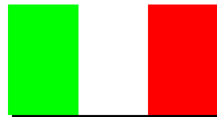

ANNUAL REPORT

ON THE

STATE OF THE DRUGS PROBLEM

IN ITALY

FOR THE YEAR 1999[1]

[1] This report includes information for 1998 and 1999 to provide a basis for future up-dating, in recognition that the report for last year was submitted late and was only provided in Italian

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INTRODUCTION

This is the first annual report on the state of the drugs problem in Italy prepared by the newly designated Italian Reitox Focal Point, based at the Department of Social Affairs of the President of the Council of Ministers. The new arrangements were established by law Nº 45 of February 1999 and were formally implemented under the Decree of the President of the Republic published in the Official Gazette of the Republic of Italy on 3 November 1999.

The administrative and organisational arrangements necessary to make operational the requirements of the legislation have inevitably led to some delay in the preparation of the documents for the EMCDDA. This is regrettable but it is anticipated that for 2000 the new National Drugs Observatory and the Focal Point will be fully operational and in a position to meet the requested deadlines for delivery of reports.

To establish a base for future up-dating of information, this report is extensive and includes information relevant for both 1998 and 1999. It has drawn on information from a wide range of sources, including Government Ministries and Departments, the Regions and public and private organisations working in the field of drug misuse. As the work of the National Drugs Observatory becomes fully operational it is expected that a more extensive network of contacts and contributing organisations will be established to provide qualitative and quantitative data for both the National Drugs Observatory and the EMCDDA.

PART 1

NATIONAL POLICIES: LEGAL AND ORGANISATIONAL FRAMEWORK

1. TRENDS AND NEW DEVELOPMENTS IN DRUG POLICY

1.1. PHILOSOPHY, DIRECTION, SCOPE, OBJECTIVES

1.1.1. There have been no major changes in philosophy, direction, scope or objectives of drug policy in the period under report. There have been important developments in the structures and administrative responsibilities, with a number of new initiatives. These are, however, designed to implement existing policy more effectively rather than representing any change in policy. The developments are reported below under the appropriate headings and are briefly summarised in section 1.2.

1.2. POLICY DEVELOPMENTS ON SPECIFIC ISSUES OF PARTICULAR INTEREST

1.2.1. One important policy development during the year has been the creation of the National Drugs Observatory, based at the Department of Social Affairs. This has created a potentially powerful central reference point for all aspects of drug misuse in which both policy and practice can be developed based on information from a wide range of sources.

1.2.2. A second important policy development has been, for the first time, a specific support for harm reduction in the development of services for people who use drugs. This has resulted in many Regions categorising harm reduction as one of the areas for funding through their proportion of the National Drugs Fund.

1.3. DEVELOPMENTS IN PUBLIC OPINION AND PERCEPTIONS OF DRUG ISSUES

1.3.1. Within Italy, there is a continuing debate between those who favour strong and unambiguous messages and actions to dissuade people from recourse to any illicit drug and those who favour damage reduction as a step towards liberalisation and the eventual legalisation of drugs. This debate is not characterised by the traditional political divisions of centre, left and right, rather, it is a transversal debate concerned with ethical, moral and philosophical positions on individual and collective rights and responsibilities.

1.3.2. The debate was most clearly displayed in the Parliamentary discussion of the new drugs law (see 2.2.1). Some Parliamentarians made a distinction between cannabis and other drugs, classifying cannabis as a soft drug (or non-drug) whilst others accepted no distinction between drugs.

1.3.3. Those who favour dissuasion from any drug use argue that the state has a duty to make all efforts to avoid the personal, family and social damage which arises from drug use. To this end, they argue that all interventions must have, as an ultimate goal, abstinence from drug use. With this consideration in mind, they have supported damage limitation activities and argued for a flexible approach aimed at limiting social and physical

harm, the expansion of intervention services and the provision of low threshold services to draw more people into treatment.

1.3.4. At the level of public opinion and media interest in drug misuse, there appears to have been a lessening of concern, with relatively low levels of media coverage. Recent surveys have suggested that public concern is more focused on issues such as petty crime and public safety, although these may often be associated with drug misuse.

1.3.5. This said, particular incidents can lead to very high levels of media interest and have a consequent impact on public opinion. A recent example in October 1999 is that of the death of a young man in Brescia, who was said, initially, to have died as a result of consumption of 4 MTA. This was not, in fact, the case. However, at the time all television networks and national newspapers carried extensive reports of the incident with special reports and features. Interviews and background briefings were sought from politicians, policy makers and experts.

2. DEVELOPMENTS IN LEGISLATION

2.1. DRUG LAWS

2.1.1. The most significant change has been the approval of Law 45 of 1999. This concluded a Parliamentary debate which was begun in 1996. Law 45 amends Law 400 of 26 August 1988 and the Decree of the President of the Republic Nº 309 of 9 October 1990. Under the new Law, the Department of Social Affairs has been given responsibility for the National Drugs Observatory which includes the development of drug policy in respect of prevention, treatment, rehabilitation and social re-insertion. It also transfers responsibility for the Italian National Focal Point from the Directorate General for Documentation of the Ministry of the Interior to the National Drugs Observatory at the Department of Social Affairs. The implications for the organisational framework, reporting systems, the National Focal Point, etc. is described in the relevant sections below.

2.2. OTHER LEGISLATION

2.2.1. No major legislation, other than that associated with Law 45/99, has been enacted or implemented in the reporting period. A number of legislative changes have occurred which relate to the administration or delivery of systems or services to a general population. These have an impact upon responses to drug misuse but are not the purpose of the legislation. Examples include the changes to the procedures for and contents of alternative to imprisonment measures and the transfer of prison health care to the national health service. The impact of these changes on drug misusers is reported on in the relevant sections of the report.

3. DEVELOPMENTS IN ORGANISATIONAL FRAMEWORK

3.1. KEY ACTORS, ROLES AND CO-ORDINATION STRUCTURES

3.1.1. As a result of Law 45 of 18 February, 1999, the Department of Social Affairs of the Presidency of the Council of Ministers has assumed the

central role for the co-ordination of drug policy. Previously, roles were separated between the Department and the Ministry of the Interior. The former was responsible for the National Fund for Interventions in the Fight Against Drugs and represented Italy on the Management Board of the EMCDDA and in a number of other inter-governmental fora. The latter provided the National Focal Point and had responsibility for co-ordinating drug supply reduction activities.

3.1.2. The new arrangement places central policy development and co-ordination arrangements within the Department of Social Affairs. This is to be undertaken by the Italian Drugs Observatory within the Department and will be supported by a Committee drawn from the relevant Ministries, a Scientific Committee appointed by the Minister of Social Affairs and a consultative council of 70 experts and operators working in the sector.

3.1.3. The exact structure of the Observatory is described in section 6.

3.1.4. Previous key actors remain with their own specific Ministry responsibilities. These include:

- the Ministry of Health, through its Department of Prevention, which is responsible for treatment through health services, primarily the SerT (community based treatment services) and for collection of treatment demand information. The Department is also the lead agency for work on the Treatment Demand Indicator. The Istituto Surperiore di Sanità (National Institute of Health) is a technical/consultative organ of the Ministry and it has responsibility for co-ordinating the Joint Action on New Synthetic Drugs between the different organisations/authorities which have a role in its implementation.

- the Ministry of the Interior, through its Central Anti-Drugs Directorate of the Department of Public Security, has responsibility for co-ordination of anti-drug activity at the level of the three police services acting at a national level (Polizia di Stato, Arma dei Carabinieri and Guardia di Finanza). It maintains a computerised data base which supports police activites against drug trafficking and which provides statistical data on seizures, arrests and direct drug related deaths.

- The Ministry of Education (Ministero della Pubblica Istruzione) has responsibilty for the school curriculum and for preventive education at the level of the school.

- The Ministry of Defence undertakes preventive and intervention activities within each branch of the armed services. (Italy has a system of male conscription into the armed services, although this will end in 2000).

- The Ministry of Justice (Ministero delle Giustizia) maintains statistical information on people who are charged with or are deported for drug related offences and on people who are referred to treatment as an alternative to prison. It is also involved through the Department of Prison Administration and the Central Office for Juvenile Justice.

- The Ministry of Finance has responsibility for the Central Directorate of the Customs Service. It participates in the MAR-INFO system, which provides links between the customs services of the ports of Europe. In 1998 it has also used the information network SCENT, to which the Italian Customs Administration is also connected.

- The 20 Regions of Italy have considerable autonomy within their jurisdiction for determining arrangements for responding to drug problems. They are requested to establish arrangements for data collection based on national guidelines and submit reports and statistical information on drug misuse to the designated national reference point. Additionally, liaison between the Government and the Regions is affected through the Committee of the Regions. Currently co-ordination of the Regions with respect to drug misuse is carried out by the Veneto Region. Reports are not always submitted, on occasions do not follow the requested format and the statistical data at present may be provided in a manner which does not permit effective analysis at the national level. These are issues which are to be addressed under the terms of the new national observatory.

3.1.5. In addition to these Government bodies, a number of independent contractors have been used to manage specific activities on behalf of the Department of Social Affairs, for instance, the EDDRA system.

3.2. BUDGETS AND FUNDING ARRANGEMENTS

3.2.1. Anti-drug activity is funded through several sources.

3.2.2. At the level of treatment, payment for client services is met by a variety of sources dependent upon the type of treatment provided and the situation of the individual client. The local health agency (ASL) meets the cost of a designated number of places within residential treatment services. The health care system meets the cost of health service based treatment. The Ministry of Justice meets the cost of treatment as an alternative to custody. Prevention programmes are financed through the regular educational budget. Enforcement costs are met through the regular budgets of the police services. Additionally, the Regions and Communes may finance specific projects and programmes relevant to drug related problems through their own resources. Social enterprises working in the sector may also obtain income from private donations and fund raising activities and a number are co-ordinators or partners in European Commission funded projects. In terms of social re-integration, vocational training may also be funded through the Ministry of Labour.

3.2.3. There is no central estimate available of the total expenditure on drug misuse prevention, treatment or control activities outside specific, short term projects funded by individual Ministries or through the National Fund for Interventions in the Fight against Drug Abuse. The Department of Social Affairs has, therefore, with the agreement of other interested Ministries, begun a special exercise using specific methodologies, to identify the total amount used nationally in responding to drug misuse. An initial calculation is that the annual budget for direct drug-related activities

is 1% of the gross national product and that 0.32% of total public expenditure is directed to this.

