     | 76                            | 56        | 57                | 43        | 106                                | 26        | 80                | 20        |
| Total               | 190                           | 112       | 63                | 37        | 246                                | 56        | 81                | 19        |
| Students ≤ 16 years | 92                            | 63        | 59                | 41        | 131                                | 24        | 84                | 16        |
| Students > 16 years | 98                            | 49        | 67                | 33        | 115                                | 32        | 78                | 22        |
| Treatment staff     | 14                            | 4         | 78                | 22        | 16                                 | 2         | 89                | 11        |
| Drug dependents     | 8                             | 3         | 72                | 28        | 2                                  | 9         | 18                | 82        |

TABLE 31

Source: [Rossi, A. et al \(2000\)](#)

**Average Staff Levels and Client Numbers for the Ser.T in 1991 and 1999**

| Staff Categories      | 1991      |            |                  | 1999        |            |            |                  |
|-----------------------|-----------|------------|------------------|-------------|------------|------------|------------------|
|                       | Full Time | Part Time  | Ave. No. Clients | Full Time   | Part Time  | Contracted | Ave. No. Clients |
| Medical               | 1.6       | 1          | 189              | 2.2         | .3         | .6         | 275              |
| Psychological         | 1.3       | .5         |                  | 1.8         | .2         | .3         |                  |
| Health/Social Workers | 3.3       | 1          |                  | 5.6         | .5         | .4         |                  |
| Administrative        | .8        | .3         |                  | 1.1         | .2         | .2         |                  |
| <b>TOTAL</b>          | <b>7</b>  | <b>2.8</b> | <b>189</b>       | <b>10.7</b> | <b>1.2</b> | <b>1.7</b> | <b>275</b>       |

Source: Ministry of Health, Health Information System, Department for Prevention

TABLE 32

**Psycho-Social and/or Rehabilitation Treatment by Year**

| Type of psycho-social /<br>rehabilitative treatment | Percentage of Clients Treated * |             |             |                               |             |             |             |             |             |
|---|---------------------------------|-------------|-------------|-------------------------------|-------------|-------------|-------------|-------------|-------------|
|   | In the Ser.T                    |             |             | In rehabilitative<br>services |             |             | In prison   |             |             |
|   | 1997                            | 1998        | 1999        | 1997                          | 1998        | 1999        | 1997        | 1998        | 1999        |
| Psychological support                               | 28.6                            | 27.2        | 26.4        | 3.4                           | 3.9         | 3.9         | 3.3         | 3.3         | 3.2         |
| Psychotherapy                                       | 11.6                            | 10.0        | 10.9        | 1.1                           | 0.9         | 0.9         | 0.3         | 0.3         | 0.4         |
| Social work intervention                            | 37.7                            | 40.2        | 40.5        | 6.9                           | 7.0         | 6.8         | 6.9         | 7.2         | 7.0         |
| <b>Total</b>  | <b>78.0</b>                     | <b>77.4</b> | <b>77.8</b> | <b>11.5</b>                   | <b>11.8</b> | <b>11.6</b> | <b>10.5</b> | <b>10.8</b> | <b>10.6</b> |

**TABLE 33**

Source: Ministry of Health, Health Information System, Department of Prevention

\* Percentage of clients exclusively receiving psycho-social and/or rehabilitative treatment

Figures

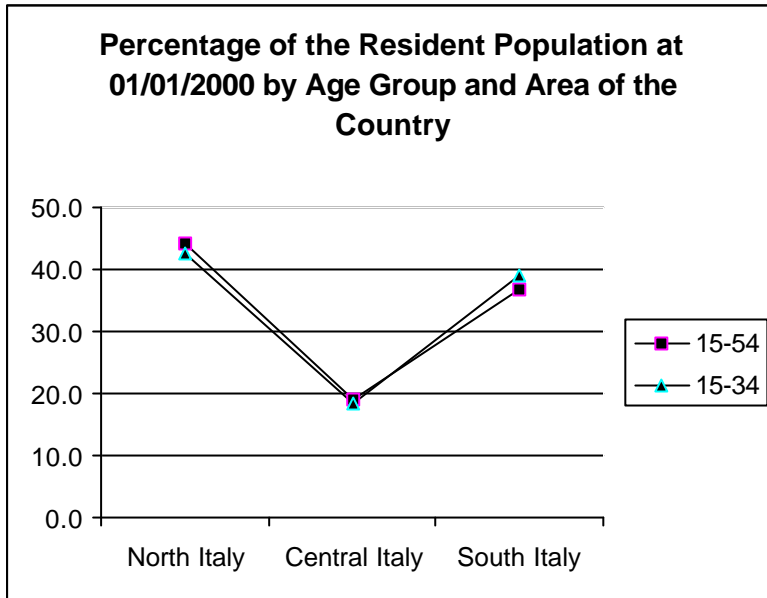


FIGURE 1

Source: ISTAT ([www.demo.istat.it/stima2000](http://www.demo.istat.it/stima2000))

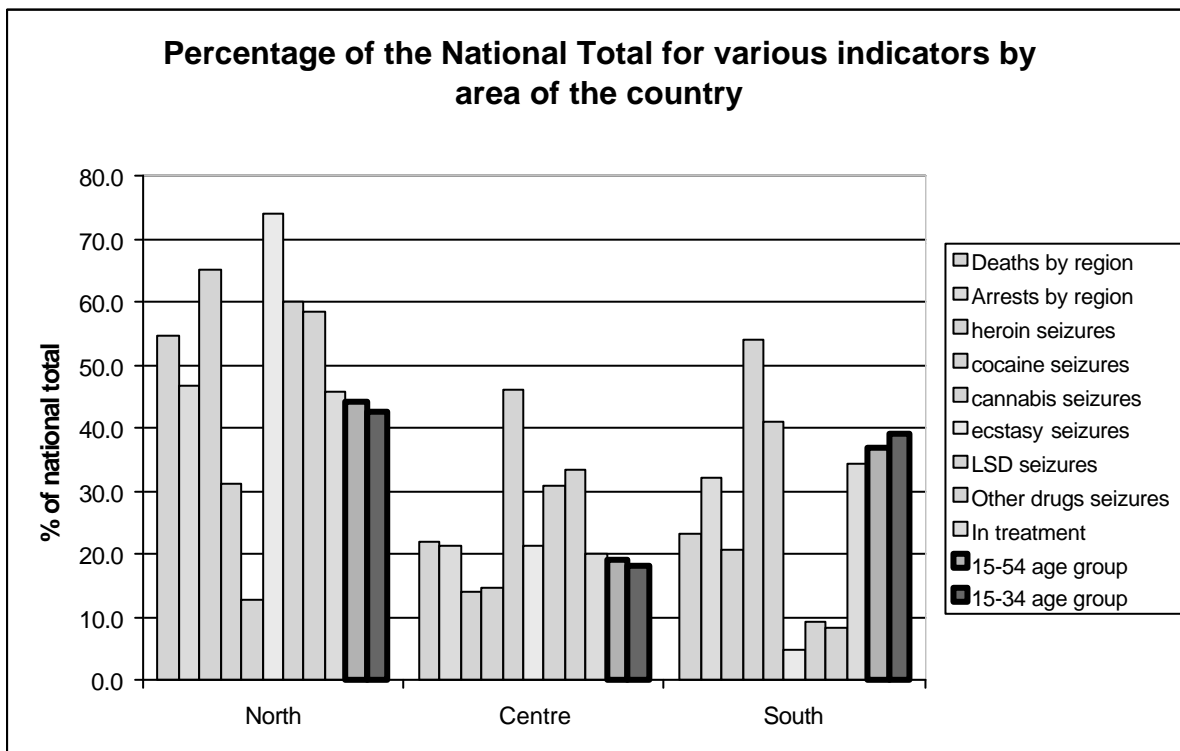


FIGURE 2

Source: Ministry of Health, Ministry of the Interior, ISTAT.

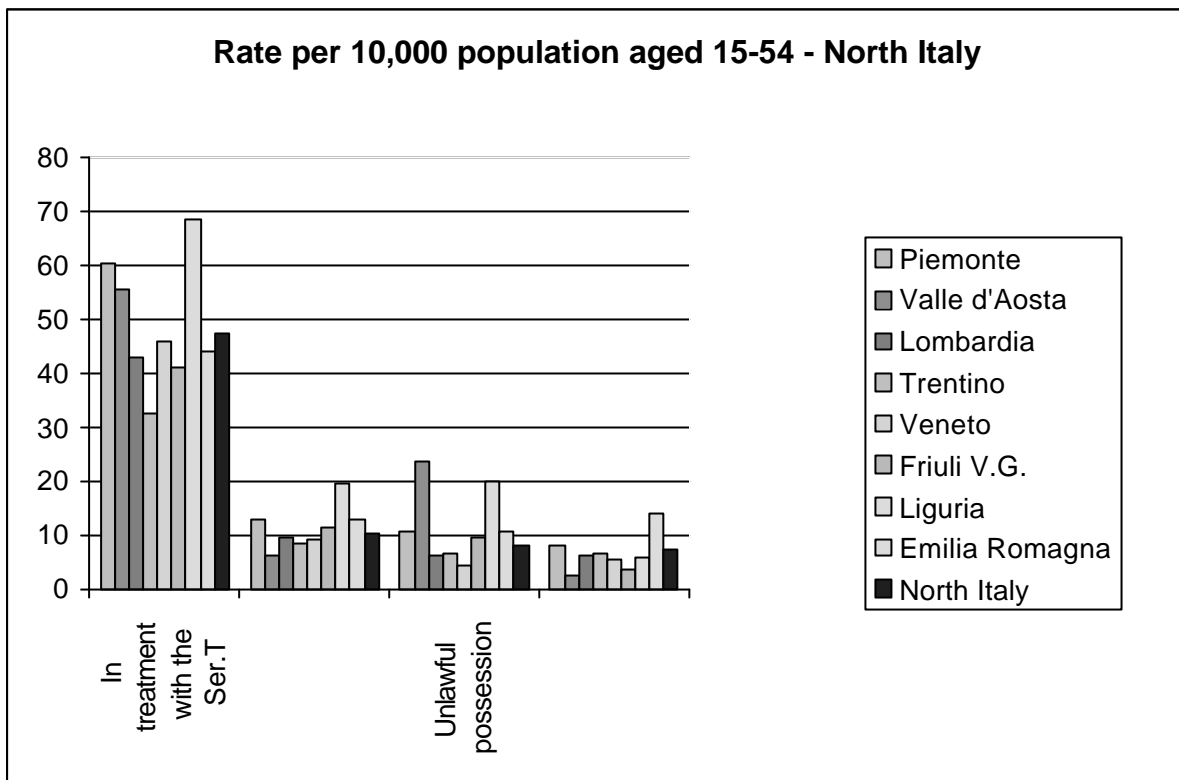


FIGURE 3

SOURCE: Ministry of Health, Ministry of the Interior and ISTAT

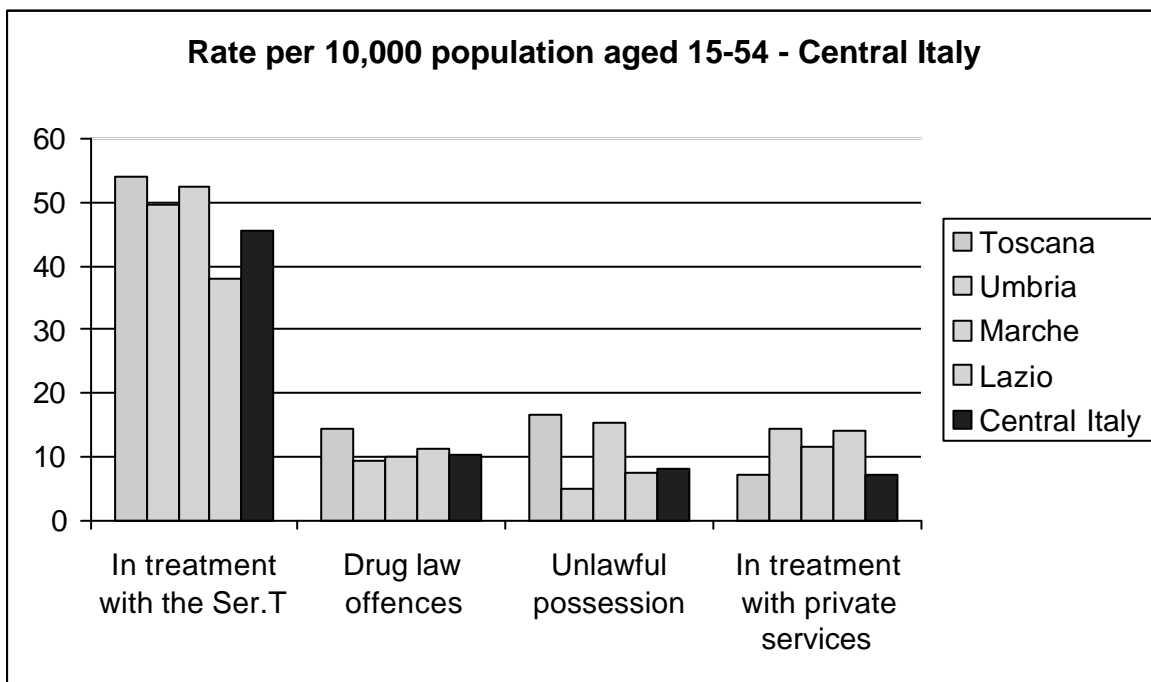


FIGURE 4

SOURCE: Ministry of Health, Ministry of the Interior and ISTAT

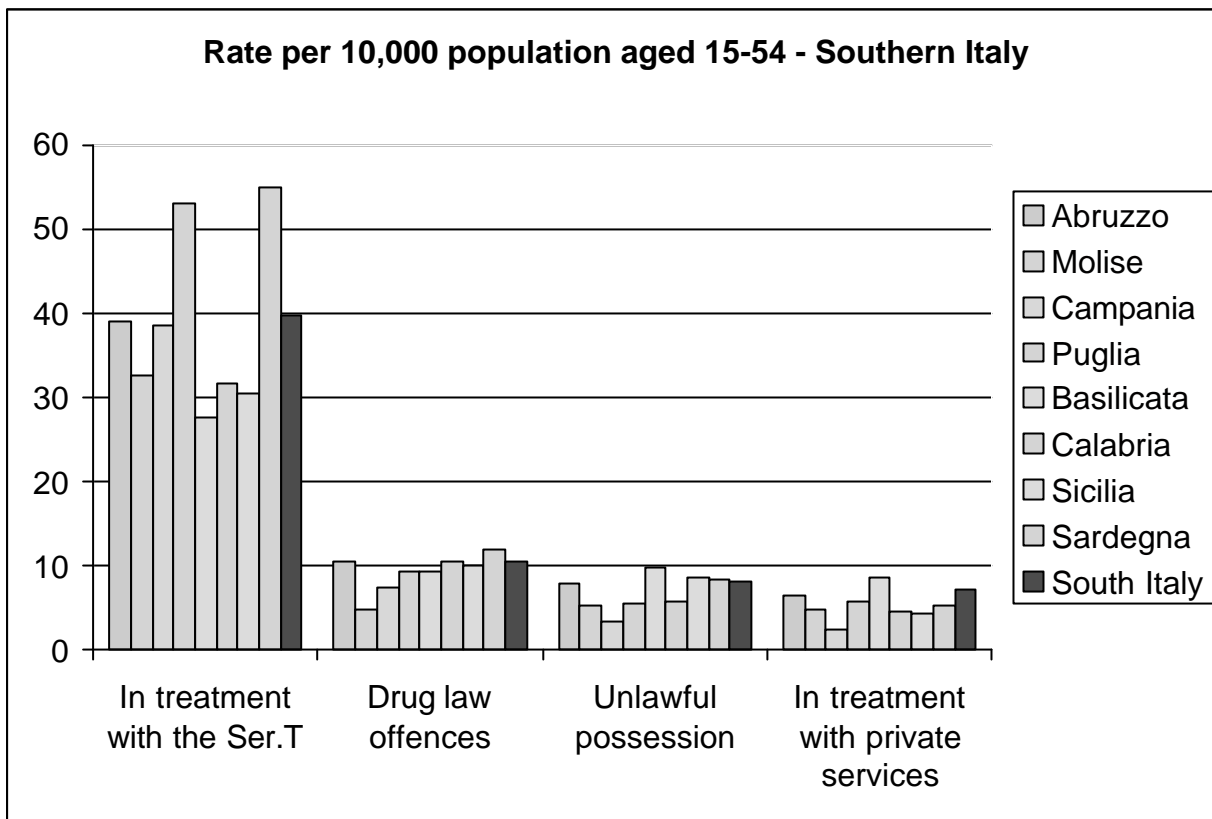


FIGURE 5

SOURCE: Ministry of Health, Ministry of the Interior and ISTAT

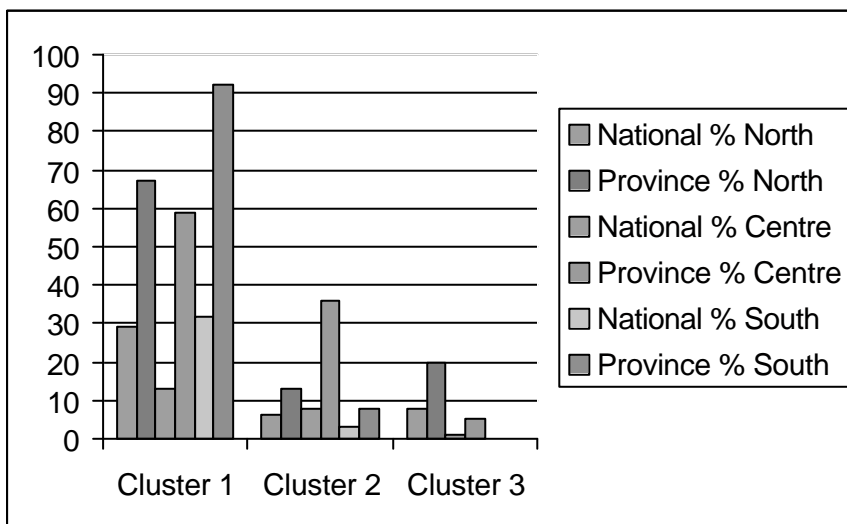


FIGURE 6

Source: Italian Observatory for Drugs and Drug Dependence ([www.genovaduemila/documenti/documenti.html](http://www.genovaduemila/documenti/documenti.html) )