3.2.4. The main dedicated funding source for anti-drug activity is the National Fund for Interventions in the Fight against Drug Abuse. This fund was established under article 127 of Decree 309 of 1990 of the President of the Republic. The amount to be allocated each year to the Fund is proposed in the National Budget and is subject to Parliamentary approval through the annual finance bill. The Fund is managed by the Department of Social Affairs and the arrangements for allocations from it have changed since it was initiated.

3.2.5. For the first period, to 1996, the Fund was managed in its entirety by the Department of Social Affairs. In total, between 1990 and 1995 some 1,262,184,535,000 lire was distributed through the National Fund. The table below shows the details of the distribution in this period.

Fund Recipients	Projects	Fund Allocation
Projects from Ministries	235	401,599,282.000
Projects from Regions	437	60,575.456,000
Projects from Local Administrations	5,097	530,818,678,000
Projects from Local Health Services	728	58,889,367,000
Projects from Social Enterprises	2,320	210,301,752,000
TOTAL	8,817	1,262,184,535,000

3.2.6. From 1996, under a decree issued by the Minister of Social Solidarity, 75% of the National Fund was transferred to the Regions, amounting to 146,250,000,000 lire. The Department of Social Affairs was given responsibility to verify the procedures and criteria used to allocate the resources. Funds which had not been allocated by the Regions by the 31 July 1998 were to be dispensed under substitute powers by a Commissioner nominated by the Government. The remaining 25% (48,750,000,000 lire) of the National Fund was directly allocated by the Department of Social Affairs to finance projects proposed by individual Ministries. Following assessment by a Commission of all the proposals, 63 proposals were accepted.

3.2.7. For 1997 and 1998, 400,000,000,000 lire was available for anti-drug projects. However, for a number of reasons, it was not possible to make any allocations from the National Fund.

3.2.8. Law 45 of 18 February, 1999 has allowed the arrangements for the operation of the National Fund to be re-activated. By the end of 1999 the whole of the funds available had been allocated at the national level (25%) and the 75% allocated to the Regions had been dispersed to them. With the funds from 1997 and 1998, a total of 600,000,000,000 lire has been made available for projects for prevention, treatment and social re-insertion.

3.2.9. Under Law 45 clear arrangements for the National Fund have been established:

- 75% of the funds will be transferred to the Regions to be used for prevention, treatment and social re-insertion projects proposed by Communes, local health services and local social enterprises. Importantly, for the first time in Italian legislation, the law specifically supports activities of "harm reduction".
- the law defines the objectives to be achieved by the projects and requires the Government to specify the criteria which Regions must adopt for project evaluation.
- If Regions fail to allocate resources within a specified time, a Commissioner appointed by the Government will carry out the procedures established for financing projects through the National Fund.
- The 25% of the National Fund retained centrally is to be used for experimental projects of prevention, to support rationalisation of the exchange of information about drug misuse and for the promotion of agreement between Ministries and co-ordination through the Department of Social Affairs of their anti-drug activities.
- The evaluation of projects proposed for funding from the centrally retained funds will be undertaken by a Commission of Experts appointed by the Minister of Social Affairs.

3.2.10. By the end of 1999, the allocation of the 25% of the National Drugs Fund to project proposals submitted by Ministries was completed. The table below shows the allocation for the last three years.

Ministries	Funds Allocated (in lire)			
	1997	1998	1999	TOTAL
Ministry of Health	10,400,000,000	6,595,000,000	11,340,000,000	28,335,000,000
Ministry of the Interior	2,115,000,000	2,896,000,000	1,001,600,000	6,012,600,000
Ministry of Justice	14,713,892,000	21,000,000,000	500,000,000	36,213,892,000
Ministry of Education	16,300,000,000	20,786,000,000	10,000,000,000	47,086,000,000
Ministry of Labour	3,836,000,000	4,889,100,000	2,000,000,000	10,725,000,000
Ministry of Defence	1,343,210,000	4,000,000,000		5,343,210,000
TOTALS	48,708,102,000	60,166,100,000	24,841,600,000	133,715,802,000

3.3. INTERNATIONAL ACTIVITIES AND CO-OPERATION

3.3.1. Within the Ambit of the United Nations

3.3.1.1. During 1998, particular attention was paid to the Special Session of the General Assembly of the United Nations. This provided the opportunity to increase the political and financial support of Italy for the

work of UNDCP based on the balanced approach between demand and supply reduction.

3.3.1.2. Italy is a major donor to UNDCP and has taken the opportunity at meetings of the major donors to present its opinions on key issues and to participate in all major decisions. Through its active participation it has been able to influence the choice of programmes to be supported and to support countries sustain their development of substitute crops.

3.3.1.3. There has been active participation in the meetings of the UN Commission on Narcotic Drugs. Representatives of Italy have participated in a number of working groups during the reporting period.

3.3.1.4. In particular, during 1999 representatives from the Department of Social Affairs and the Ministries of Health, the Interior and Foreign Affairs participated in two meetings of the working group advising on the development of international instruments for collection and analysis of data on drug demand reduction, seeking to provide a European perspective to the international discussion.

3.3.1.5. Particular attention has been given to developing a dialogue with Mediterranean countries on anti-drug activities. Italy has played a central role in this Europe-Mediterranean dialogue and in the meetings of Ministers of the Interior of western Mediterranean countries.

3.3.2. *At the level of the European Union*

3.3.2.1. Italy was active in the preparatory work of the European Union for the UN Special Session aimed at developing a common position between the Member States.

3.3.2.2. It has participated in the Cordo Group of the EU and in the Horizontal Drugs Group. In the context of regional initiatives, it has had a focus on the development of appropriate anti-drug activities in the countries of Latin America and the Caribbean.

3.3.2.3. At the level of bi-lateral co-operation, Italy has promoted, organised and co-financed seminars and courses for the functionaries and officials from Police and Customs Services in many countries.

3.3.2.4. Throughout the year there was close co-operation with the EMCDDA on a range of activities, amongst which were:

- Participation in the second phase of the EDDRA project and attendance at meetings relevant to its development at European and national levels
- Participation in the Joint Action on New Synthetic Drugs
- Joint work by the National Institute of Health and the Central Anti-Drugs Directorate of the Ministry of the Interior through the preparation of an exploratory questionnaire aimed at assisting in the definition of standardised indicators for drug related deaths for use throughout the Union

- Participation in the project co-ordinated by the Greek Focal Point to improve the quality and compare data about treatment modalities provided within the Union

- Participation as an observer of the project co-ordinated by TOXIBASE to develop a virtual library in the field of drug dependence.

- Work to support the validation, at a European level, of the national infrastructure of hardware and software within the framework of the IDA project.

3.3.3. In the context of the Dublin Group, Italy has been an active participant and has assumed the presidency of the mini-group of countries who were members of the former Soviet Union.

3.3.4. Italy has continued involvement in the Pompidou Group of the Council of Europe, especially in the study and analysis required to develop international standards for co-ordinated repression of drug trafficking.

3.3.5. Under the Initiative for Central Europe (INCE), from the 9 to 10 October 1998 the first meeting of Ministers of the Interior from countries participating in the Initiative was held in Trieste. The Deputy Minister of the Interior of Russia attended as an observer. The meeting was arranged following a proposal from Italy. The declaration against organised crime which was approved at the end of the meeting included intensification of collaboration against trafficking and marketing of drugs and of precursors.

3.3.6. Other Areas of International Activity and Collaboration

- Many social enterprises and community services have been active in international projects and networks throughout the year. A significant number of the projects are financed by the European Commission and involve partnerships with other organisations in Member States. These have included projects funded by several different Directorates and by the European Social Fund. Italian organisations have also been active in ERIT, ITACA, the COST A6 Group, ELISAD, EuroMeth, FESAT, IREFEA, etc. The ERIT Conference was hosted in Italy (Bologna) in 1998.

4. DEVELOPMENTS IN INFORMATION REQUIREMENTS FOR DRUG POLICY

4.1. As reported elsewhere, there are a number of important developments in information requirements in order that drug policy may be advanced and meet present and future needs.

4.2. The establishment of the new National Drugs Observatory and the appointment of the Scientific Committee has permitted a review to begin of present qualitative and quantitative data and the identification of information gaps. In particular, knowledge of drug use within the general population, prior to any treatment demand, is limited. This will be a priority in order that prevention programmes might be most effectively targeted. The major school survey which is referred to in this report will provide a basis for some aspects of prevention work but a

continued monitoring system will be required in order that changing patterns can be identified and adjustments made as required.

4.3. A second gap relates to information about specific populations. In particular, drug use by women and by non-Italian populations may require specific enquiries if initiatives are to be developed for them.

4.4. It is anticipated that the work of the Scientific Committee and of the Observatory will result in clear priorities for information being established and that these will permit national policy to become more focused as well as inform the general development of this policy.

PART II

DRUG MONITORING SYSTEMS AND SOURCES OF INFORMATION

5. DEVELOPMENTS AND CHANGING PRIORITIES IN NATIONAL MONITORING SYSTEMS, INFORMATION SOURCES AND RESEARCH

5.1. EPIDEMIOLOGY

5.1.1. As reported elsewhere, Law 45/99 has now established the national drugs observatory within the Department of Social Affairs of the President of the Council of Ministers. One of the primary functions of the Observatory is statistics and epidemiology.

5.1.2. The Observatory is only now being brought fully into operation. Under the guidance of the Scientific Committee, the priorities for statistical and epidemiological information will be established. A particular priority will be ensuring improved compatibility and consistency in the data collected.

5.2. DEMAND REDUCTION

5.2.1. As above, the Observatory also has a sector concerned with demand reduction. It will be reviewing needs in terms of demand reduction and determining priorities in light of these.

5.3. DRUG POLICY AND LEGISLATION

5.3.1. The legislation referred to above establishes the basis for the revised national monitoring system and the roles of key actors in providing information to the Observatory. The combined work of the Observatory in epidemiology, demand reduction and at the European level will provide the future basis for guiding national policy and any additional legislation which is felt to be necessary.

5.4. DOCUMENTATION CENTRES

5.4.1. In terms of documentation centres, those which are already operating have continued. Additionally, the Observatory will itself act as a major documentation centre.

6. DEVELOPMENTS AT THE NATIONAL FOCAL POINT

6.1. ORGANISATION, LEGAL BASIS, OPERATION, STAFFING, FINANCING

6.1.1. The role of National Focal Point for Italy had previously been undertaken by the General Directorate for Documentation of the Ministry of the Interior. Under Law 45 of 1999 [1], which concluded a debate within Parliament begun in 1996, the Department of Social Affairs of the Presidency of the Council of Ministers was given responsibility for the National Drugs Observatory. The Decree establishing the Observatory, and placing the Focal Point within the Observatory, was published on 3 November, 1999 [2] although the effective change to the Department occurred during the summer of 1999.