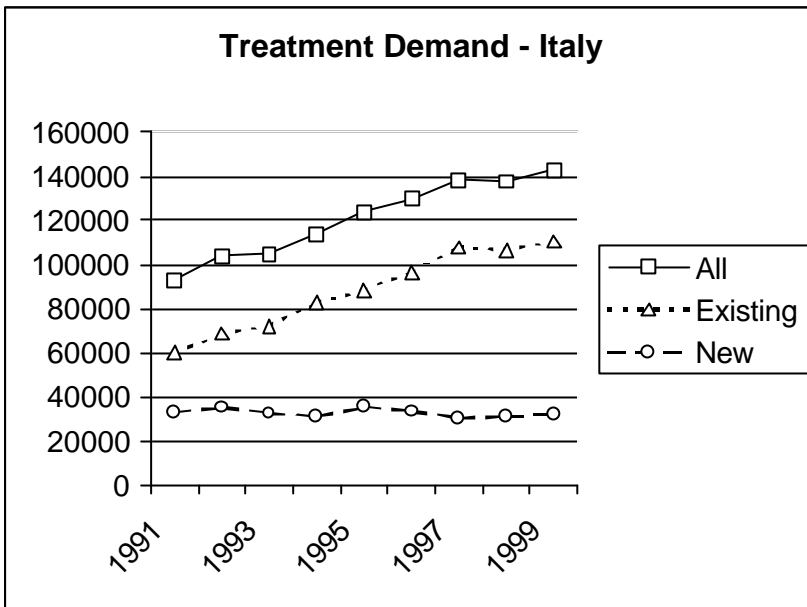


FIGURE 7

Source: Ministry of Health, Health Information System, Department of Prevention

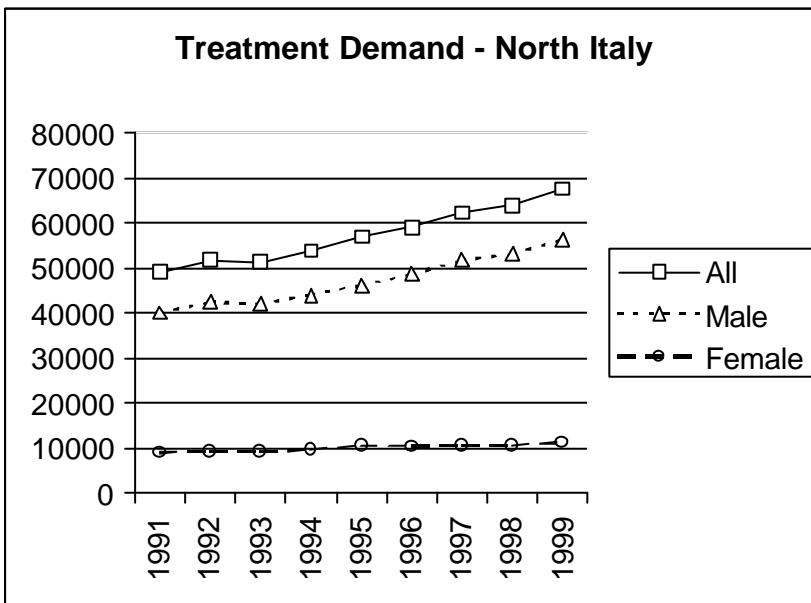


FIGURE 8

Source: Ministry of Health, Health Information System, Department of Prevention

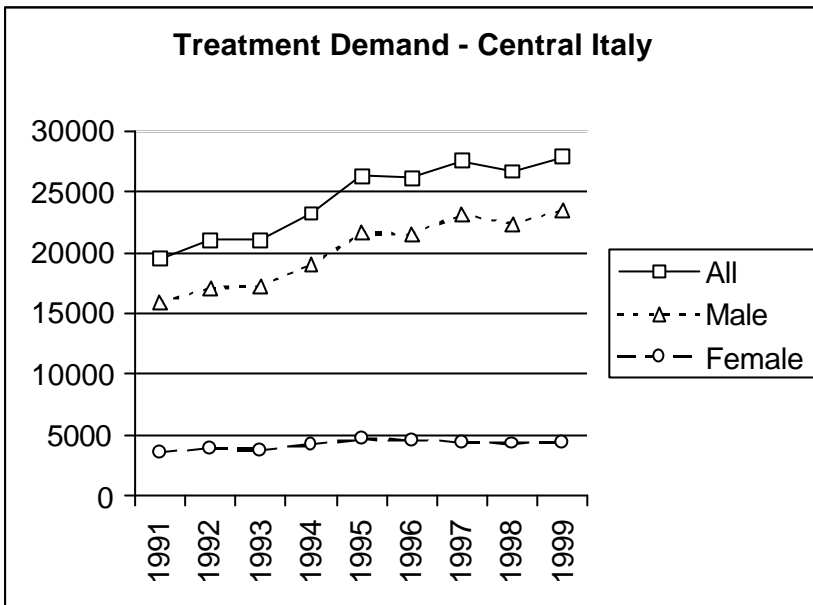


FIGURE 9

Source: Ministry of Health, Health Information System, Department of Prevention

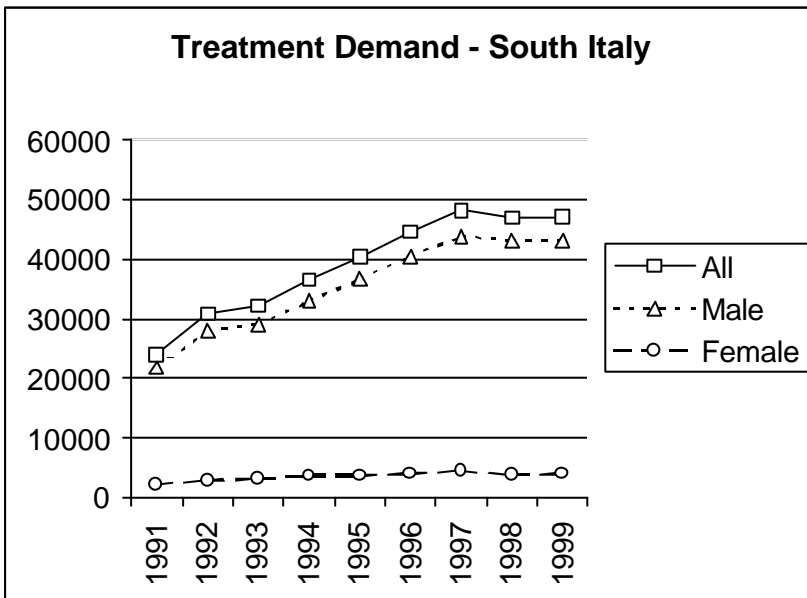


FIGURE 10

Source: Ministry of Health, Health Information System, Department of Prevention



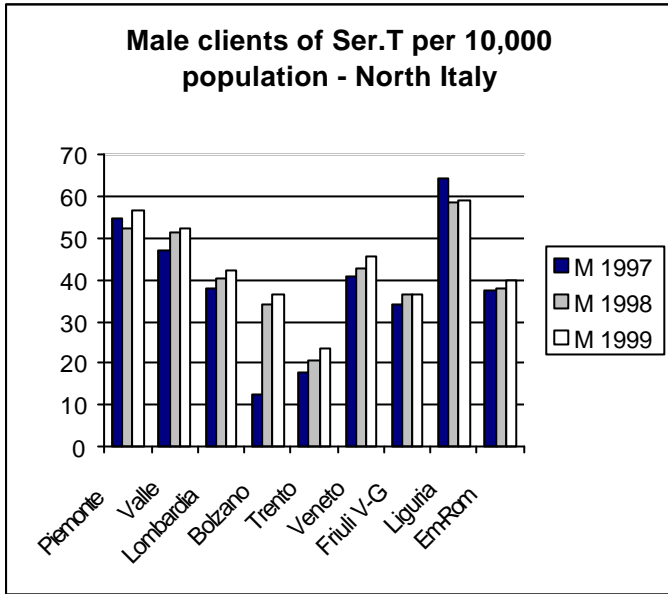


FIGURE 11 (A)

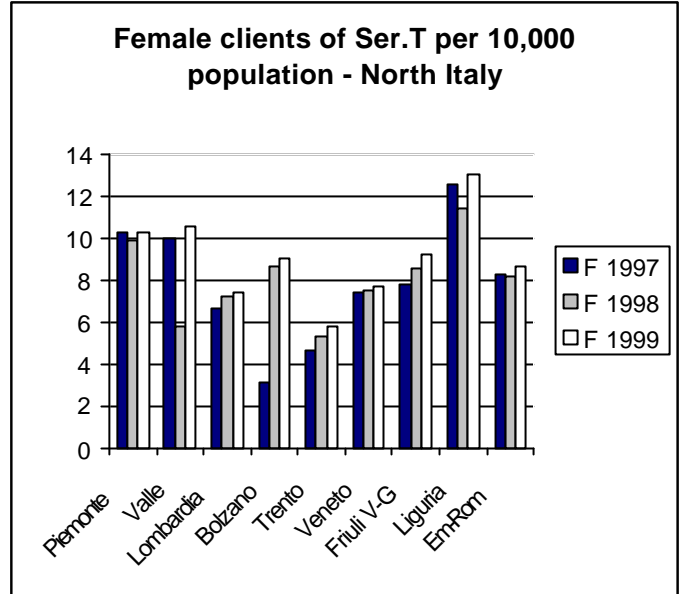


FIGURE 11 (B)

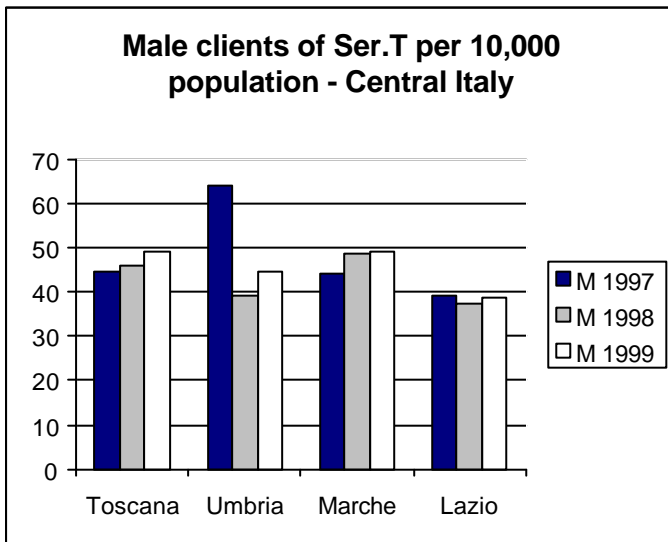


FIGURE 12 (A)

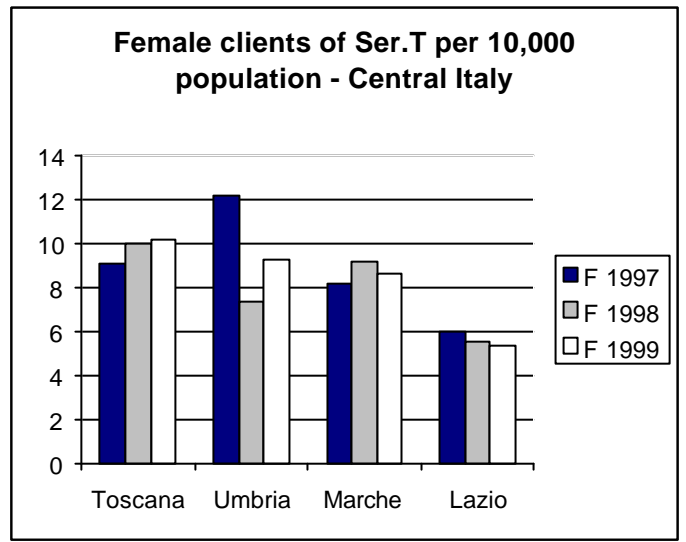


FIGURE 12 (B)

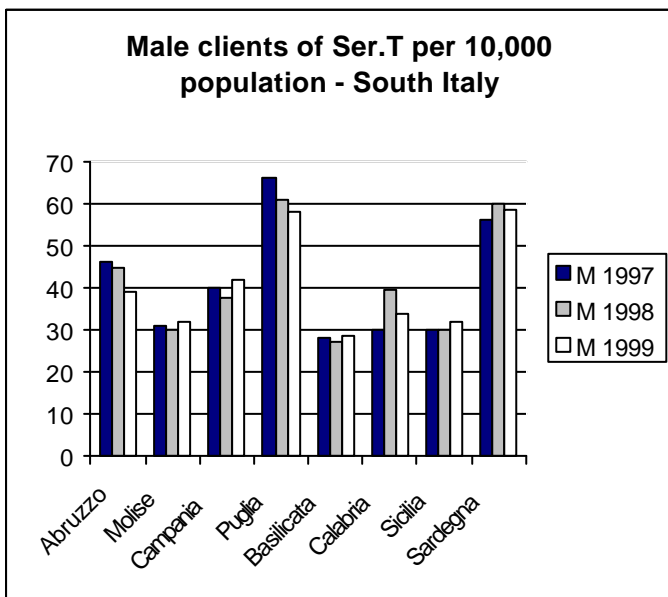


FIGURE 13 (A)

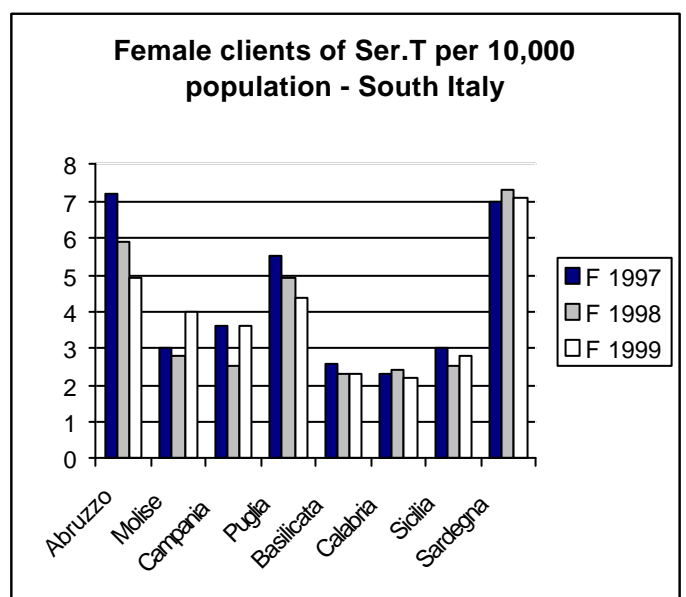


FIGURE 13 (B)