6.1.2. The activities of the Observatory, as defined in Article 2 of the Decree are:

- The collection, elaboration and interpretation of data, statistics and documentation on the use, abuse, selling and trafficking in drugs and psychotropic substances
- To provide the technical/scientific support for elaborating the impact of different policies as they affect consumption, abuse, selling and trafficking in drugs and psychotropic substances and to meet the information and documentary needs of national, regional and local governmental administrations and social enterprises concerned with drug and drug related issues.
- To provide the National Focal Point for the EMCDDA

6.1.3. The detailed roles of the Observatory and of the National Focal Point within the Observatory are defined in Article 4 of the Decree as follows:

- *Statistics/Epidemiology Sector:* to collect, elaborate and analyse all data relevant to the consumption and abuse of drugs and psychoactive substances through an electronic data system and to co-ordinate and develop research on specific statistical/epidemiological aspects of drug misuse.
- *Drug Demand Reduction Sector:* to collect documentation and elaborate data on the activities of national, regional and local governmental administrations and of social enterprises in the fields of prevention, treatment and rehabilitation of drug misuse as well as data on consumption, misuse and trafficking in drugs; to co-ordinate research in the sector; to support links between the various networks of those working in the field in Italy; to produce, distribute and make available documents and bibliographies relevant to the sector.
- *National Focal Point:* to be the link with the EMCDDA

6.1.4. A Scientific Committee composed of seven experts in the drugs field has been established by the Minister of Social Solidarity. Its President is Prof. Luigi Cancrini and its members are Dr Maurizio Coletti, Prof. Enrico Tempesta, Prof. Carla Rossi, Dr Fabio Mariani, Dr Franco Giannotti and Dr Paolo De Nardis.

6.1.5. The Observatory has the power to agree conventions with qualified public or private organisations to undertake work which it cannot carry out directly within its own resources. It may also use experts outside the public administration who have qualifications and experience in documentation, statistics, computer science, anthropology and sociology.

6.1.6. Government Departments (Interior, Justice, Defence, Education, Health and Labour) are required to nominate one or more persons as the reference point for relations with the Observatory.

6.1.7. At present the NFP draws its staff from the Department for Social Affairs and from consultants and experts external to the Department. No full time

staff have been appointed to the NFP to date whilst the detailed staffing structure of the Observatory is finalised.

6.1.8. The financing of the NFP is 200,000 Euro per annum with the National Fund contributing 100,000 Euro. Additionally, activities funded through the National Fund and carried out by other Ministries or one or more Regions, contribute data and information relevant to the work of the NFP. The aim of the reforms which have occurred this year have been to create a co-ordinated and integrated structure which can inform and support both national policies and actions and international obligations.

6.2. NETWORK OF PARTNERS OF THE FOCAL POINT

6.2.1. The Focal Point has a number of partners drawn from all the relevant Ministries/Departments, from specialist organisations and research centres and from the Regional/Local administrations. Essentially the NFP has been established to co-ordinate the implementation of the Core Tasks and other contractual obligations rather than as the direct executor of these tasks and obligations.

6.2.2. The key national partners are the Ministries of Health, the Interior, Education, Defence, Labour and Justice. Each Ministry has nominated an officer to be the official liaison with the Observatory and the NFP.

6.2.3. For specific core tasks, the NFP has contracted external organisations to undertake work on its behalf. Under these arrangements:

- The Centro Italiano di Solidarietà is responsible for preparation of the Italian National Report and epidemiological information, the dissemination of documentation and the development/maintenance of the Focal Point web site. It also contributes to a range of other activities undertaken by the Focal Point.
- The National Institute of Health is responsible for co-ordinating the Joint Action on New Synthetic Drugs between the different organisations/authorities who have a role in its implementation
- I.E.F.Co.S. is responsible for implementation of the second phase of the EDDRA project guided by a Steering Group consisting of representatives of the Department of Social Affairs, the Ministry of Health, the Co-ordination of the Regions and the EDDRA Manager
- The Ministry of Health is responsible for the Key Indicators, especially those concerned with treatment, whilst the Ministry of the Interior and the National Institute of Health have undertaken work on drug-related deaths.

6.2.4. At the level of specialist research and university institutes, the NFP has close working relations with a number of bodies which undertake contracted work for the NFP as well as independent work which has relevance for monitoring, evaluation and the provision of information for the national report.

6.2.5. Regional/local administrations are required to supply data on drug misuse to the relevant Ministry or Department. To facilitate effective communication with the Regions and Autonomous Provinces, the Regions have nominated one representative to act on their behalf on issues concerning the drug problem. The nominated Region at present is Veneto.

6.3. Role of the NFP in national monitoring and information systems

6.3.1. As described above, under Law 45 of 18 February, 1999, the Focal Point has been placed within the National Drugs Observatory based in the Department of Social Affairs. Under Article 4 (3) of the Decree establishing the Observatory, the role of the National Focal Point is defined as: the link with the EMCDDA with responsibility for collecting and elaborating statistical/epidemiological data as required by the Centre; to collect the necessary information and prepare the Italian National Report; national dissemination of EMCDDA publications and; provision of Italian participation in the REITOX network. Moreover, the Department of Social Affairs, as the Department responsible for the National Fund for Interventions in the Fight against Drug Abuse, is able to use the 25% retained for national projects to support activities which take forward implementation of the core tasks through improved monitoring and information systems.

6.3.2. In general, the NFP has no direct role in carrying out the national monitoring and information systems. It is the recipient of data and information from national and regional government bodies. It does, however, have a role in specifying the information which is required and to this extent, along with the Observatory, can require data and information to be supplied in a specified format. It is anticipated that this will permit implementation of reports and recommendations from the EMCDDA and a more standardised and co-ordinated system for data collection and analysis.

6.4. Other roles and activities of the NFP within the Member State

6.4.1. As already indicated, the NFP is based within the National Drugs Observatory, which is part of the Department of Social Affairs of the President of the Council of Ministers. Staff of the NFP, who have a responsibility for co-ordinating the work of the NFP, also have responsibility for other aspects of the work of the Observatory.

7. Developments in Reporting to other International Organisations

7.1. There have been no specific developments in reporting to other international organisations. As reported above, Italy has participated in the working group of UNDCP concerned with the development of international instruments for collection and analysis of data on drug demand reduction. It is anticipated that, when this work is completed, the instrument will be used within Italy as an additional mechanism for data collection.

7.2. Work with the monitoring / evaluation instruments developed through the Council of Europe Pompidou Group and the EMCDDA is proceeding and wherever possible these instruments will be piloted and brought into full operation. The report on Key Indicators and the future work programme has been submitted separately.

PART III

EPIDEMIOLOGICAL SITUATION

8. NEW INFORMATION ON HISTORICAL DEVELOPMENT OF DRUG USE

8.1. No significant new information on the historical development of drug use has become available in the reporting period.

9. TRENDS AND NEW DEVELOPMENTS IN DRUG USE

9.1. DRUG CONSUMPTION IN THE GENERAL POPULATION

9.1.1. There have been no general population surveys carried out in Italy in recent years. Information about levels of drug consumption is, therefore, based on a limited number of local studies, informed reports from service providers in both the public and private sectors and on anecdotal evidence.

9.1.2. Based on the available evidence, there appears to have been a levelling off of the use of the drugs which cause most public concern, that is, heroin and the opiates. At the same time, there is no clear evidence of any diminution in the use of cannabis and there are reports of a continuing increase in the use of ecstasy by young people. There also appears to be a continuing increase in the use of cocaine, with the number of treatment demands increasing for each of the last three years, suggesting that there is a higher level of consumption in the general population.

9.1.3. A major school survey has been undertaken and its report is due shortly. No information is currently available but the survey is of a fully representative sample of the whole secondary school system of Italy. The results of this survey will be communicated as soon as they are available.

9.1.4. Italy still has male conscription into the military services. Drug use within these services may, therefore, be a useful indicator of drug use within the general population. In 1998, 2,852 people were identified as drug users within the military services (Table 1).

Type of Drug	No. of People	% of total	Type of Drug	No. of People	% of total
Heroin	198	6.9	Amphetamine	53	1.9
Morphine	4	0.1	Ecstasy	36	1.3
Opium and derivatives	69	2.4	Cocaine	205	7.2
Methadone (licit)	12	0.4	Marijuana/Hashish	2,093	73.4
Methadone (illicit)	1	0.0	Hashish oil	4	0.1
Other opiates	4	0.1	Hallucinogens	20	0.7
Alcohol	61	2.1	Crack	1	0.0
Barbiturates	1	0.0	Inhalants	1	0.0
Hypnotic sedatives	7	0.2	Other drugs	82	2.9
TOTAL				**2,852**	**100**

Table 1

9.1.5. Marijuana/hashish is clearly the most used substance, followed a long way behind by cocaine and heroin. All other drugs are relatively infrequently used. It is perhaps surprising that cocaine has a higher profile than amphetamine and ecstasy combined.

9.1.6. 2,426 people (85.5%) were conscripts whilst only 129 people (4.5%) were regular members of the military services.

9.1.7. Substantial socio-demographic information is available on this population which is shown below.

Employment before entry into the Military Services

Employment	No.	%
Student	425	15.0
Manual/semi-skilled/skilled	1,020	35.9
Office/administrative worker	71	2.5
Self-employed	193	6.8
Professional	56	2.0
Manager	2	0.1
Entrepreneur	10	0.4
Unemployed	852	30.0
Other	198	7.0
Not known	11	0.4
Total	**2838**	**100**

Table 2

Educational Level attained before entry into the Military Services

Educational Level	No.	%
Illiterate	17	
Licenza Elementare	307	
Licenza Media	1,909	
Diploma	582	
Laurea Breve	4	
Laurea	9	
Not known	10	
Total	**2,838**	**100**

Table 3

Civil Status on entering the Military Services

Civil Status	No.	%
Single	2,786	98.2
Married	26	0.9
Widower	1	0.0
Separated	3	0.1
Living with partner	12	0.4
Not known	10	0.4
Total	**2,838**	**100**

Table 4

Frequency of drug use

Frequency of Use	No.	%
Several times/year	537	18.9
Several times/month	735	25.9
Weekly	647	22.8
Daily	298	10.5
Not known	621	21.9
Total	**2,838**	**100**

Table 5

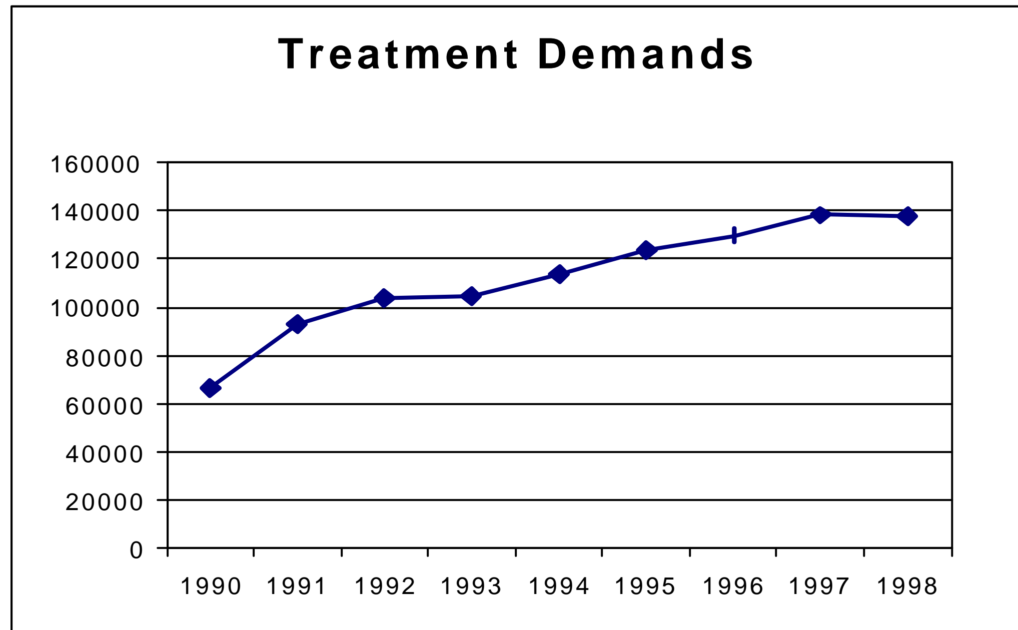
9.1.8. In terms of the reason for drug use, the two most mentioned factors were curiosity (40.8%) and peer group pressure (30.1%).

9.1.9. Only males between the ages of 18-30 are conscripted. This socio-demographic information may, therefore, offer a picture of male drug use patterns in the population usually considered most at risk to drug use. With no national or local general population surveys currently available, at the least it provides some broad indications of drug use in the population.

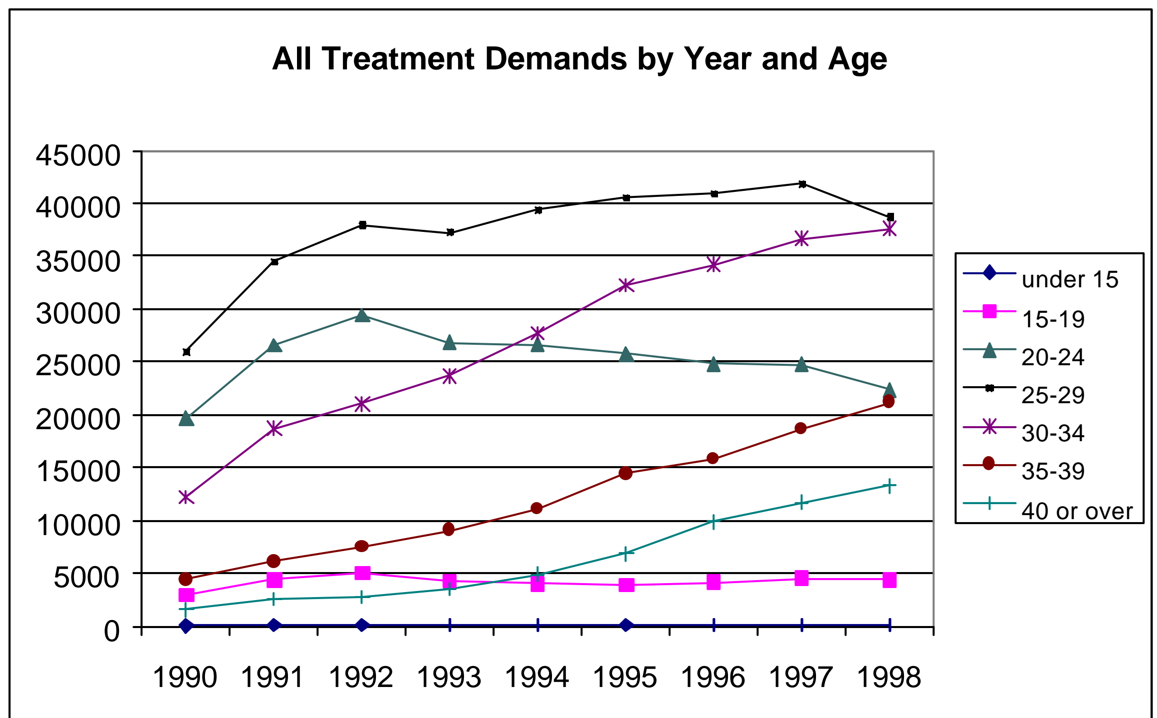
9.2. PROBLEMATIC DRUG USE PREVALENCE

9.2.1. The prevalence of problematic drug use appears to be still increasing with only a small decrease in the total number of treatment demands (Graph 1)

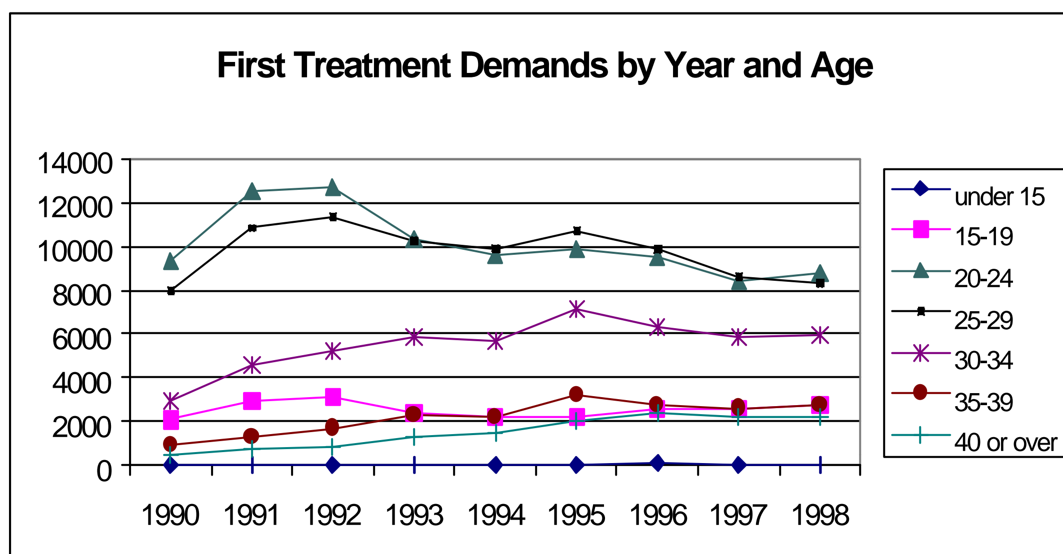
and a small increase in the number of first treatment demands (Graph 2). It is almost impossible to determine if this reflects a greater success in attracting problematic drug users into treatment, a relatively stable situation or that the pool from which those requiring treatment is continuing to grow. Anecdotal evidence, and the fact that there were increased first treatment demands from those in the 15-19 and in the 20-24 age groups (Graph 3), suggests that there is still a substantial pool of problematic users outside the treatment system.



Graph 1



Graph 2



Graph 3

9.2.2. The number of people between the ages of 15 and 54 who have used heroin at some time in their life is estimated to be not less than 300,000 people. This estimate is based on a European study and its application to Italy for 1998. Using other methodologies (capture/recapture and back calculation), it is estimated that around 274,000 people between the ages of 15 and 54 require assistance from treatment services as a result of drug use. In all cases, the main drug of use is heroin.

9.2.3. Some 50% of heroin users are concentrated in 5 Regions which in general, are the most heavily populated. A slightly different pattern emerges when the rate per 1,000 in the 15-54 age range is examined.

Region	Nº in Treatment	Nº of Heroin Users	% Heroin Users	Rate per 1,000 (15-54 yrs)
Lombardia	20,868	46,798	17.1	9.07
Lazio	11,013	30.697	11.2	10.27
Campania	11,327	25,662	9.4	7.72
Piedmonte	13,083	21,315	7.8	9.0
Emilia Romagna	8,942	20,590	7.5	9.63
Sicilia	8,103	19,553	7.1	6.89
Veneto	11,032	19,348	7.1	7.53
Puglia	13,178	17,679	6.5	7.53
Toscana	9,673	16,750	6.1	8.78
Liguria	5,546	12,284	4.5	14.33
Calabria	4,294	8,100	3	7
Sardegna	5,506	7,677	2.8	7.76
Marche	4,110	5,649	2.1	7.27
Abruzzo	3,171	5,354	2	7.71
Fruili V.G.	2,591	4,740	1.7	7.25
Trentino A.A.	1,558	4,243	1.5	8.1

Umbria	1,897	3,469	1.3	7.85
Basilicata	893	2,189	0.8	6.56
Molise	534	1,081	0.4	6.11
Valle d'Aosta	338	821	0.3	12.1
ITALY	137,657	274,000	100	8.48

Table 6

9.2.4. The national rate of heroin use per 1,000 people aged 15-54 is 8.48. 14 Regions have rates below the national rate.

9.2.5. The estimated number of heroin users is almost double the number of people in treatment within the public services (based on returns from 518 Ser.T representing 95% of these services nationally and 100% of their clients). It should also be noted that the national estimate is of heroin users requiring treatment whilst the treatment returns concern all drug users attending for treatment.

9.2.6. For those people who attend the Ser.T for treatment, heroin is the primary drug for 88.5%, followed by cannabis (7.6%) and cocaine (3.2%). Secondary drugs are cannabis (39.2%), cocaine (18.4%), alcohol (15.6%) and benzodiazepines (14.9%). Table 7 shows the pattern of primary and secondary drug use for the last 5 years.