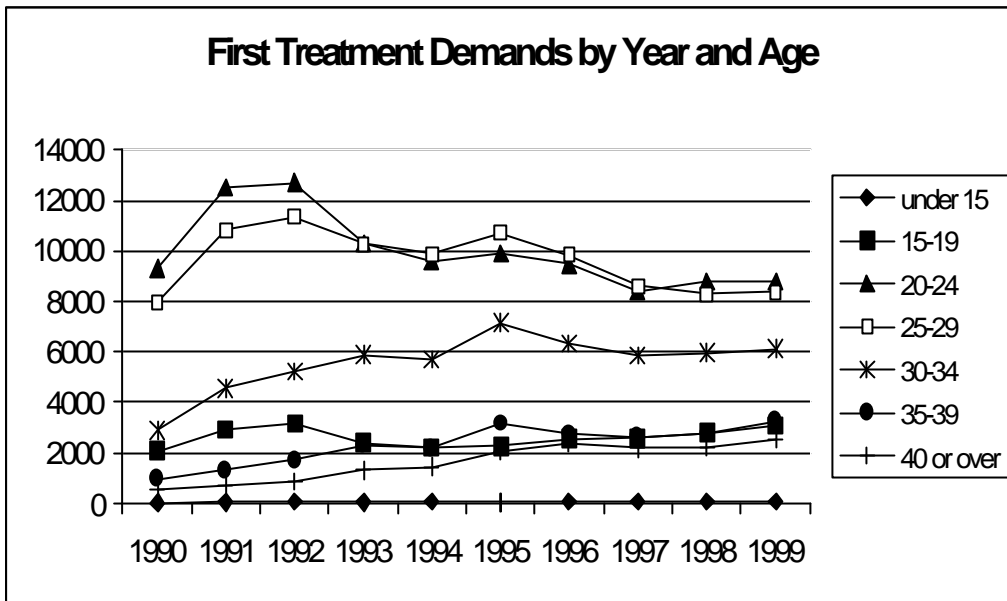


FIGURE 14

Source: Ministry of Health, Health Information System, Department of Prevention

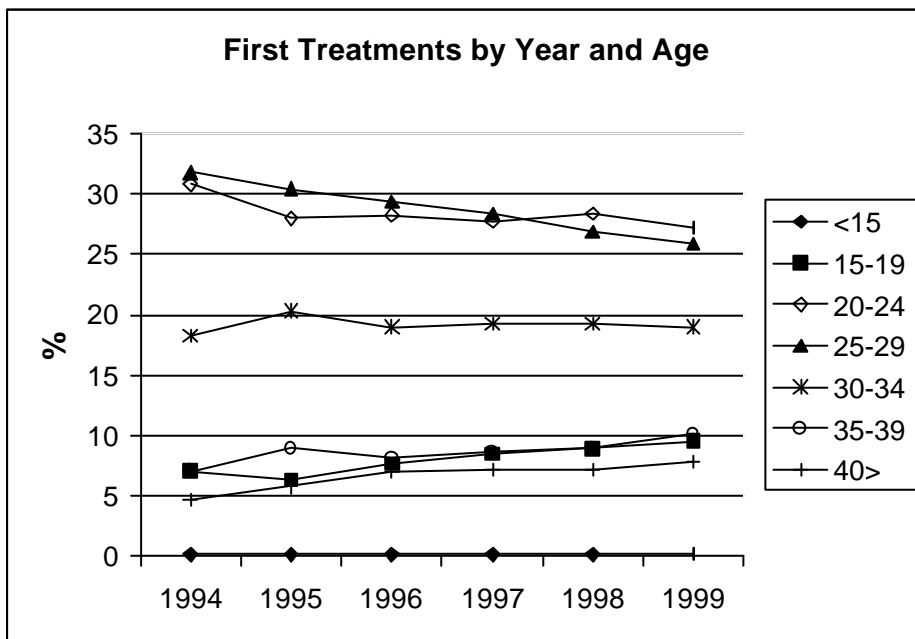


FIGURE 15

Source: Ministry of Health, Health Information System, Department of Prevention

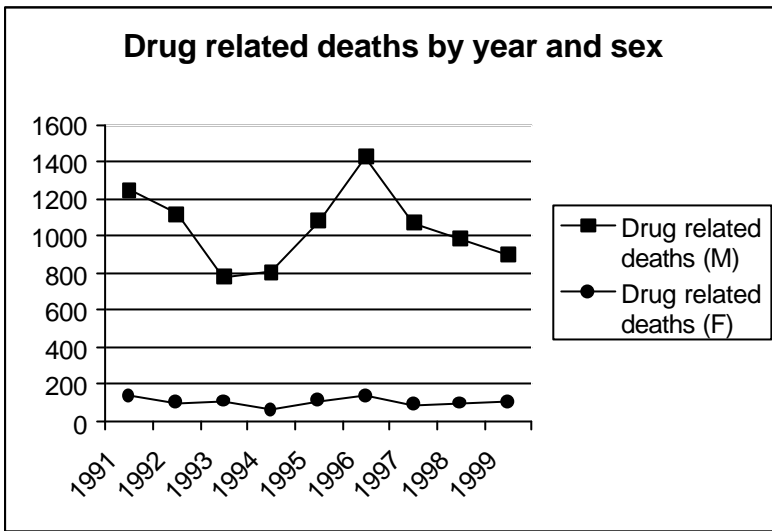


FIGURE 16

Source: Ministry of the Interior

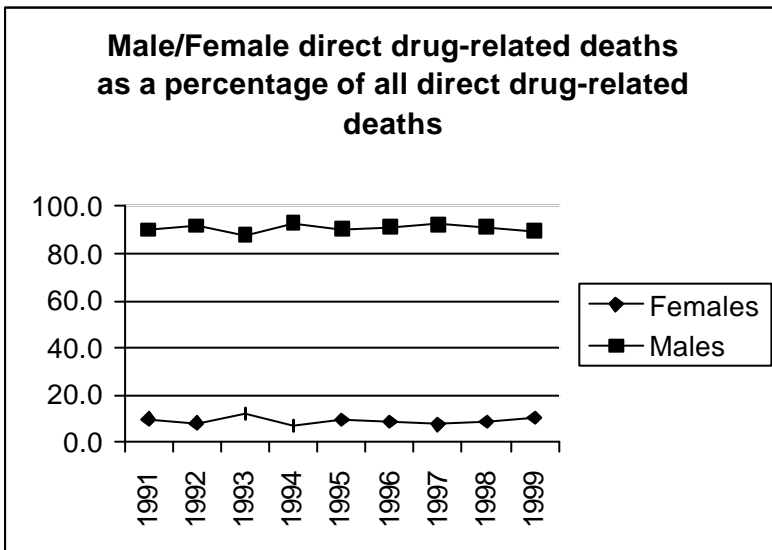


FIGURE 17

Source: Ministry of the Interior

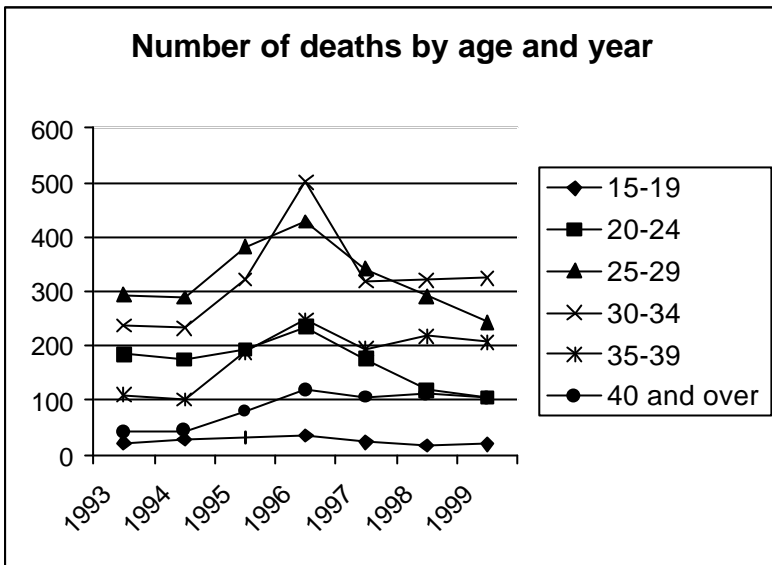


FIGURE 18

Source: Ministry of the Interior

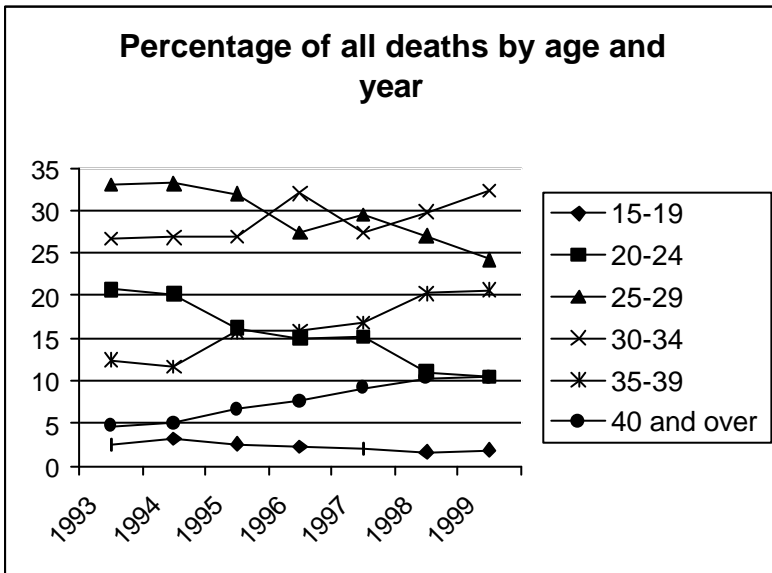
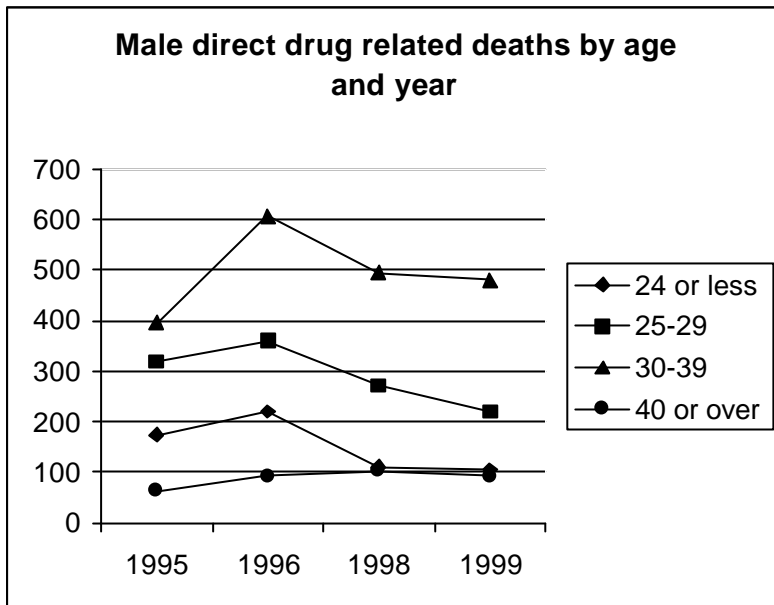


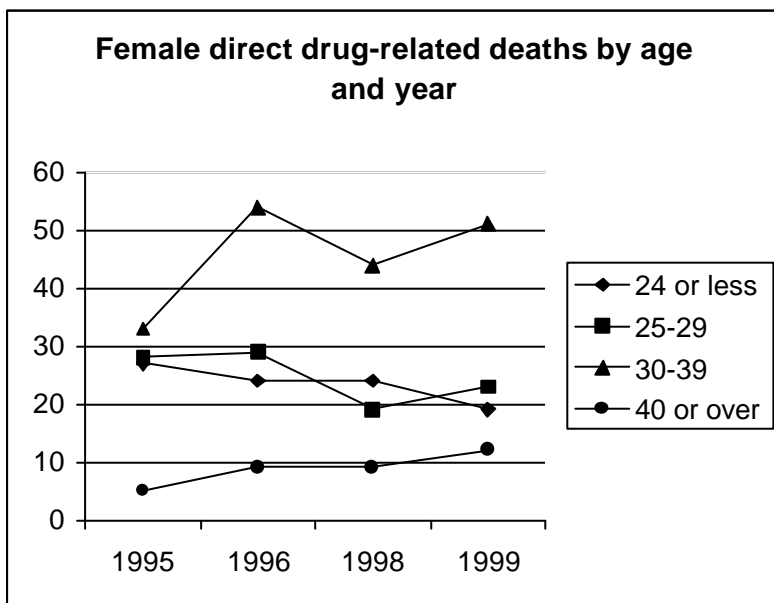
FIGURE 19

Source: Ministry of the Interior



**FIGURE 20**

Source: Ministry of the Interior



**FIGURE 21**

Source: Ministry of the Interior

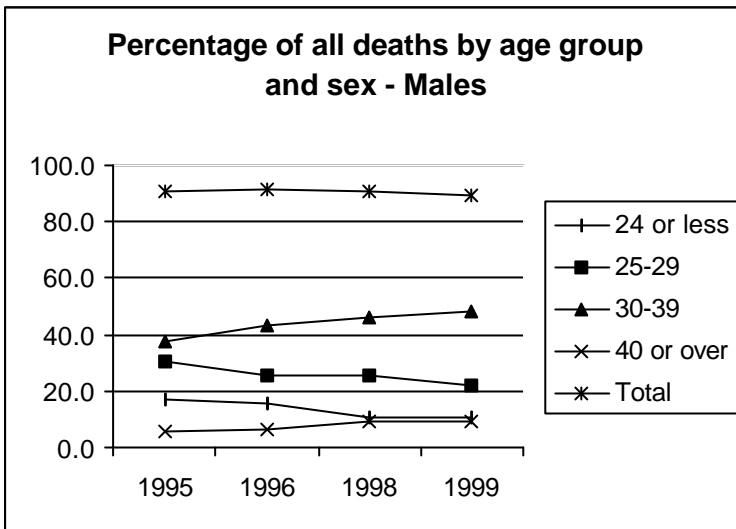


FIGURE 22

Source: Ministry of the Interior

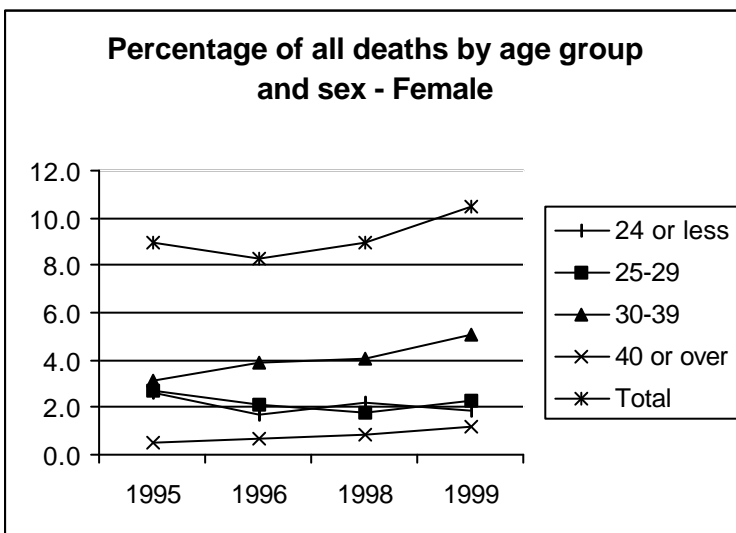


FIGURE 23

Source: Ministry of the Interior

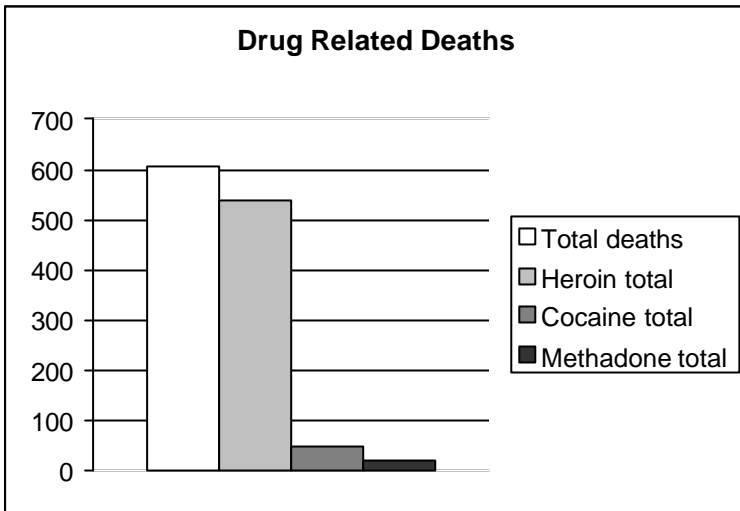


FIGURE 24

Source: Study by the Forensic Toxicologists Group of the Italian Society of Legal Medicine