Drugs Misused	Primary Use					Secondary Use				
	1994	1995	1996	1997	1998	1994	1995	1996	1997	1998
Hallucinogens	0.3	0.1	0.2	0.2	0.2	1.0	1.0	1.0	0.8	0.8
Amphetamines	0.3	0.3	0.4	0.2	0.2	2.6	3.2	3.7	2.3	1.7
Ecstasy & analogues	- - -	- - -	- - -	0.4	0.7	- - -	- - -	- - -	2.4	2.4
Barbiturates	0.0	0.1	0.1	0.0	0.1	0.9	0.9	0.6	0.6	0.5
Benzodiazepines	0.5	0.4	0.5	0.4	0.5	19.2	19.3	17.3	16.2	14.9
Cannabis	5.1	5.8	5.8	6.9	7.6	41.1	41.5	41.8	40.1	39.2
Cocaine	1.9	1.6	1.8	2.3	3.2	12.7	13.5	13.6	15.1	18.4
Crack	0.1	0.6	0.5	0.0	0.0	0.1	0.1	0.2	0.1	0.2
Heroin	88.5	89.1	88.8	87.5	85.6	1.8	2.2	3.2	2.1	1.9
Methadone	0.4	0.2	0.3	0.6	0.7	0.8	0.7	0.6	2.4	2.4
Morphine	0.1	0.5	0.0	0.1	0.0	0.1	0.2	0.2	0.2	0.1
Other opiates	- - -	- - -	- - -	0.1	0.1	- - -	- - -	- - -	0.4	0.6
Inhalants	- - -	- - -	- - -	0.0	0.1	- - -	- - -	- - -	0.1	0.1
Alcohol	- - -	- - -	- - -	- - -	- - -	15.4	14.9	15.0	14.4	15.6
Other	2.7	1.1	1.7	1.3	0.9	4.3	2.5	2.8	2.8	1.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 7

9.2.7. The patterns displayed by the above table show a small decrease in the use of heroin as a primary drug and small increases in the use of cocaine, cannabis and ecstasy. In the pattern of secondary drugs, there has been a continuing increase in the use of cocaine whilst the use of all other drugs remains broadly the same. This may suggest that in terms of problematic use, there may be a future increase in treatment demands from those whose primary drug use is cocaine.

9.2.8. The pattern of primary drug use is broadly consistent throughout the country, with heroin the dominant drug of misuse. However, there are variations between Regions as shown in Table 8.

Region	Heroin	Cannabis	Cocaine	Other
Piemonte	92.9	2.7	2.1	2.2
Valle d'Aosta	97.3	0.6	1.2	0.9
Lombardia	86.8	4.8	5.8	2.6
Prov.Aut.Bolzano	79.8	17.7	0.9	1.6
Prov.Aut.Trento	92.8	2.9	2.1	2.1
Veneto	79.6	10.3	3.2	6.9
Friuli V.Giulia	77.9	12.1	1.9	8.1
Liguria	83.8	9.7	3.9	2.7
Emilia Romagna	85.8	6.3	3.5	4.4
Toscana	86.5	9.5	2.2	1.8
Umbria	88.7	7.1	1.4	2.8
March	76.0	16.1	2.7	5.2
Lazio	91.0	4.9	3.1	1.0
Abruzzo	75.2	9.2	2.9	12.7
Molise	80.5	13.2	3.3	3.1
Campania	81.2	12.7	2.1	4.0
Puglia	80.3	8.4	4.8	6.5
Basilicata	91.4	7.2	1.2	0.2
Calabria	81.1	14.0	1.7	3.2
Sicilia	89.4	7.0	1.6	2.0
Sardegna	96.9	2.1	0.3	0.8
Total	100.0	100.0	100.0	100.0

Table 8

9.2.9. It is not clear why there are these differences between regions. They may reflect relative availability of drugs in different regions, treatment policy and practice in the regions or different attitudes towards drug use in the regions. More detailed examination would be required to provide a satisfactory explanation.

9.2.10. There is limited information about problem drug users attending social/rehabiltative services and it is not possible to determine how many are already included in the information received from the Ser.T.

9.2.11. In 1998, there were an average of 21,532 drug users in treatment in 1,282 (out of a total of 1,344) of these services. This is a reduction in the number of clients from the high point of 1994, when there was an average of 24,073 clients in 1,203 (out of 1,275) such services.

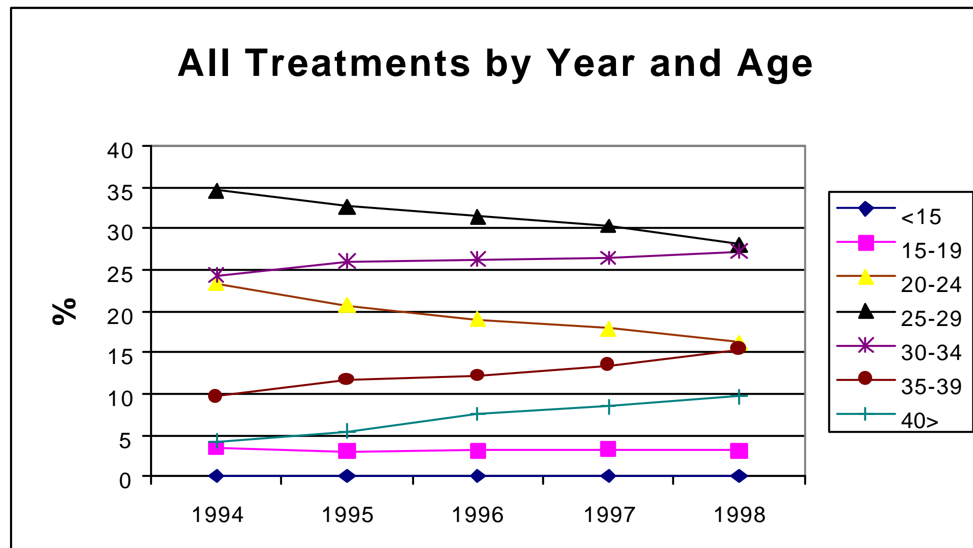
9.3. PATTERNS AND MODES OF DRUG USE, CHARACTERISTICS OF USERS

9.3.1. The majority of drug users in treatment at the Ser.T inject their drugs. However, for those whose primary drug is not heroin, injecting is less common, with less than a third injecting other opiates and

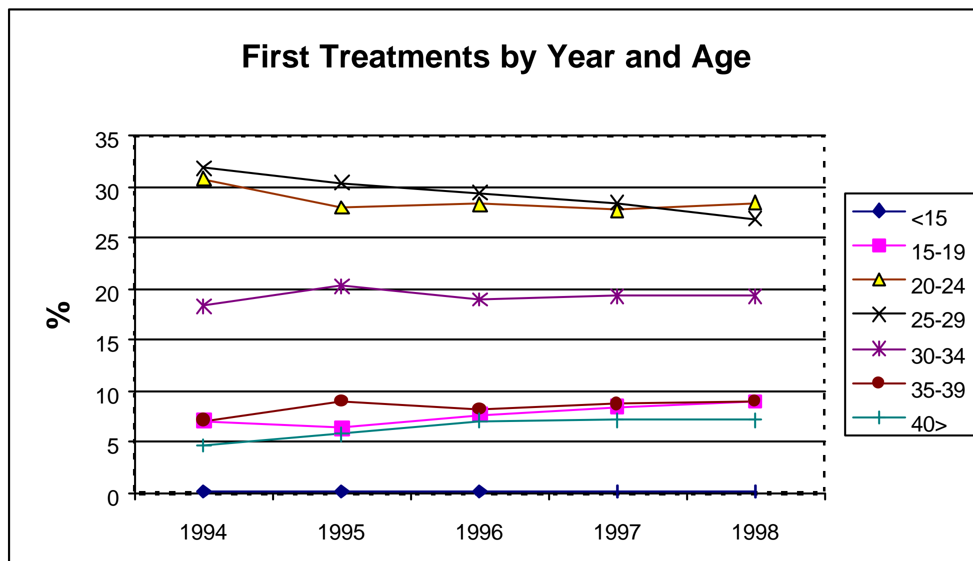
benzodiazepines, just over one fifth injecting cocaine and very small numbers injecting other drugs.

9.3.2. The ratio of male to female drug users has continued to increase for both all treatments and for first treatments. This has been a consistent pattern throughout the 1990s. In 1994, the male to female ratio for all treatments was 5.4:1, but by 1998 it was 6.3:1 For first treatments there was a similar change from 5.5:1 in 1994 to 6.7:1 in 1998.

9.3.3. In terms of age of those attending for treatment at the Ser.T, the trend is broadly towards an ageing population of drug users as shown by the graphs below.



Graph 4



Graph 5

9.3.4. From the available data, the implication is that the population in treatment is becoming older whilst more people are attending for first treatments at an earlier stage in their drug using career. For this to be confirmed,

however, more information is necessary about retention in and completion of treatment and about the level of drug use within the general population.

9.4. NEW USER GROUPS, NEW DRUGS, NEW DRUG USE PATTERNS

9.4.1. There is at present little epidemiological information available about new user groups, new drugs or new drug use patterns. There are indications that the level of cocaine use is continuing to increase and this is reflected in the number of people attending for treatment where cocaine is the primary or secondary drug of choice. It is also reflected in the information on drug use by those in the military services, where cocaine is easily the second most used drug after cannabis and in reports from several local studies.

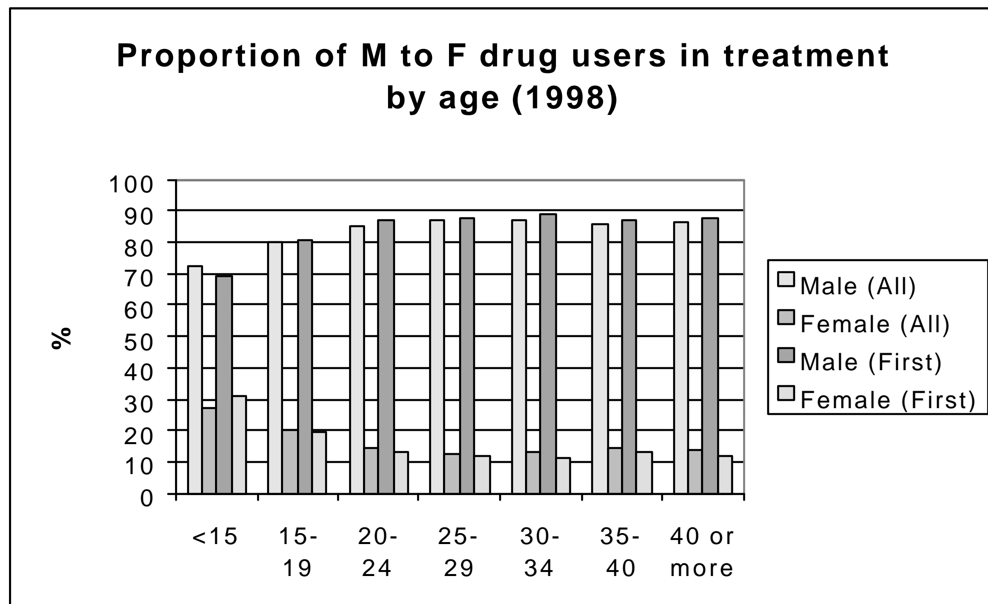
9.4.2. There are reports of a continued increase in the use of amphetamine and amphetamine analogues, such as MDMA. The recent death in Brescia, was initially attributed to 4 MTA, although this was not the case, and information from a variety of sources suggests that these drugs are more readily available. However, there is little confirmed evidence about the extent of use of these drugs. At present it appears to be located in the northern Regions of Italy. The data arising from the major school survey which is due to be available shortly should provide greater information about the wider pattern of drug use.

9.5. HEALTH CONSEQUENCES AND RISK BEHAVIOUR

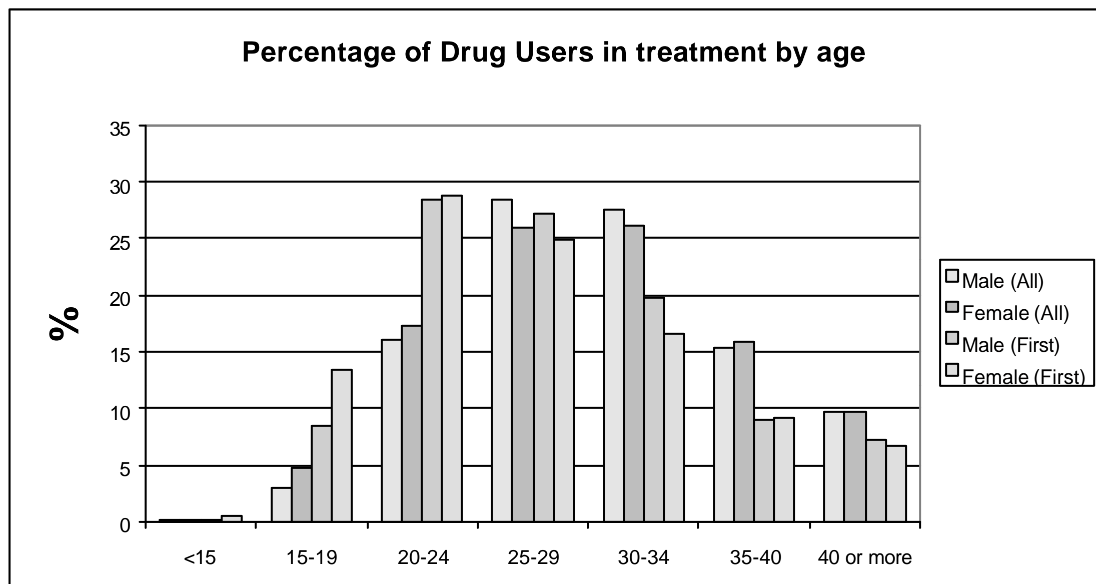
9.5.1. Much information regarding treatment demand has already been dealt with in earlier sections as the main information about trends and patterns of drug use.

9.5.2. There has been no change in the pattern of drug use, with heroin being the primary drug of misuse and injecting being the main consumption method.

9.5.3. It is interesting to note, however, that females appear to enter into treatment earlier than males and to leave or complete treatment earlier than males. For all treatments, the percentage of males to females is 86.3% to 13.7% and for first treatments this is 87% to 13%. There are significant differences in the age groups, however, as shown in Graphs 6 and 7. Graph 6 shows the proportion of male to female drug users by age group whilst Graph 7 shows the percentage of male and female drug users coming from each age group.



Graph 6



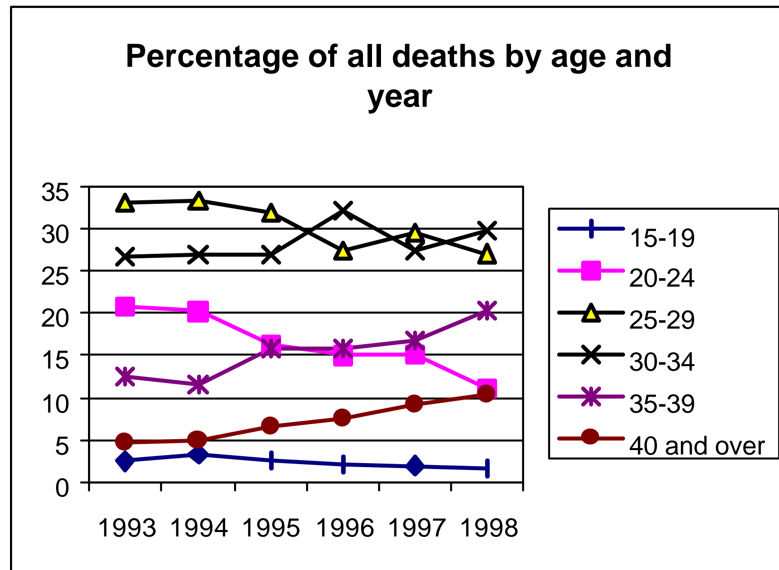
Graph 7

9.5.4. In the under 15, 15-19 and 20-24 age groups, for all treatments, and particularly for first treatments, the percentage of female drug users is significantly higher than that when all age groups are combined.

9.5.5. At present within Italy information is only available on deaths directly related to drug misuse. In 1998 there were 1,076 such deaths recorded, a 20% reduction since 1996, when 1,566 deaths were recorded. There was, however, a small increase in the number of female deaths compared to 1997 whilst there was a decrease in the number of male deaths.

9.5.6. In less than half the deaths was the drug used recorded. In the 526 cases where the drug involved was known, heroin was recorded for 96.8% of cases followed by cocaine in 2.1% of cases.

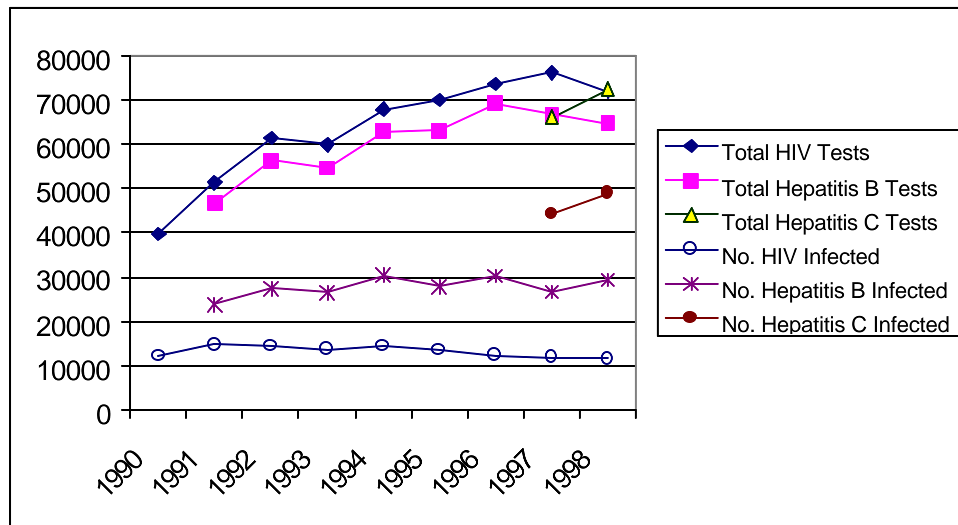
9.5.7. The trend in drug related deaths shows an increase in the percentage of deaths occurring amongst older drug users and a decrease in the percentage of deaths recorded amongst younger drug users (Graph 8). It is difficult to interpret the reasons for this trend.



Graph 8

9.5.8. Trends in HIV, Hepatitis B and Hepatitis C infections amongst drug users are shown in Graphs 9, 10, 11 and 12. In principle, clients should be tested on entering treatment. However, around 40% of clients remain untested.

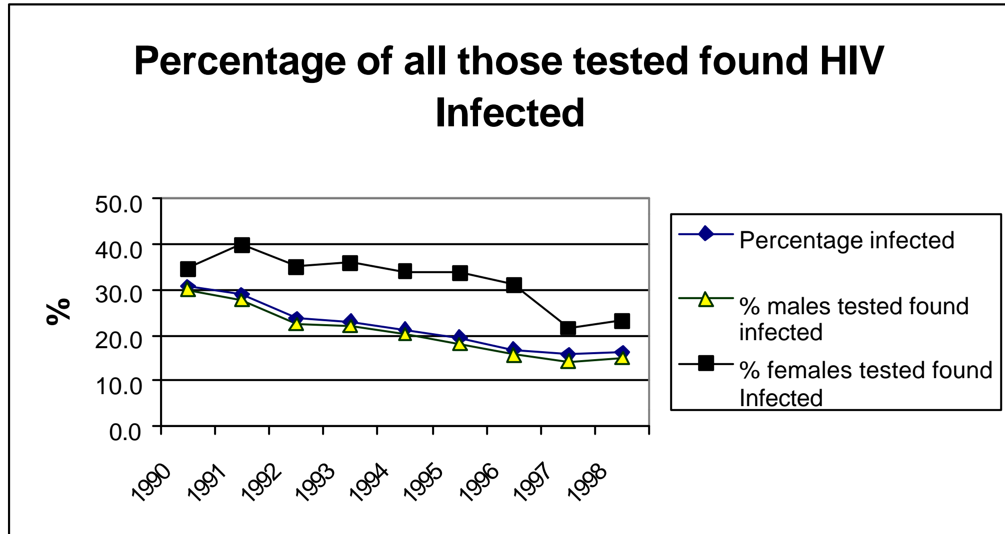
9.5.9. The total number of tests for HIV infection and for Hepatitis B infection have declined whilst the total number of tests for Hepatitis C infection, which only commenced nationally in 1997, have increased (Graph 9). The number of people found to be HIV positive has shown a slow but steady decline whilst hepatitis infections (both B and C) have risen. It is too early to draw any conclusions from the data about hepatitis C but it may



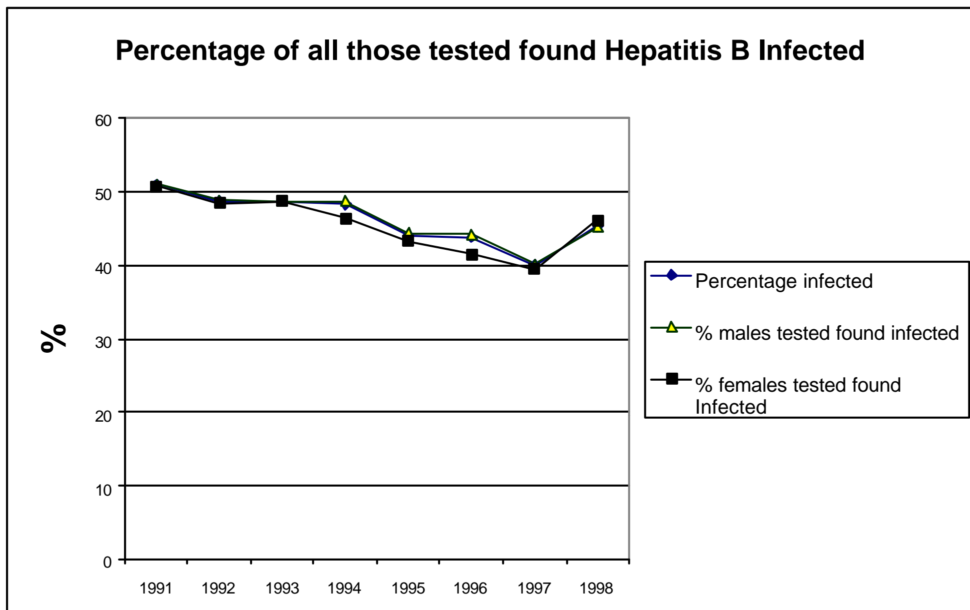
Graph 9

reasonably be assumed that hepatitis infections will continue to be a cause for concern for some time to come.