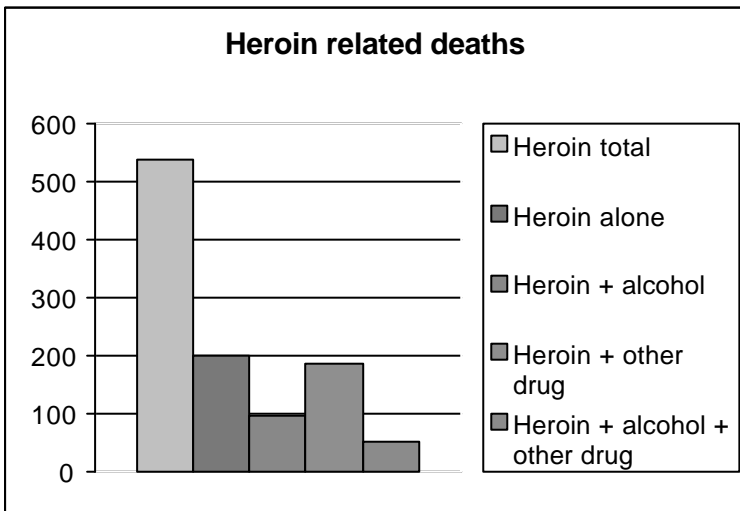
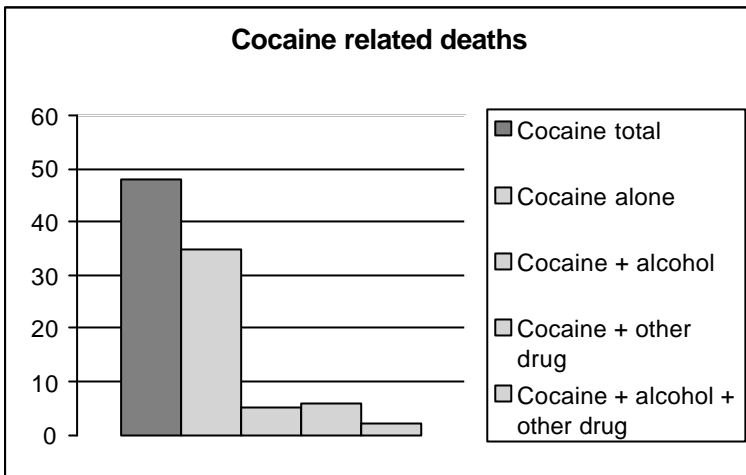


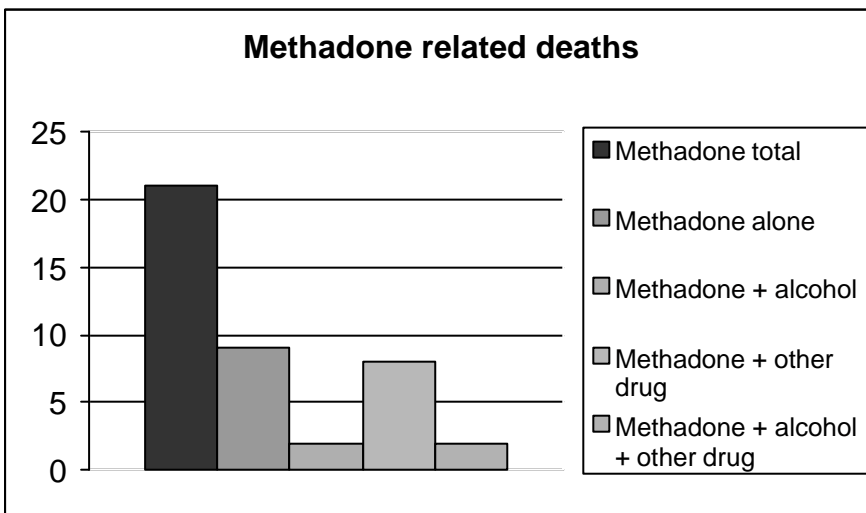
FIGURE 25

Source: Study by the Forensic Toxicologists Group of the Italian Society of Legal Medicine



**FIGURE 26**

Source: Study by the Forensic Toxicologists Group of the Italian Society of Legal Medicine



**FIGURE 27**

Source: Study by the Forensic Toxicologists Group of the Italian Society of Legal Medicine