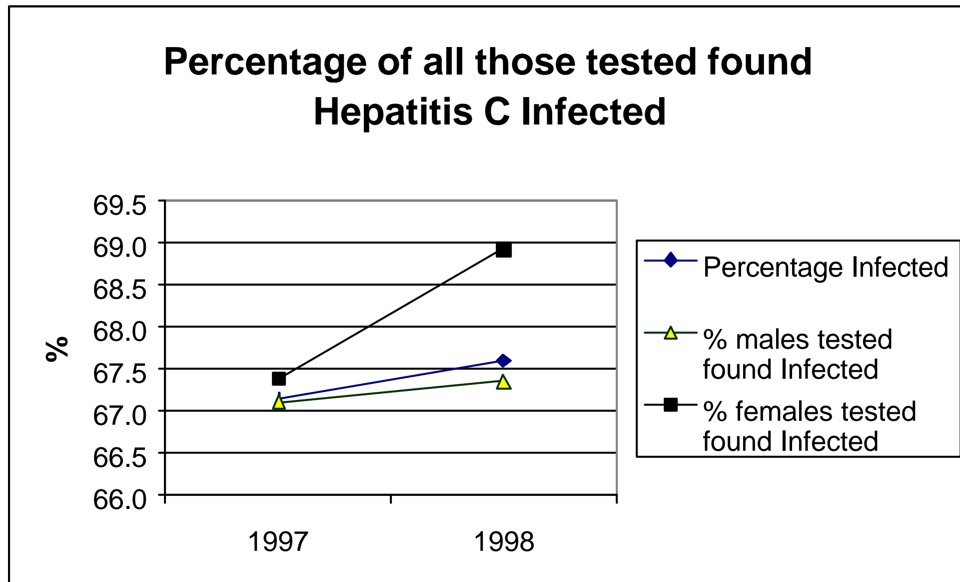
9.5.10. Looking more specifically at the three different forms of infection, it can be seen that the percentage of female drug users infected by HIV, hepatitis B and/or hepatitis C is higher than the percentage of males infected. This is most clearly seen with regard to HIV and hepatitis C infection and is marginally higher for hepatitis B infection. There is no clear explanation for this difference but it must be assumed that they are more likely to share injecting equipment.



Graph 10



Graph 11



Graph 12

9.5.11. It is noteworthy that new clients to the Ser.T who have been tested for HIV and for hepatitis B and C have consistently shown a lower percentage of infection than those already in treatment (Table 9).

9.5.12. It is not possible to determine with any precision why such a difference should exist. Some of the factors involved are straightforward, such as a higher percentage of new clients not having been tested, a higher refusal rate to testing amongst new clients and a higher percentage of unavailable data relating to new clients compared to existing clients. Whilst these are important factors, they do not entirely explain the differences and it may be that new clients are now engaging in less risk behaviour for infection than clients already in treatment engaged in before entering treatment.

	% New Clients tested positive						% Clients already in Treatment tested positive					
	HIV		Hep. B		Hep. C		HIV		Hep. B		Hep. C	
	M	F	M	F	M	F	M	F	M	F	M	F
1994	9	15.3					24	30.2				
1995	9.5	17.3					20.8	29.3				
1996	6.4	11.7					18.4	26.8				
1997	6.2	9.6	12.1	10.5	47	44.8	16.6	25.6	22.3	22.6	71.9	73.7
1998	6.1	9.8	10.7	11.5	45.9	43.5	16.9	26.2	25.4	25.1	71.9	74.7

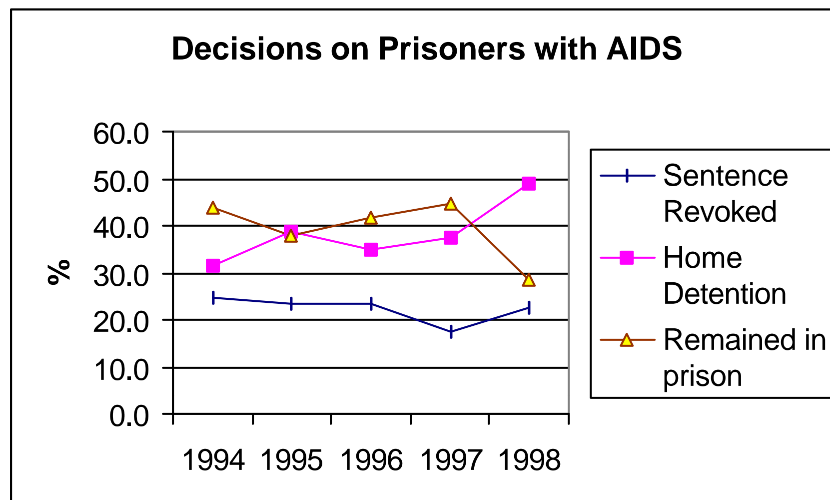
Table 9

9.5.13. At 31/12/1998,1,546 prisoners were HIV seropositive, representing 3.25% of the total prison population on that day. 1,334 (86.3%) of these were drug dependents which represented 9.83% of all the drug dependent prisoners. This is a lower rate of HIV infection than in the drug dependent population outside prison and there has been a continuing decline in the number of drug dependent prisoners who were seropositive. At 31/12/90, 2,378 drug dependent prisoners were seropositive, representing 32.6% of

all drug dependent prisoners. At the same time. There has been an increase in the number of non-drug dependent prisoners found to be seropositive, although the broad trend had been downwards after peaking in 1995.

9.5.14. HIV testing is offered on a voluntary basis to all prisoners. There has, however been a reduction in the number of prisoners asking to be tested. In 1998, of 94,216 people who were imprisoned at some time during the year, 33,047 undertook screening for HIV. Within this figure there were substantial Regional variations, with over half of new prisoners in the northern Regions and under a quarter of new prisoners in the southern Regions and the Islands undertaking screening. These factors might have had an impact on the data and might mask a higher underlying rate of seropositivity.

9.5.15. Legislation allows for prisoners with serious illnesses to be considered for an alternative to continued incarceration. Graph 13 shows the decision taken with regard to prisoners with AIDS. Although this refers to all prisoners, given that drug dependent prisoners the vast majority of seropositive prisoners and that they are likely to have been HIV infected for a longer time, it is reasonable to assume that this legislation has benefited drug dependent prisoners.



Graph 13

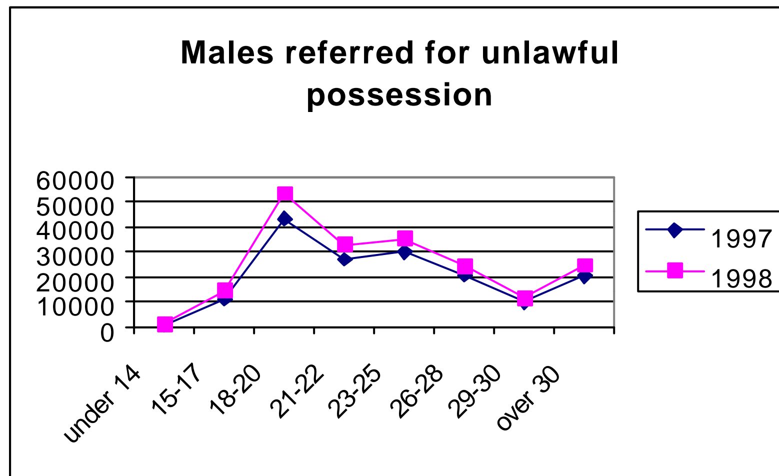
9.5.16. At 31/12/98, 111 non-Italian prisoners were seropositive. Of these, 64 (57.7%) were drug dependent. This is a significantly higher percentage than the percentage of Italian drug dependent prisoners.

9.6. LEGAL CONSEQUENCES

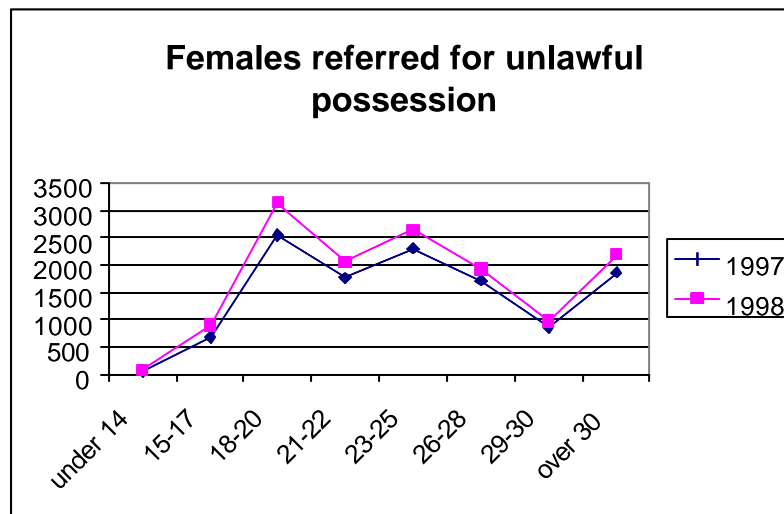
9.6.1. There is no criminal offence in Italy for possession of small quantities of controlled drugs, the legal consequences for drug use are administrative actions and referral to rehabilitation. Criminal offences under the drugs laws are possession for trafficking, sale, production and being involved in any of these offences (including financing and money laundering). The information concerning non-criminal drug offences concerns the number of

people referred for administrative action. There is slightly fuller information about juveniles referred to the Justice Authority who were drug users.