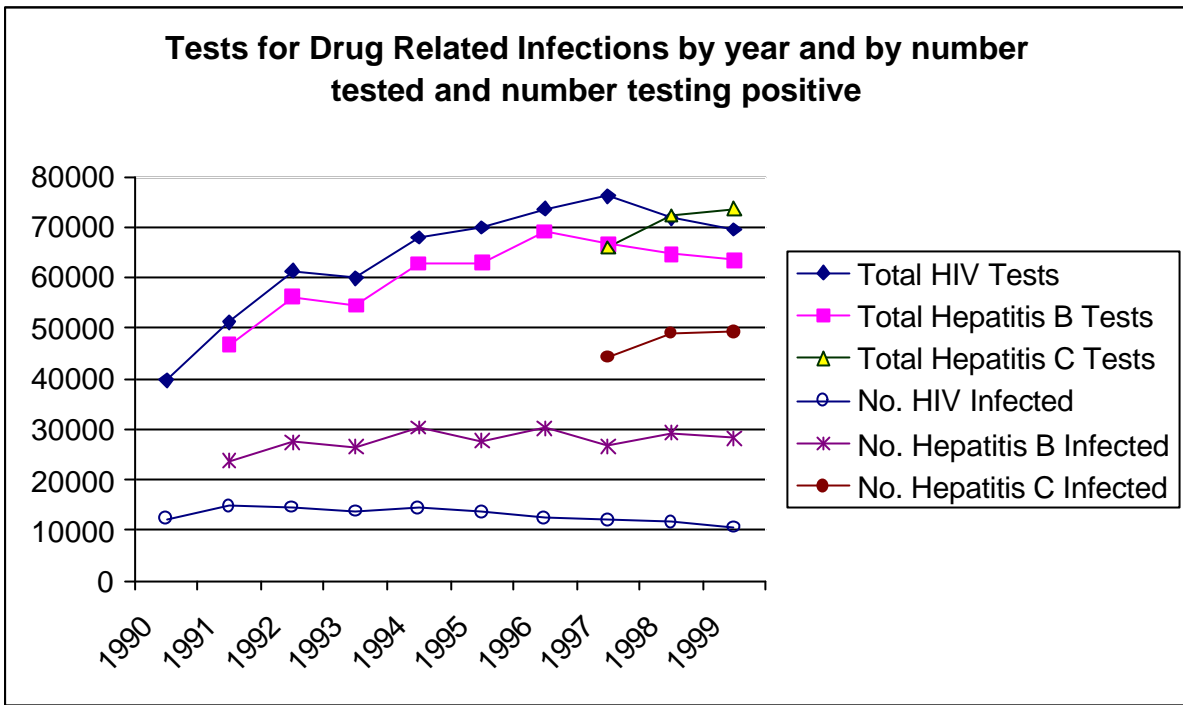


FIGURE 28

Source: Ministry of Health, Health Information System, Department of Prevention

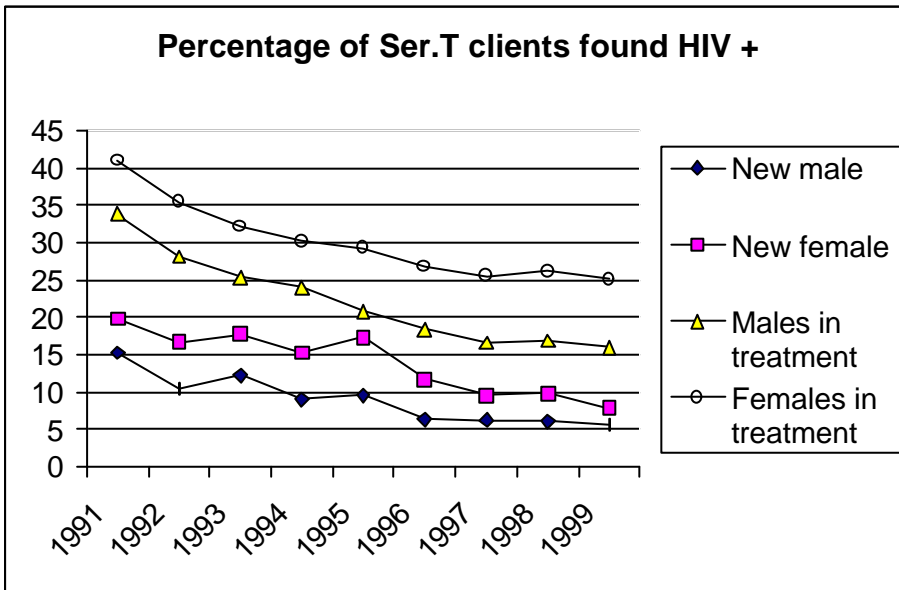


FIGURE 29

Source: Ministry of Health, Health Information System, Department of Prevention

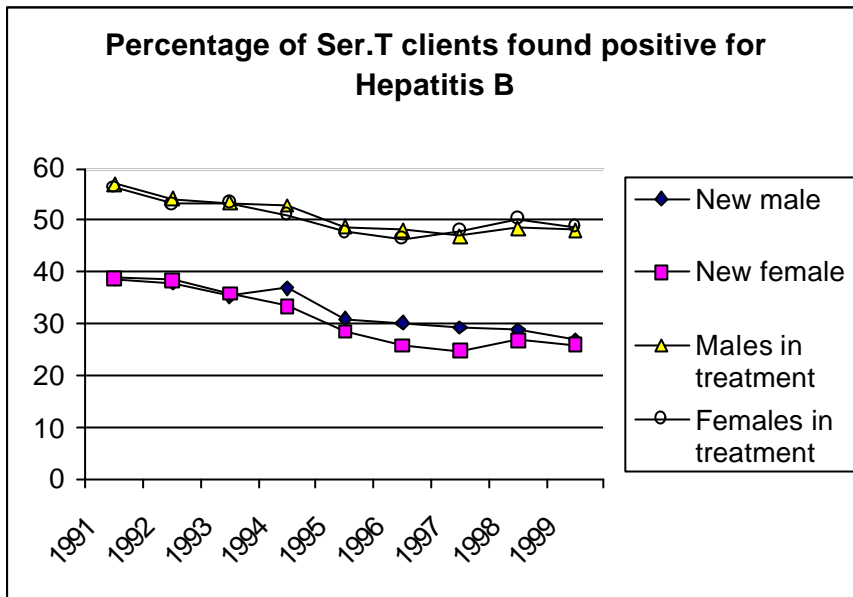


FIGURE 30

Source: Ministry of Health, Health Information System, Department of Prevention

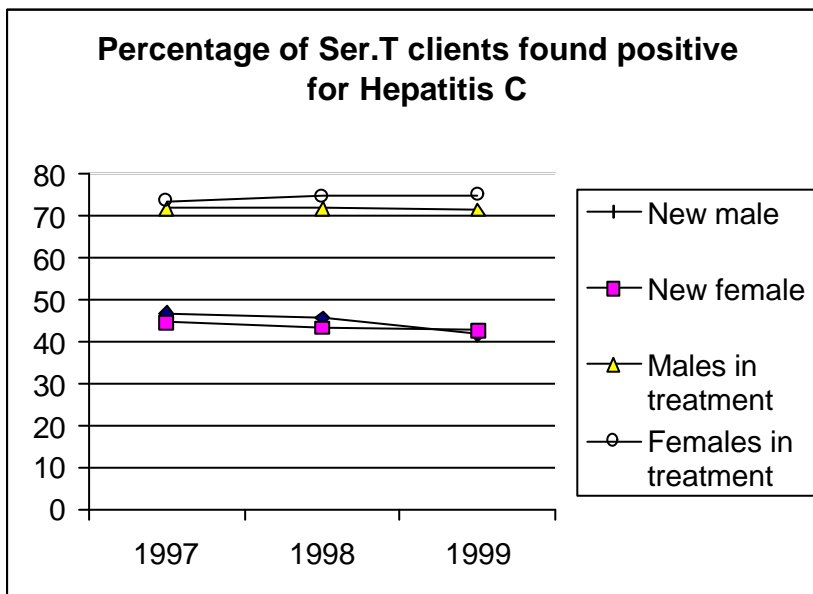


FIGURE 31

Source: Ministry of Health, Health Information System, Department of Prevention

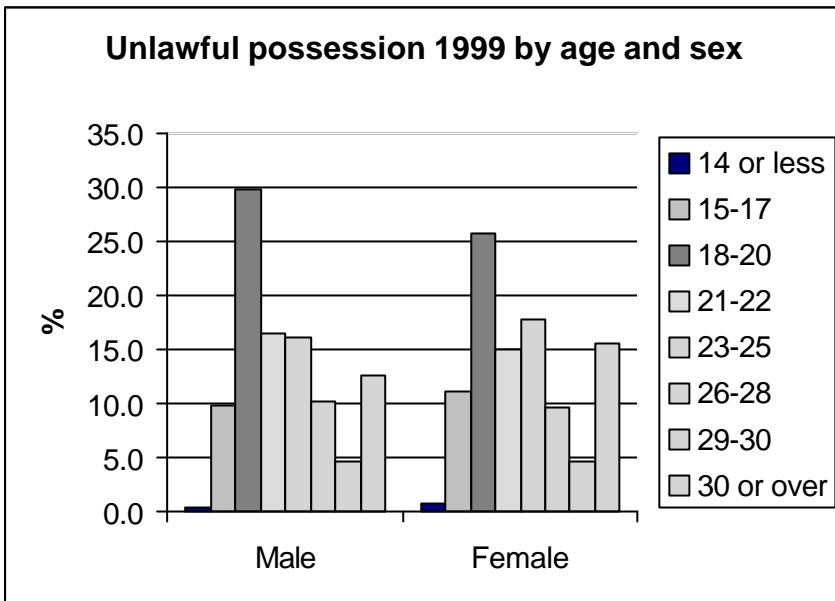


FIGURE 32

Source: Ministry of the Interior

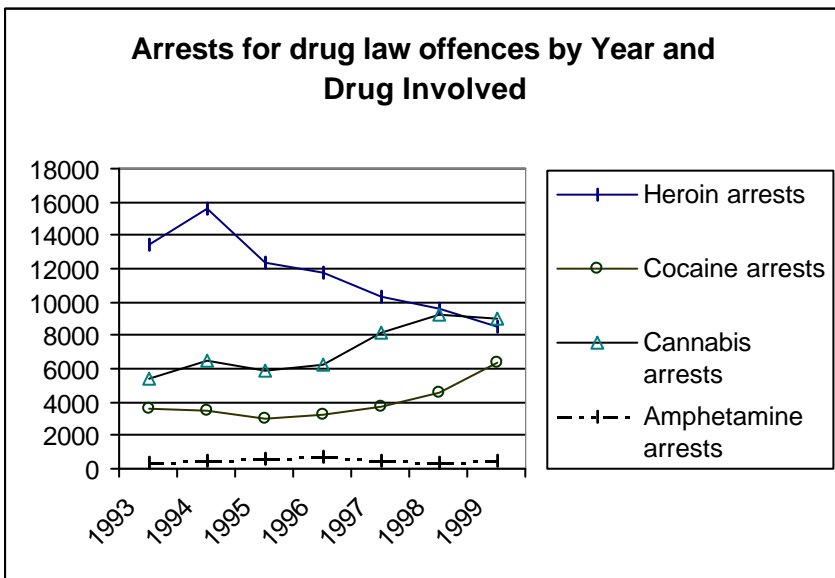


FIGURE 33

Source: Ministry of the Interior

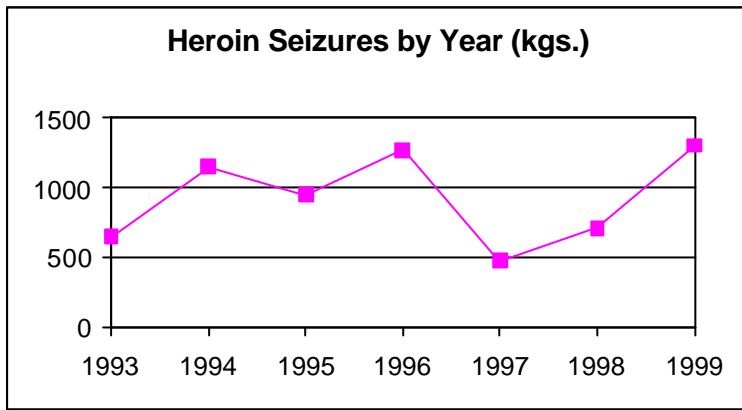


FIGURE 34

Source: Ministry of the Interior

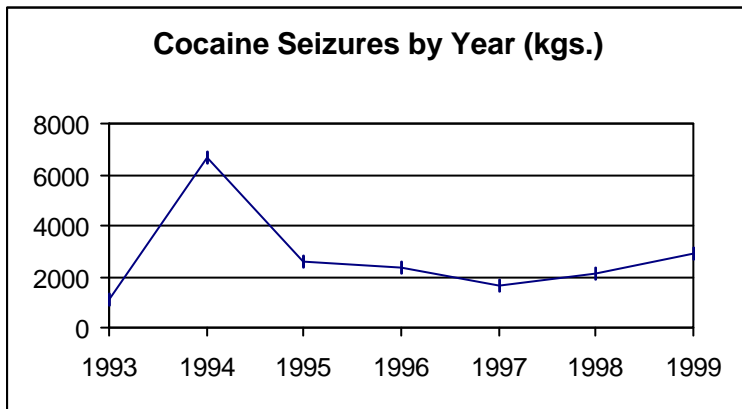


FIGURE 35

Source: Ministry of the Interior

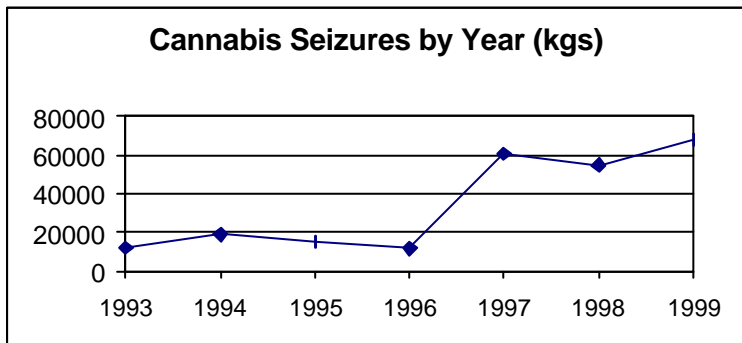


FIGURE 36

Source: Ministry of the Interior

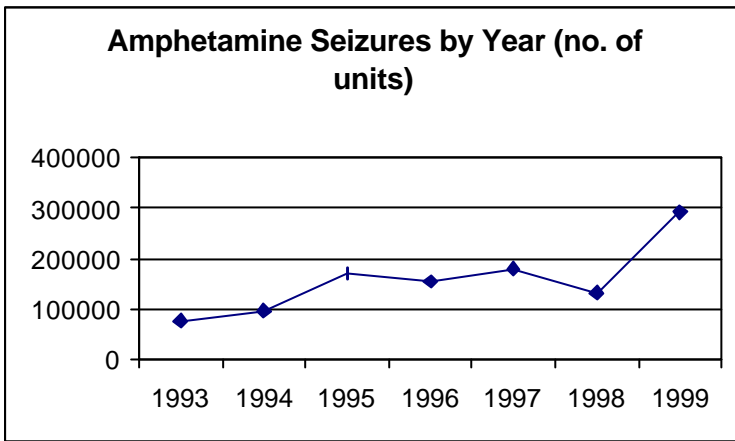


FIGURE 37

Source: Ministry of the Interior

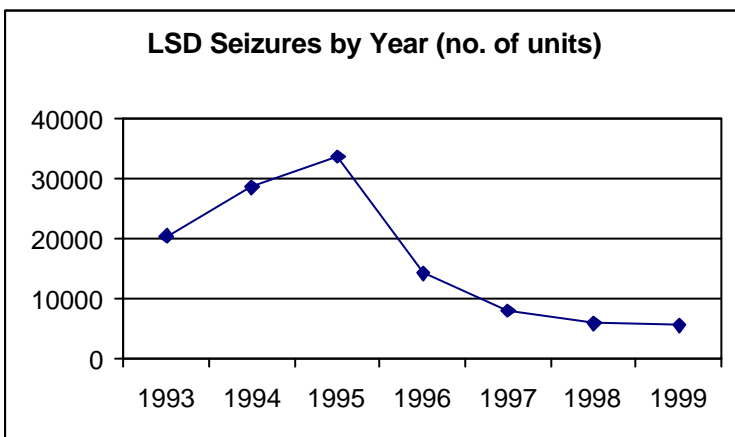


FIGURE 38

Source: Ministry of the Interior

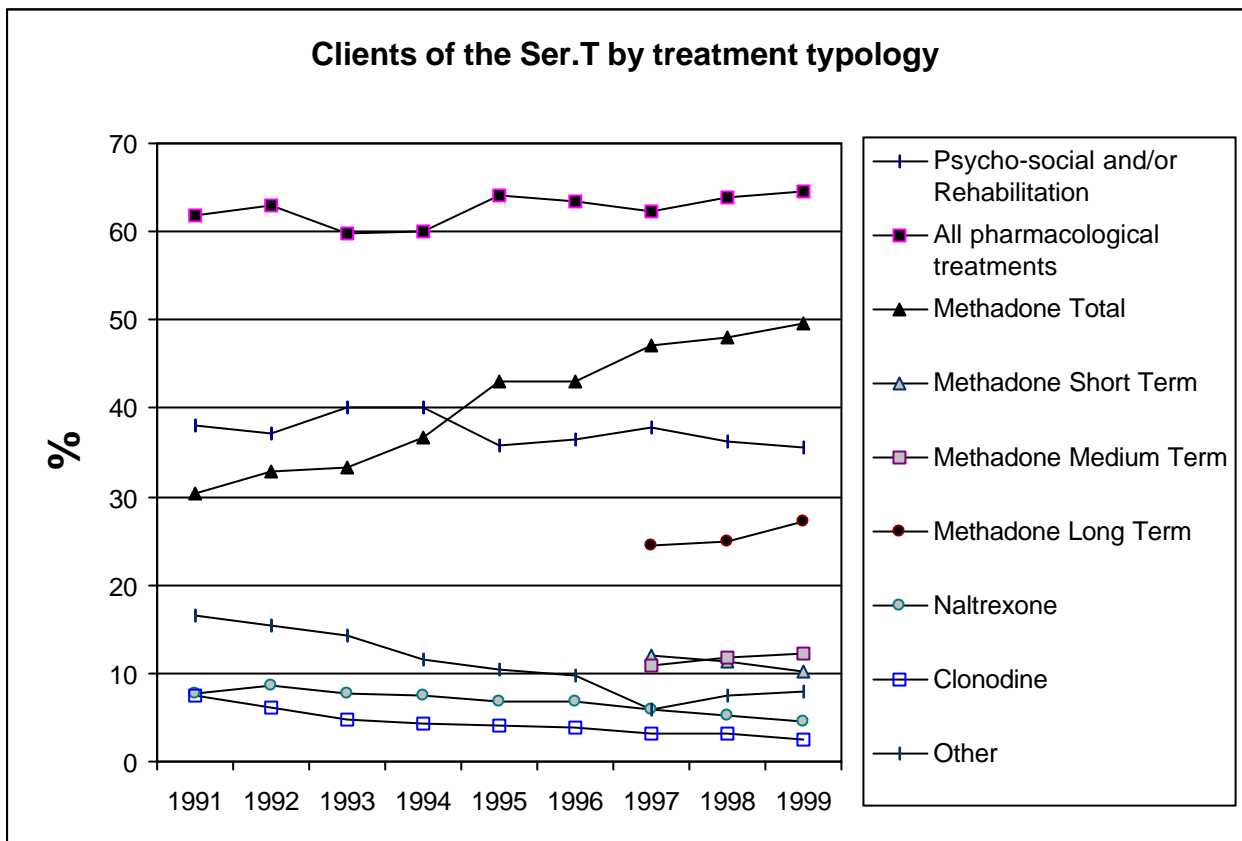


FIGURE 39

Source: Ministry of Health, Health Information System, Department of Prevention

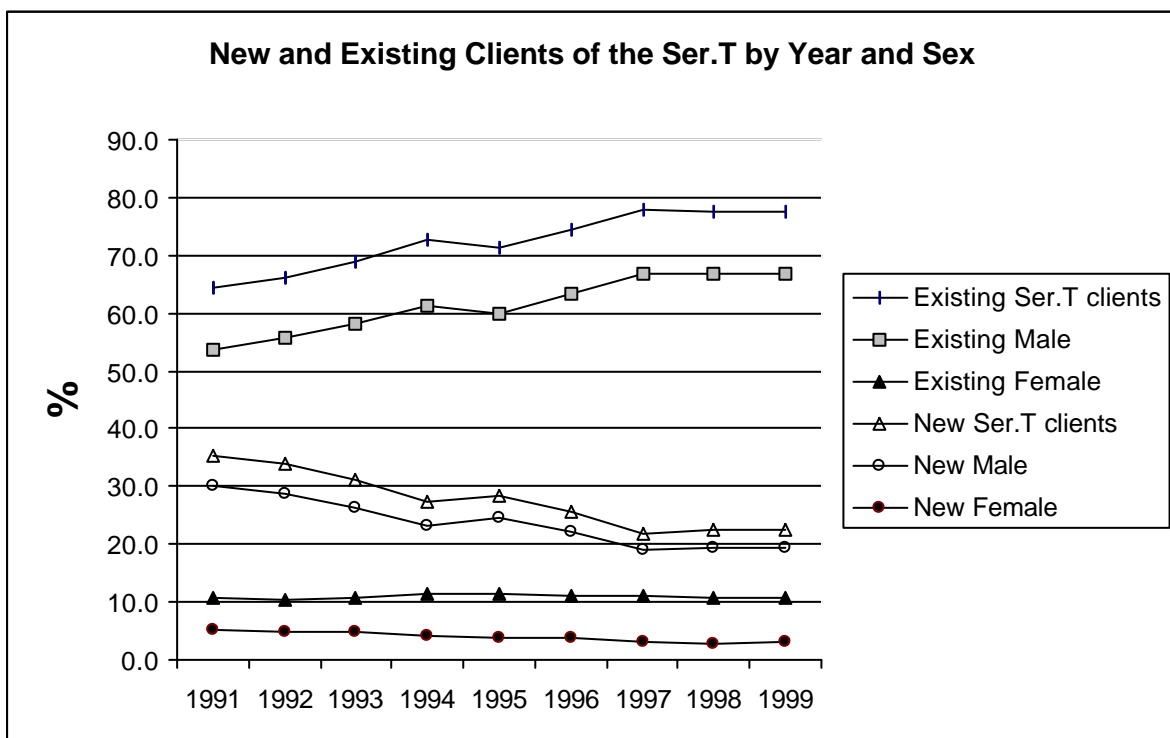


FIGURE 40

Source: Ministry of Health, Health Information System, Department of Prevention

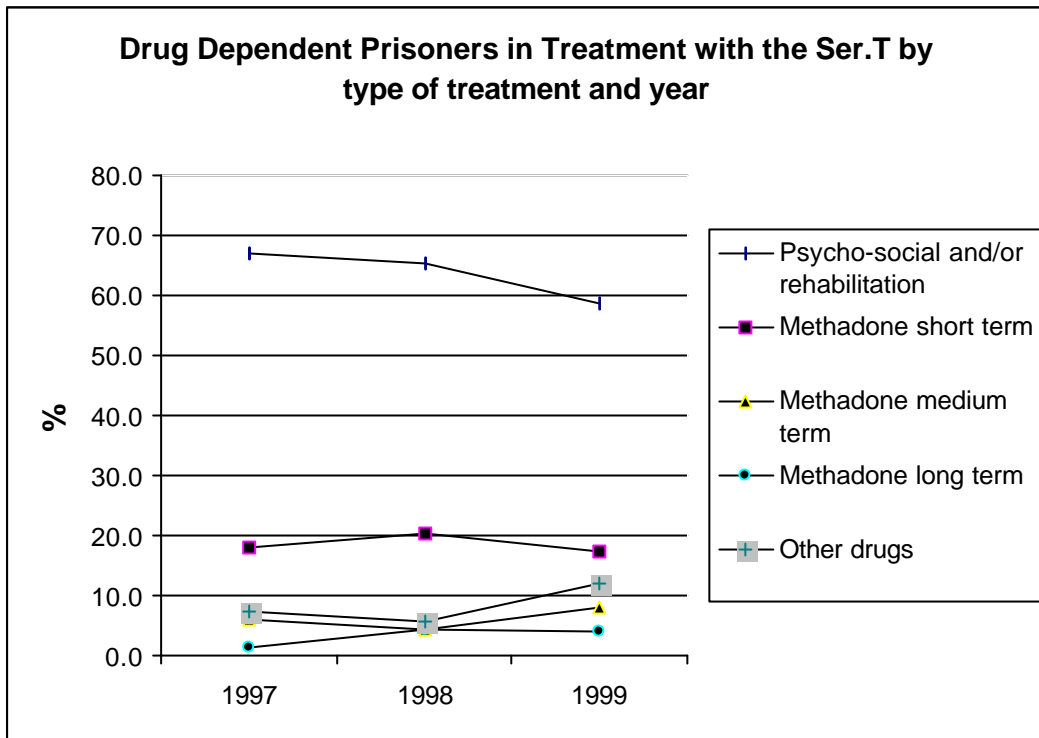


FIGURE 41

Source: Ministry of Health, Health Information System, Department of Prevention

## Maps

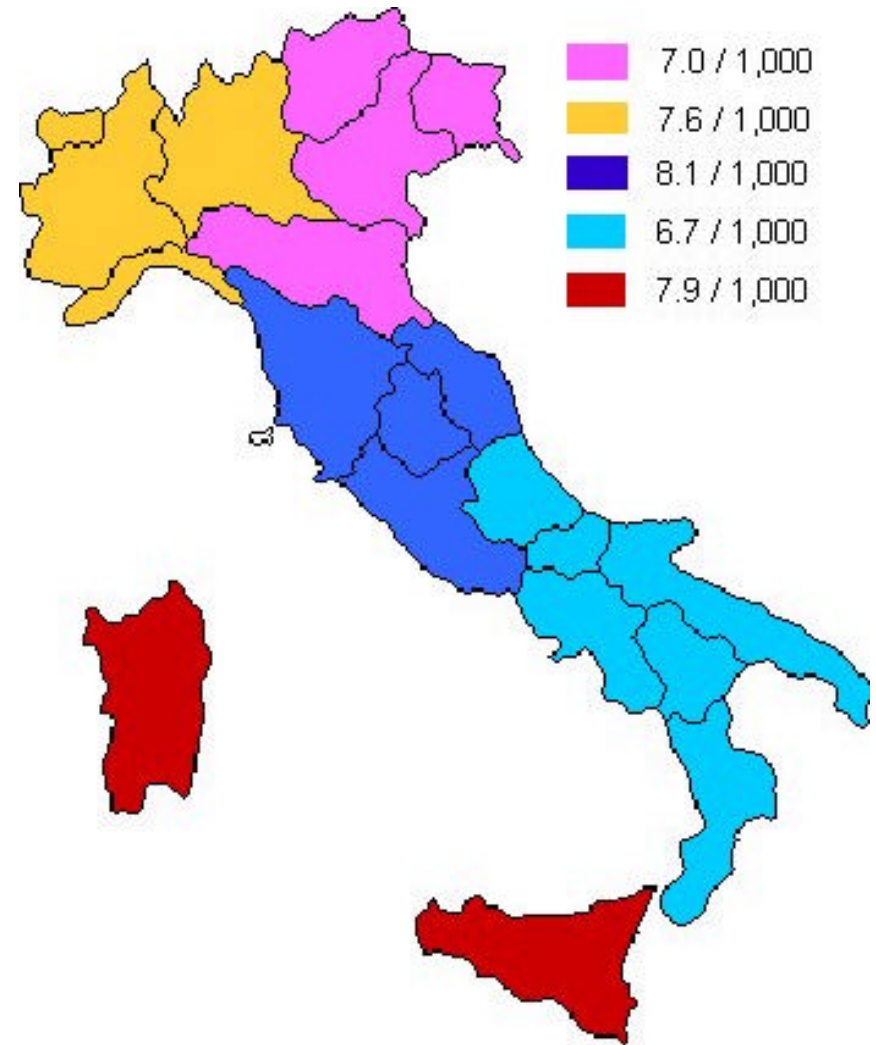
### Prevalence Rate per 1,000 of the Total Population



**MAP 1**

Source: Epidemiological Section of the National Observatory on Drugs and Drug Abuse

### Prevalence Rate per 1,000 of the 15 - 64 Population

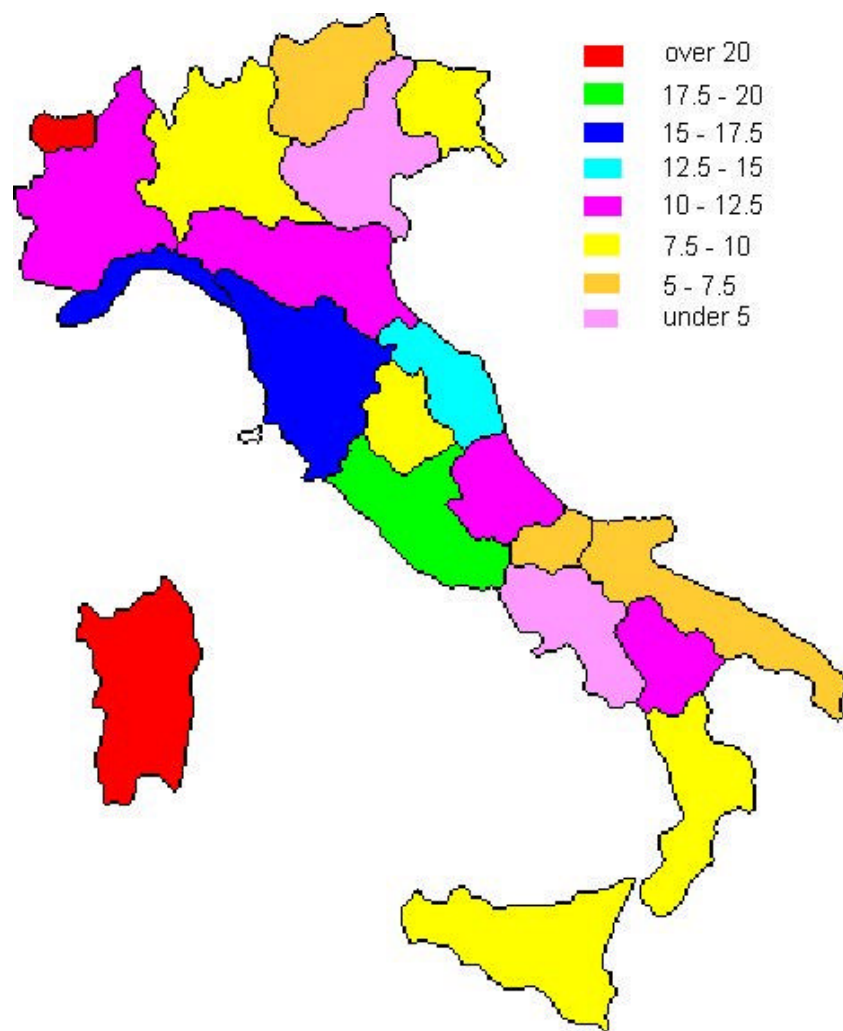


**MAP 2**

Source: Epidemiological Section of the National Observatory on Drugs and Drug Abuse



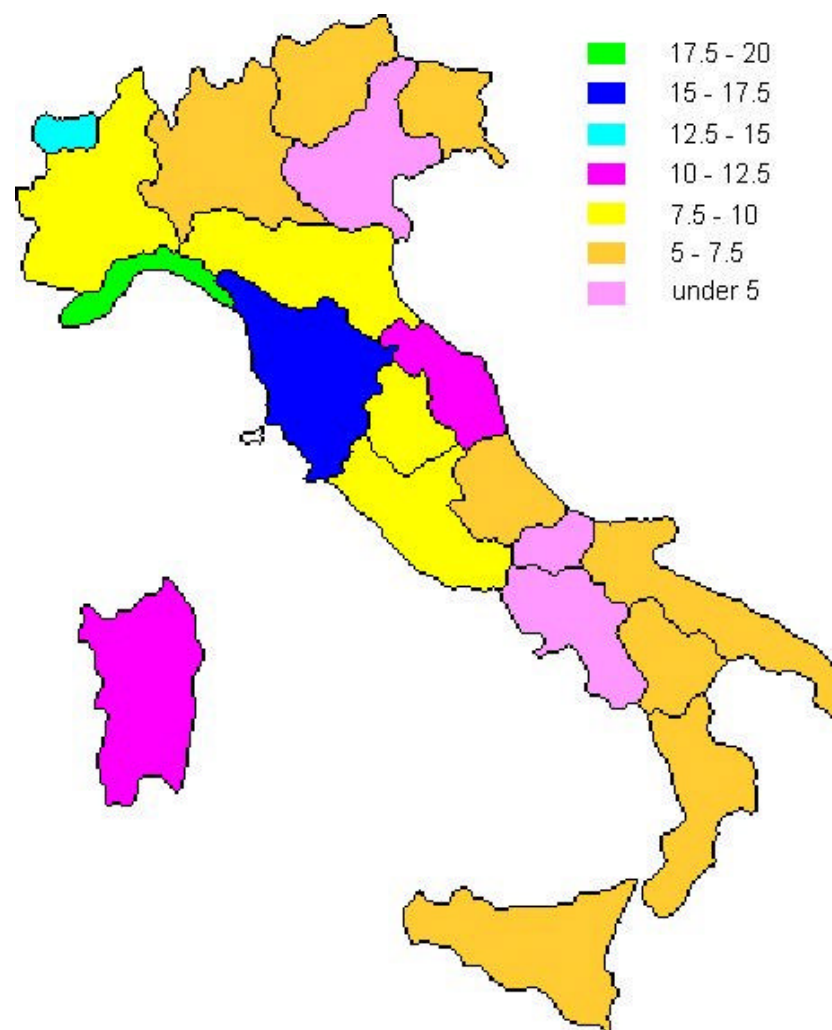
**Adult Referrals for Possession. Rates per 10,000 population aged 15 - 54**



MAP 3

Source: Ministry of the Interior and ISTAT ([www.demo.istat.it/stima2000](http://www.demo.istat.it/stima2000))

**Juvenile Referrals for Possession. Rates per 10,000 population aged 10 - 17**



MAP 4

Source: Ministry of the Interior and ISTAT ([www.demo.istat.it/stima2000](http://www.demo.istat.it/stima2000))

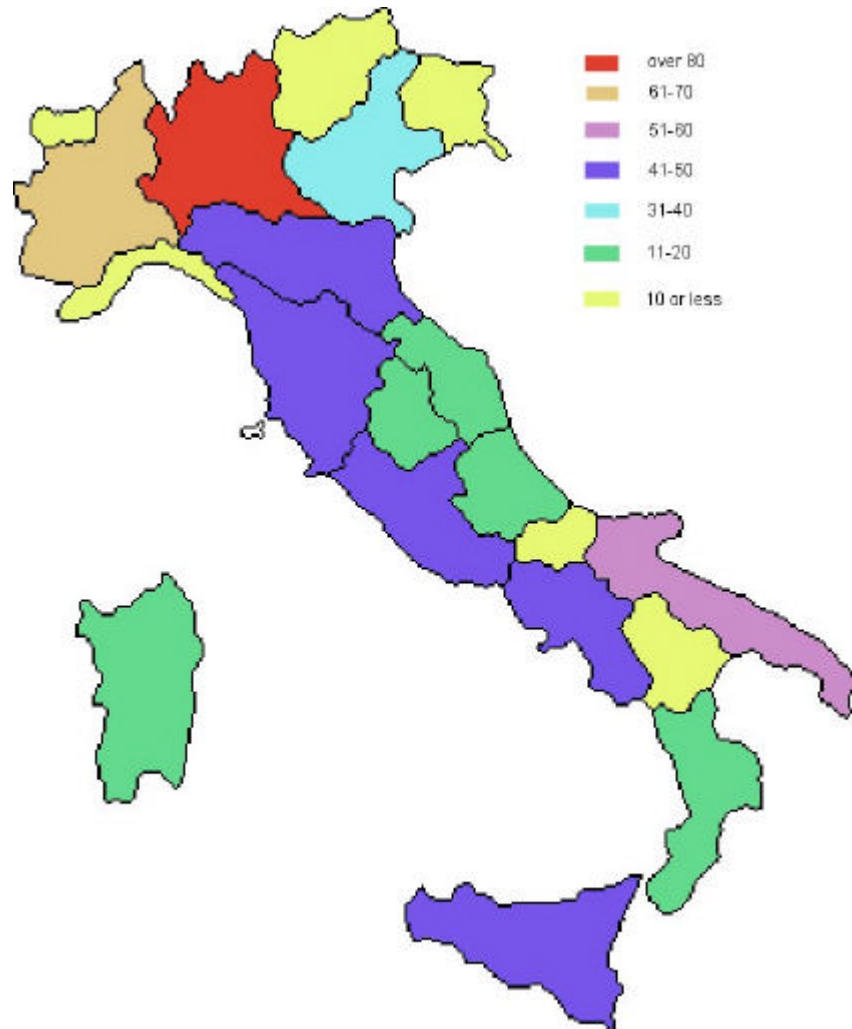
**Re-referrals for Possession. Rate per 10,000 population aged 15 - 54**



**MAP 5**

Source: Ministry of the Interior and ISTAT

**Distribution of the Ser.T by Region (1999)**



**MAP 6**

Source: Ministry of Health, Health Information System, Department for Prevention

**Distribution of Socio-Rehabilitative Services by Region (1999)**



**MAP 7**

Source: Ministry of the Interior, Directorate General for Administration and Personnel, Central Directorate for Documentation

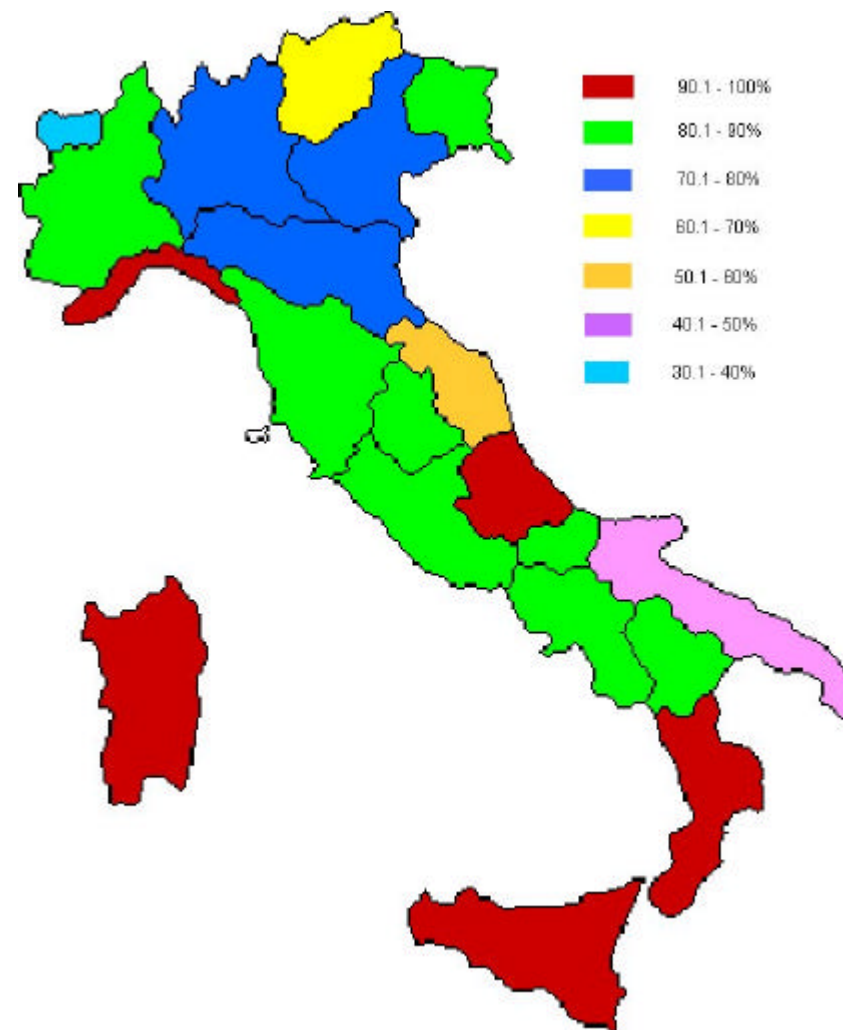
Percentage of Full Time staff employed in the SerT - 1991



MAP 8

Source: Ministry of Health, Health Information System, Department for Prevention.

Percentage of Full Time Staff employed in the Ser.T - 1999

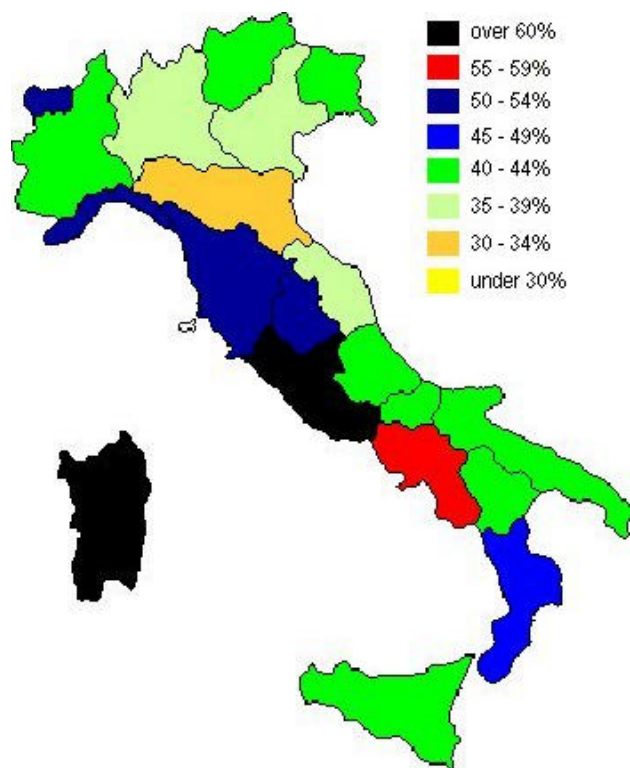


MAP 9

Source: Ministry of Health, Health Information System, Department for Prevention.



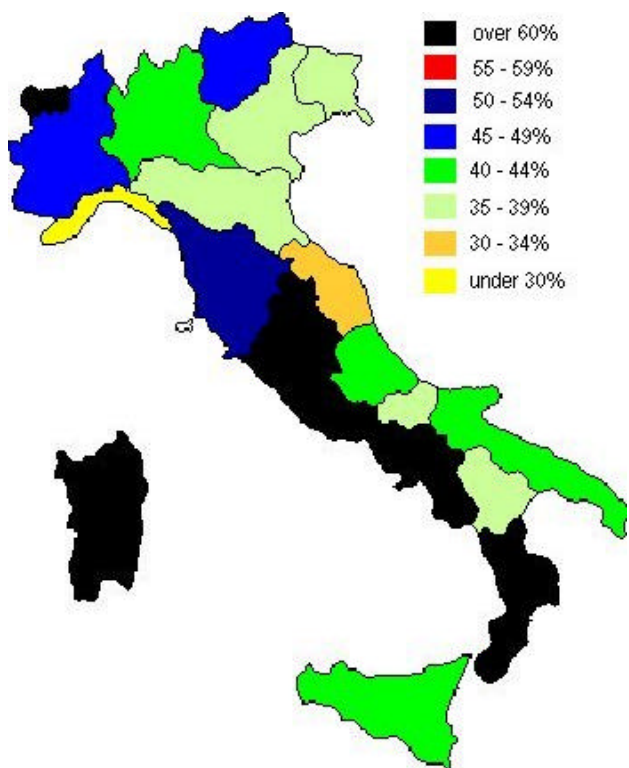
Percentage of clients receiving Methadone in 1997



MAP 10

Source: Ministry of Health, Health Information System, Department of Prevention

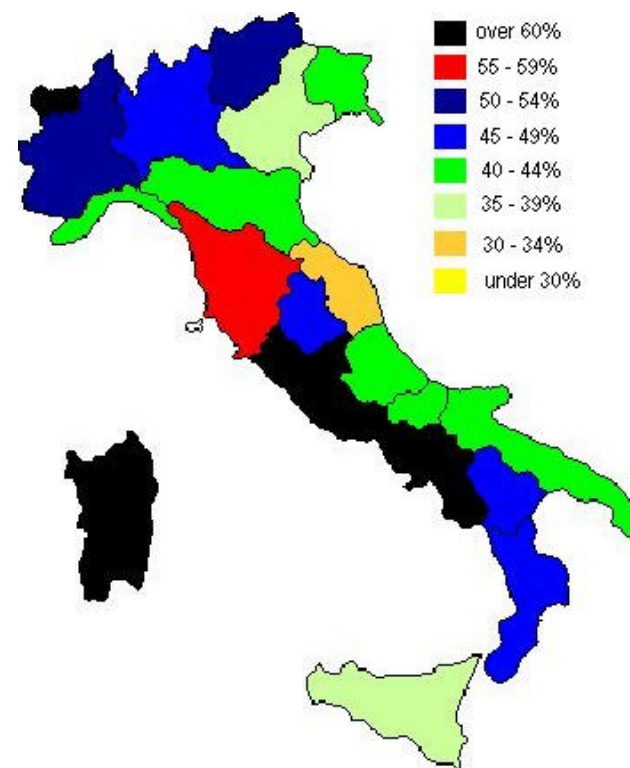
Percentage of clients receiving Methadone in 1998



MAP 11

Source: Ministry of Health, Health Information System, Department of Prevention

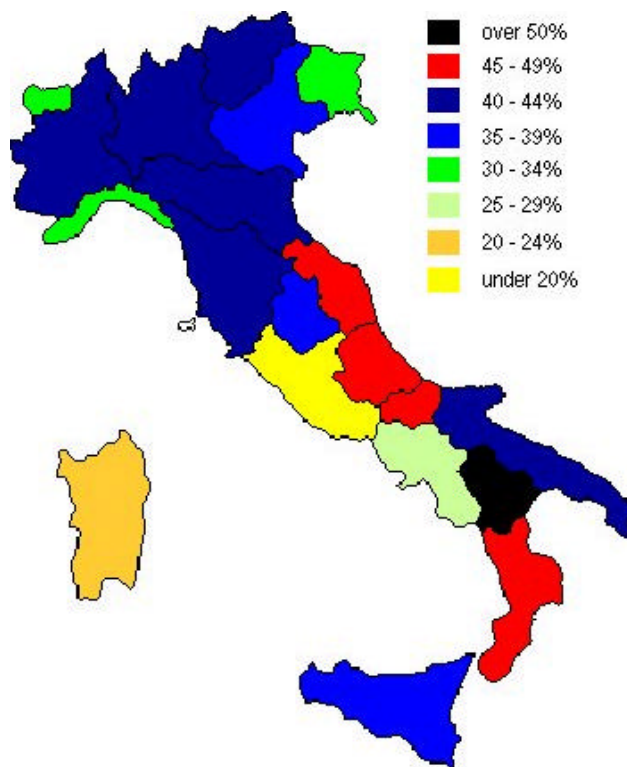
Percentage of clients receiving Methadone in 1999



MAP 12

Source: Ministry of Health, Health Information System, Department of Prevention

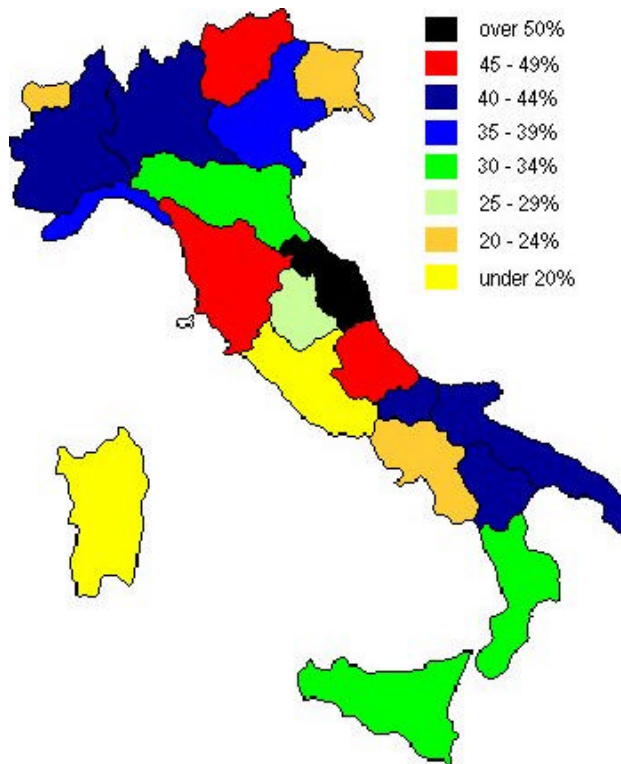
**Percentage of clients receiving Psycho-Social and/or Rehabilitation Treatment in 1997**



**MAP 13**

Source: Ministry of Health, Health Information System, Department of Prevention

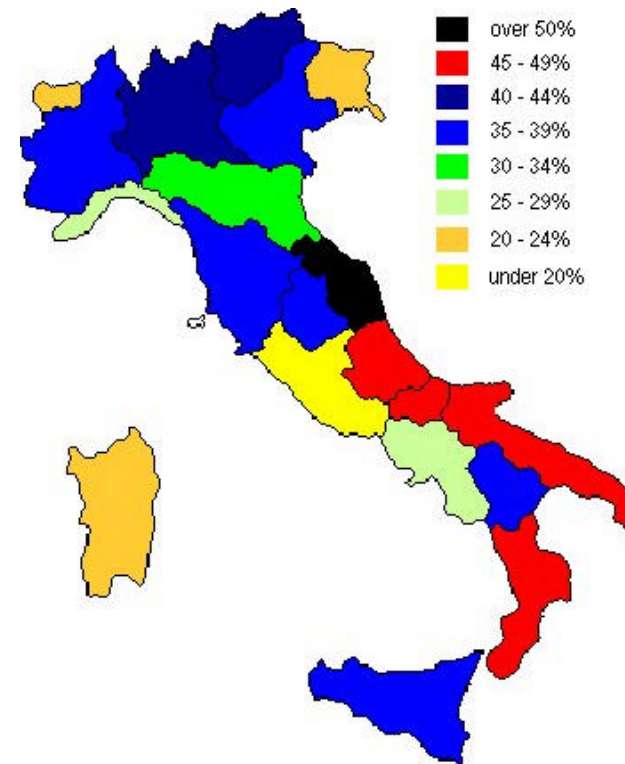
**Percentage of clients receiving Psycho-Social and/or Rehabilitation Treatment in 1998**



**MAP 14**

Source: Ministry of Health, Health Information System, Department of Prevention

**Percentage of clients receiving Psycho-Social and/or Rehabilitation Treatment in 1999**

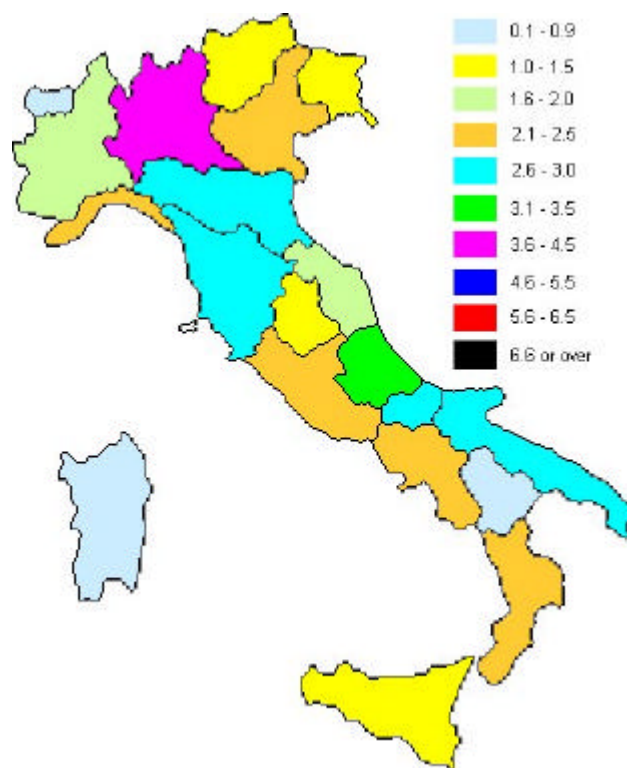


**MAP 15**

Source: Ministry of Health, Health Information System, Department of Prevention

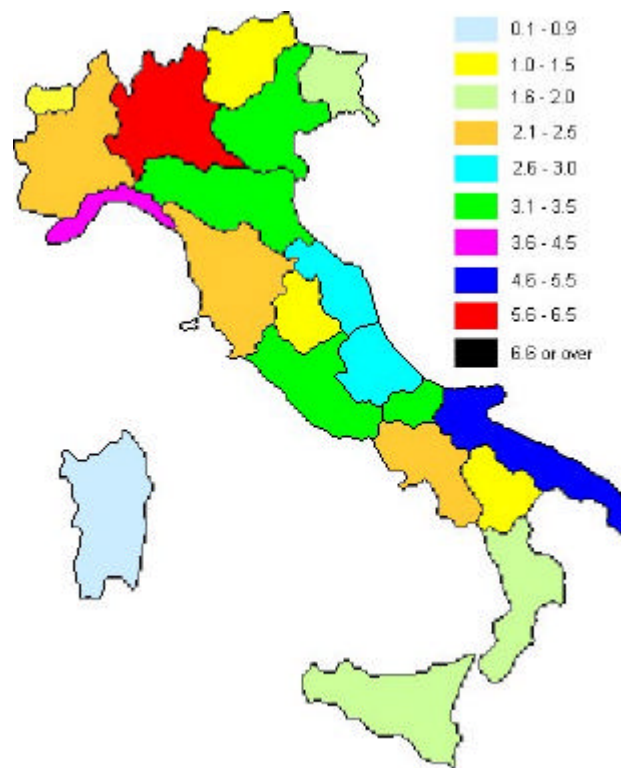
Percentage of clients of the Ser.T reporting primary use of cocaine

1997



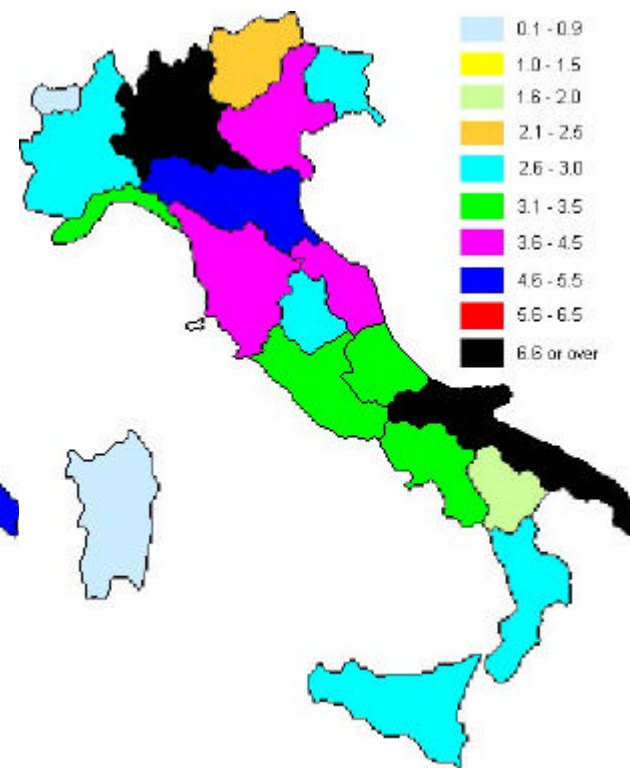
MAP 16

1998



MAP 17

1999

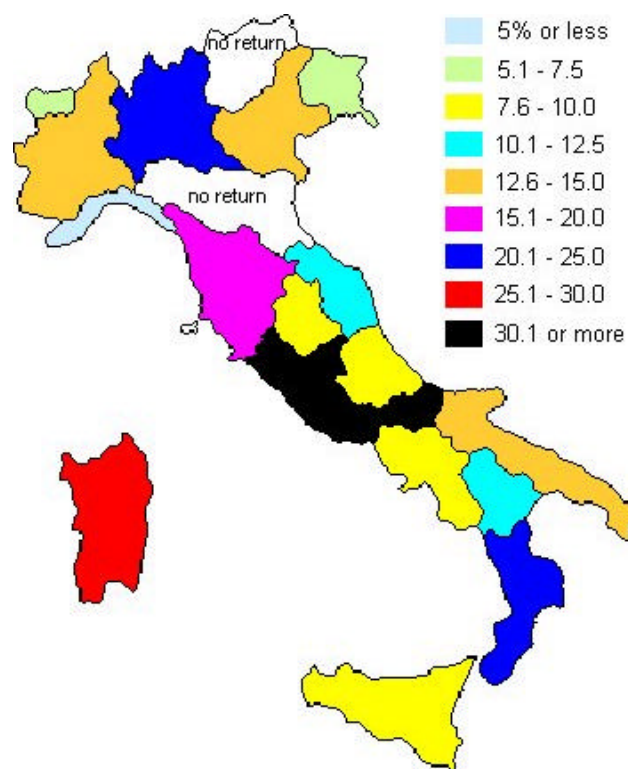


MAP 18

Source for maps 16-18: Ministry of Health, Health Information System, Department for Prevention

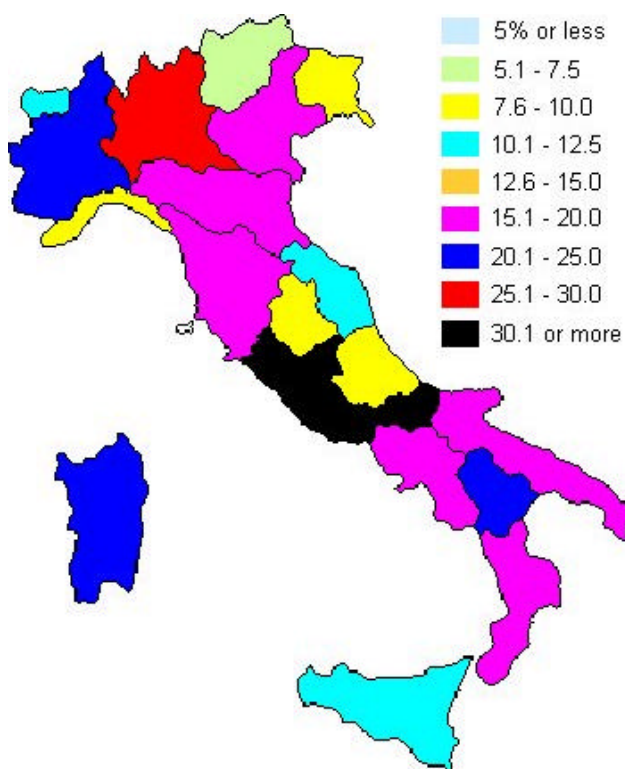
Percentage of clients of the Ser.T reporting secondary use of cocaine

1997



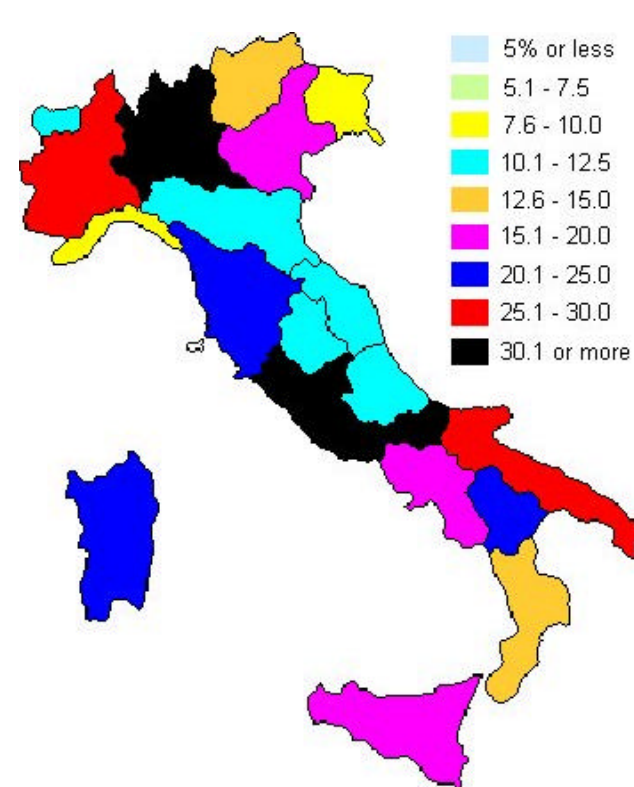
MAP 19

1998



MAP 20

1999



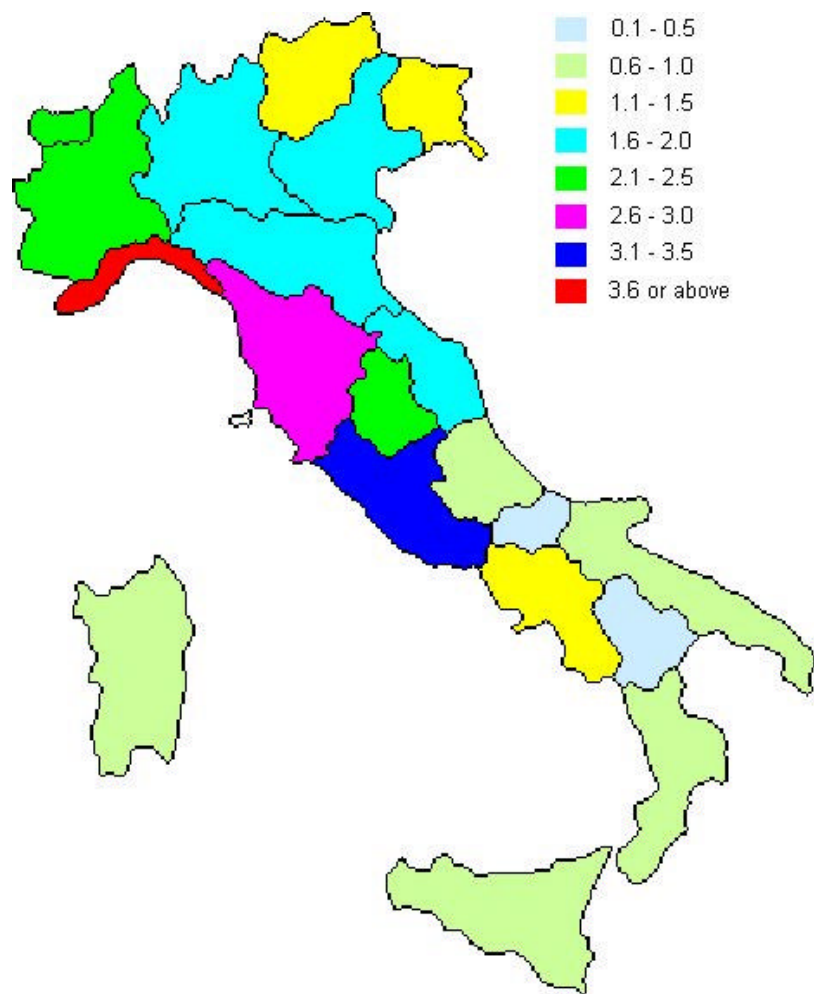
MAP 21

Source for Maps 19 - 21: Ministry of Health, Health Information System, Department for Prevention



Referrals for Drug Law Offences involving Cocaine: Rate per 10,000 population

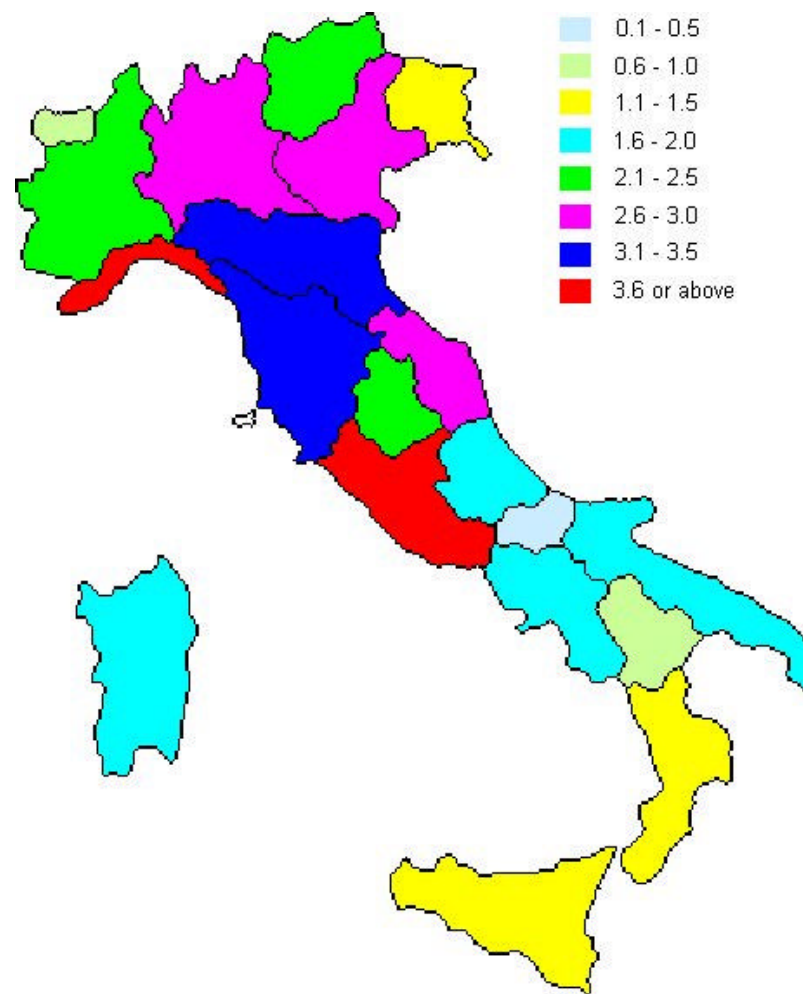
1998



MAP 22

Source for Maps 22 and 23: Ministry of the Interior, Central Directorate for Anti-Drug Services

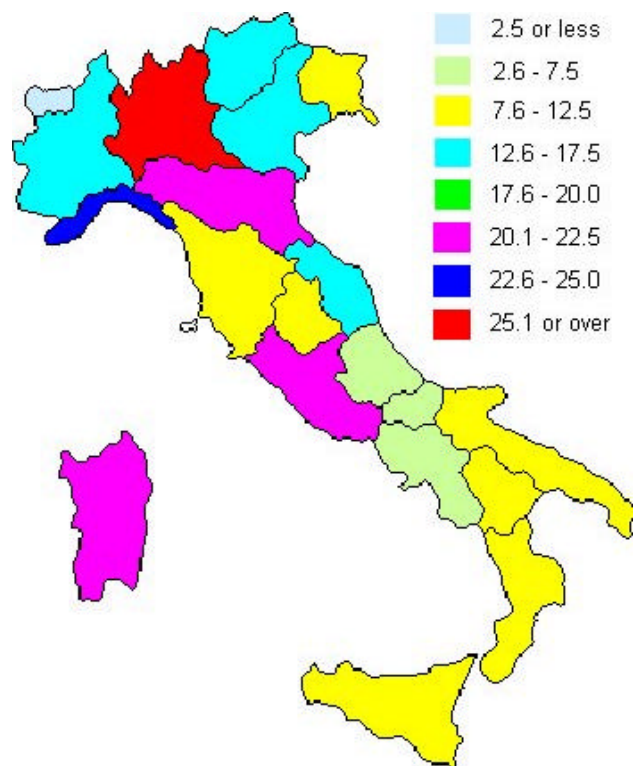
1999



MAP 23

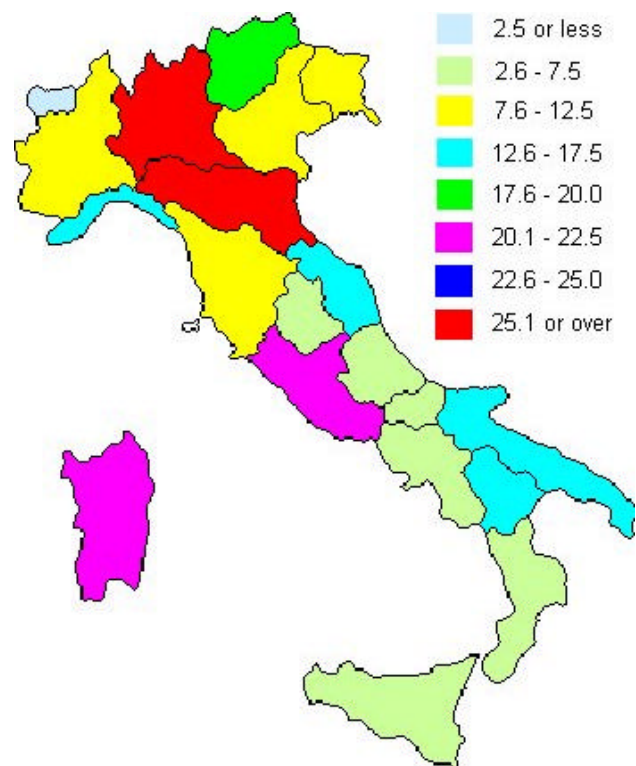
Percentage of clients of the Ser.T testing positive for HIV infection

1997



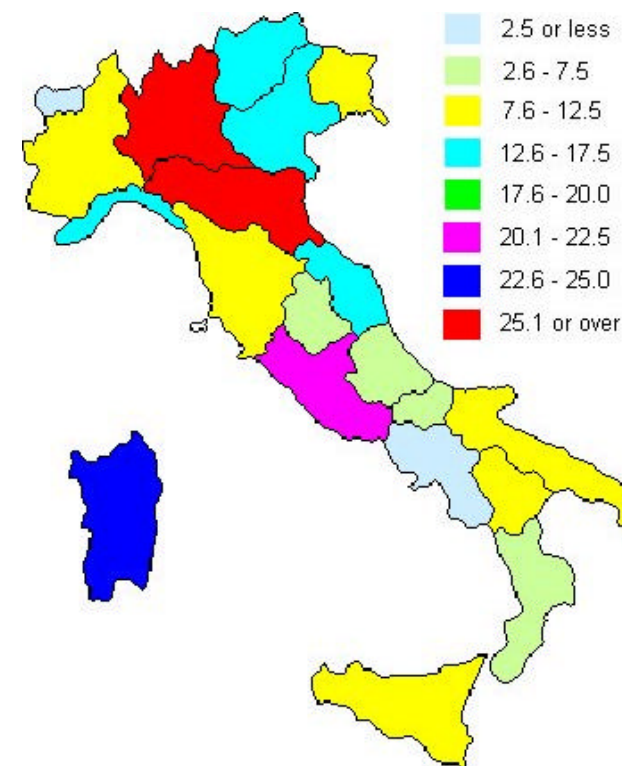
MAP 24

1998



MAP 25

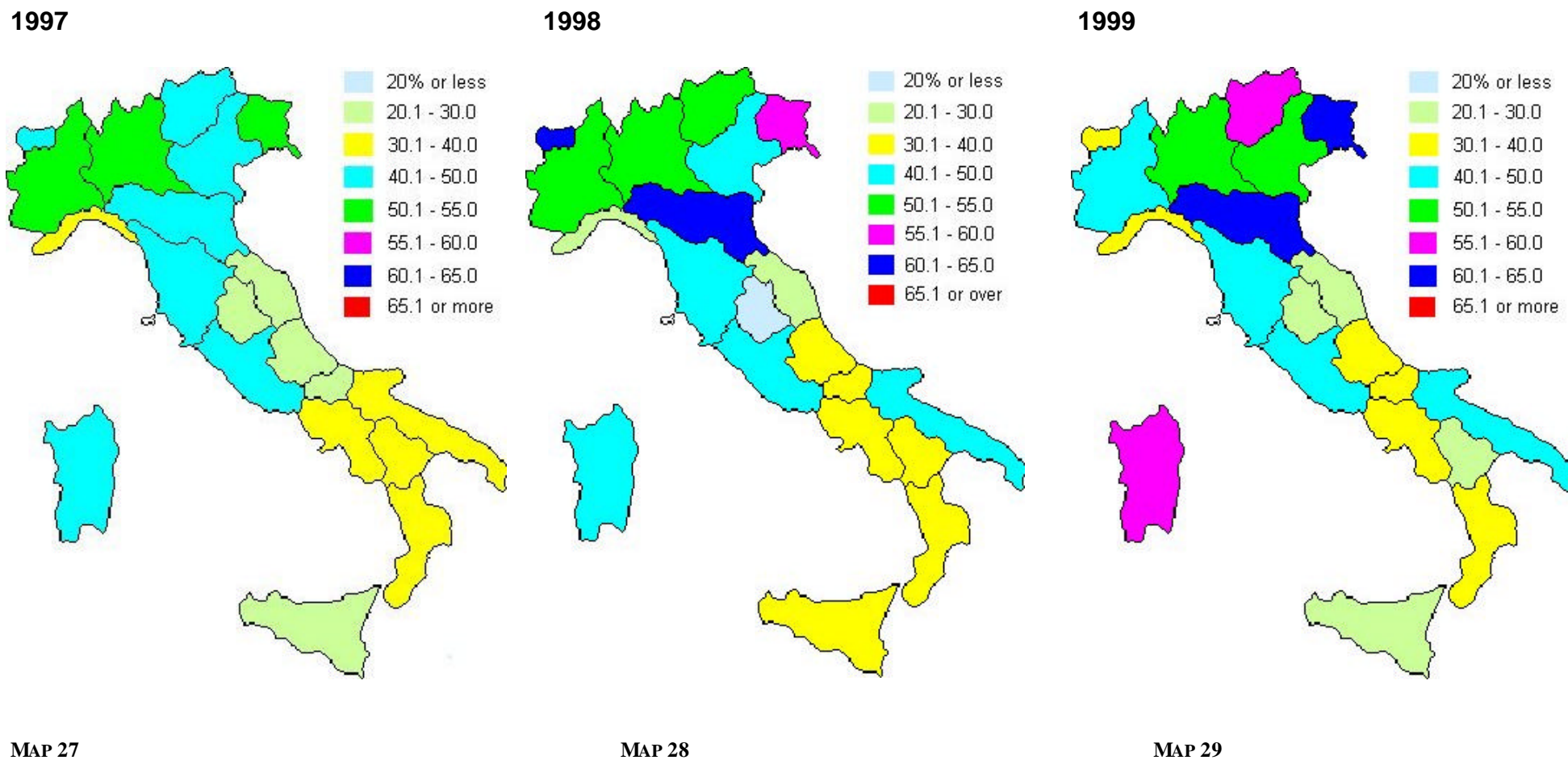
1999



MAP 26

Source for Maps 24 - 26: Ministry of Health, Health Information System, Department for Prevention

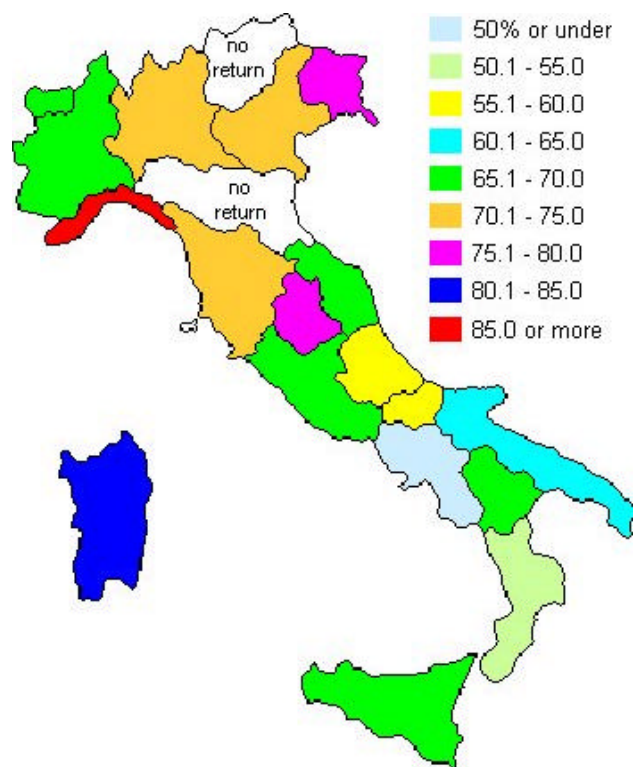
Percentage of clients of the Ser.T testing positive for Hepatitis B infection



Source for Maps 27 - 29: Ministry of Health, Health Information System, Department for Prevention

Percentage of clients of the Ser.T testing positive for Hepatitis C infection

1997



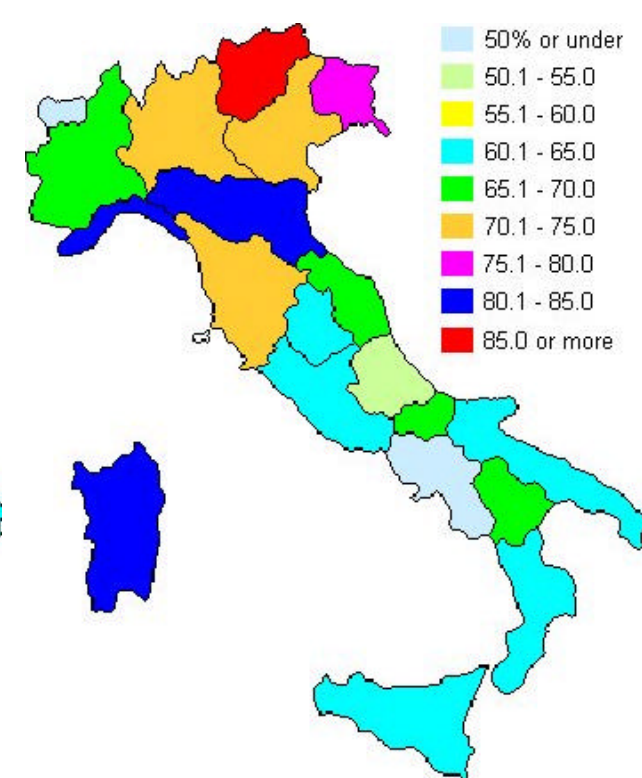
MAP 30

1998



MAP 31

1999



MAP 32

Source for Maps 30 - 32: Ministry of Health, Health Information System, Department for Prevention



**Che fare se chi cala va a male**

**Colpo di calore**

- FALLO STENDERE AL FRESCO
- RINFRESCALO CON UN FAZZOLETTO UMIDO SULLA FRONTE O GHIACCIO SUL COLLO
- QUANDO LA SUA TEMPERATURA SCENDE AVVOLGILO IN UN ASCIUGAMANO ASCIUTTO
- FAGLI BERE BIBITE FRESCHE MA NON FREDE. NO ALCOOL
- ANCHE SE SI RIPRENDE, ACCOMPAGNALO DAL MEDICO

**Bad trip**

- ALLONTANALO DALLA RESSA
- RIMANI CON LUI, CONVERSA, TIENILO CALMO
- ANCHE SE MIGLIORA, PORTALO AL PRONTO SOCCORSO

**B-careful**

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**IN OGNI CASO DI MALORE CHIAMA IL 118 O COMUNQUE L'AMBULANZA**

SCAN 1

Agenzia Comunale per le tossicodipendenze  
Comune di Roma

**"NOTTE AMICA"**

**IO NON CALO LA MIA VITA**

SCAN 2

**CAMPAGNA DI PREVENZIONE E DISSUAZIONE DALL'USO DI NUOVE DROGHE**

**NUMERO VERDE**  
Se hai bisogno di informazioni, consigli ed indirizzi, chiama il numero 800.27.27.27

**Pronto Intervento**  
Se stai male o hai un amico che sta male, se ti serve un aiuto per tornare a casa chiama il numero 06/65741188

SCAN 3

**List of Abbreviations**

|       | Italian  | English  |
|-------|--|--|
| OIDT  | Osservatorio Italiano per la verifica dell'andamento del fenomeno delle Droghe e delle Tossicodipendenze | Italian Observatory for Drugs and Drug Addiction |
| Ser.T | Servizi per le Tossicodipendenze   | Public drug treatment service                    |
| ASL   | Azienda Sanitario Locale   | Local health authority                           |
| DCSA  | Direzione Centrale Servizi Antidroga   | Central Directorate for Anti-Drug Services       |
| ISS   | Istituto Superiore di Sanità   | National Health Institute                        |
| ISTAT | Istituto Statistiche   | National Statistics Institute                    |