9.6.2. In 1998, a total of 210,345 people were found in unlawful possession of a drug and were dealt with initially by administrative procedures. This represented an increase of 20.8% over 1997. Graphs 14 and 15 show the distribution by age and sex of those referred.



Graph 14



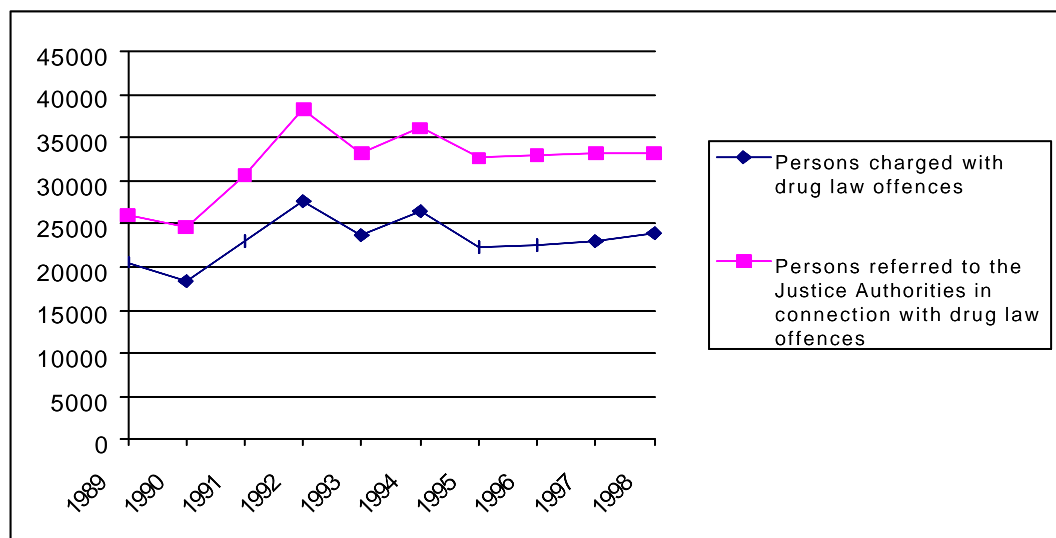
Graph 15

9.6.3. In terms of drugs which the person possessed unlawfully, cannabis was by far the most common, representing 61% of all possession in 1997 and 64% in 1998. A considerable way behind was heroin, followed by cocaine, ecstasy and other opiates. Between 1997 and 1998 there was an increase for unlawful possession of all controlled drugs. The most significant rises were for possession of cannabis, cocaine, amphetamines and other drugs (primarily benzodiazepines). There were also important but smaller increases in possession of methadone and ecstasy. The following table shows the distribution by drug, sex and year of people referred for unlawful possession. It should be noted that this table refers to the drugs which a person possessed and is therefore a greater number than the number of persons found in unlawful possession.

Drugs	1997 Male	1997 Female	1997 TOTAL	1998 Male	1998 Female	1998 TOTAL
Heroin	59248	7127	66375	63480	7554	71034
Methadone	579	113	692	676	122	798
Morphine	264	40	304	289	43	332
Opiates	2317	292	2609	2329	292	2621
Cocaine	9516	684	10200	11750	849	12599
Amphetamine	438	27	465	562	35	597
LSD	420	41	461	468	46	514
Ecstasy & analogues	2748	221	2969	3192	250	3442
Cannabis	126720	6364	133084	156254	7920	164174
Other drugs	765	82	847	1223	120	1343

Table 10

9.6.4. In 1998, 33,179 people were referred to the Justice Authority in connection with criminal offences against the drug laws. Of these, 23,886 were arrested whilst the remaining 9,283 were released without charge. Graph 16 shows the pattern of referrals and arrests over the last 10 years.



Graph 16

9.6.5. The vast majority of offences were for the sale of drugs (80%), followed by production and trafficking (10.3%), involvement in the financing of drug trafficking (8.6%) and involvement in the financing of drug sales (1%). Approximately one third (10,525 people) of those referred to the Justice Authority were non-Italians and of these, almost 90% were arrested. By contrast, of the 22,654 Italians referred, only 65% were arrested. A significant factor in this is the increasing involvement of non-Italians in the sale, production and trafficking of drugs.

9.6.6. There has been a steady increase in the number of minors referred to the Justice Authority over recent years for drug law offences, rising from 987 in 1994 to 1,296 in 1998. A significant proportion of these were non-Italians (44.5%). Of the referrals, 768 (59.3%) were arrested, 42.2% of the Italians referred and 80.6% of the non-Italians.

9.6.7. There has also been a steady increase in the number of drug using minors passing through the Juvenile Justice Service, from 1,162 in 1994 to 1,418 in 1998. Of these, the vast majority were Italian (81.4%) and were male (96.6%).

9.6.8. 179 (12.6%) were drug dependent, 720 (50.8%) were habitual users and 469 (33%) were occasional users. The drug most frequently used was cannabis (906 people), followed by opiates (243) and cocaine (101).

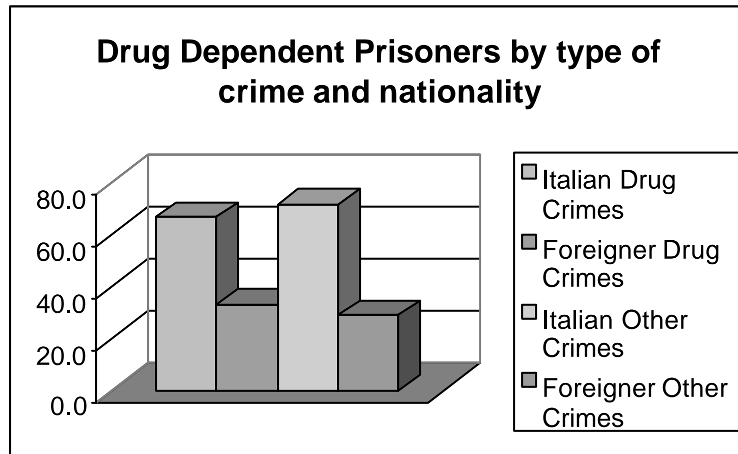
9.6.9. In terms of the offences for which they were arrested, the majority were either offences against property (theft etc.) (46.9%) or drug law offences (42.5%). Interestingly, the largest number of Italians came from the southern Regions of Italy (567 out of 1,154) although it is the northern Regions which have the highest number of drug users in treatment.

9.6.10. On 31/12/1998 there were 47,560 persons serving a prison sentence. Of these, 13,567 (28.5%) were drug dependent. This is a slight decrease over the number of drug dependent prisoners at the same time in 1997 and maintains the slow downward trend in the number of drug dependent prisoners at the end of each year. Within these figures, however, there has been a continuing increase in the number of non-Italian drug dependent prisoners, matching the decrease in Italian drug dependent prisoners.

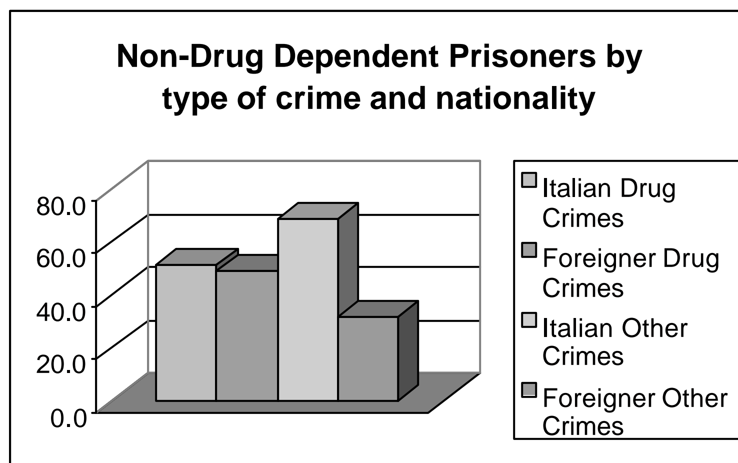
9.6.11. The information on drug dependent prisoners shows that 6,800 were held for offences against the drug laws and 6,767 for other offences. The vast majority (96%) were male. In total, 17,216 persons were held for offences against drug laws, representing 36.2% of the total detained population. 6,255 of those detained for these offences were non-Italians, representing 36.3% of the total population held for drug law offences.

9.6.12. Data on new prisoners detained at some time between 1/7/98 and 31/12/98 shows more detailed information. A total of 46,651 new prisoners entered the prison system in the period of whom 16,427 (35.2%) were held for Drug Law crimes. Of these, 58.5% were Italian and 41.5% were non-Italians. New non-drug dependent prisoners accounted for 53% of all Drug Law crimes

9.6.13. 15,492 prisoners were drug dependent, amounting to 33% of all prisoners. Of these, 10,693 (69%) were Italian and 4,799 (31%) were non-Italian. Graphs 17 and 18 below illustrate the offences committed by drug and non-drug dependent prisoners by nationality. As can be seen by these graphs, drug dependent prisoners, whether Italian or non-Italian, were almost evenly balanced between Drug Law crimes and other crimes. By comparison, for non-drug dependent prisoners had substantial differences. Where Italian prisoners were more commonly imprisoned for other crimes, non-Italian prisoners were predominantly imprisoned for Drug Law crimes. This is to be expected and suggests that couriers of drugs were more frequently caught than those involved in organising and financing Drug Law crimes.



Graph 17



Graph 18

9.6.13. There are noticeable Regional differences in the distribution of drug dependent prisoners. 2,168 (28%) of those imprisoned for Drug Law crimes were in the Lazio Region. The Region with the second highest number of drug dependent prisoners jailed for Drug Law crimes was Piemonte, with 800 (10%). By contrast, the Regions of Campania and Lombardia had the highest number of non-drug dependent prisoner jailed for Drug Law crimes, 1,895 (22%)and 1,585 (18%) respectively. For other crimes committed by drug dependent prisoners, the largest number of prisoners were in Piemonte, with 1,938 (25%), followed by Lombardia, Campania and Lazio with 11.4%, 8.3% and 8.3% respectively.

9.6.14. Looking more closely at the drug dependent prisoners, Italians accounted for 66.7% of Drug Law and 71.3% of other crimes committed by drug dependent prisoners. In eight Regions, foreign drug dependent prisoners represented one third or more of all drug dependent prisoners. In Liguria they represented over 50% of drug dependent prisoners and in Toscana over 60% of drug dependent prisoners.

9.6.15. Looking specifically at the Drug Law and other crimes committed by drug dependents, in nine Regions foreign drug dependents represented over one third of drug dependent prisoners convicted for Drug Law offences and in six of them they represented over 50% of such prisoners. By

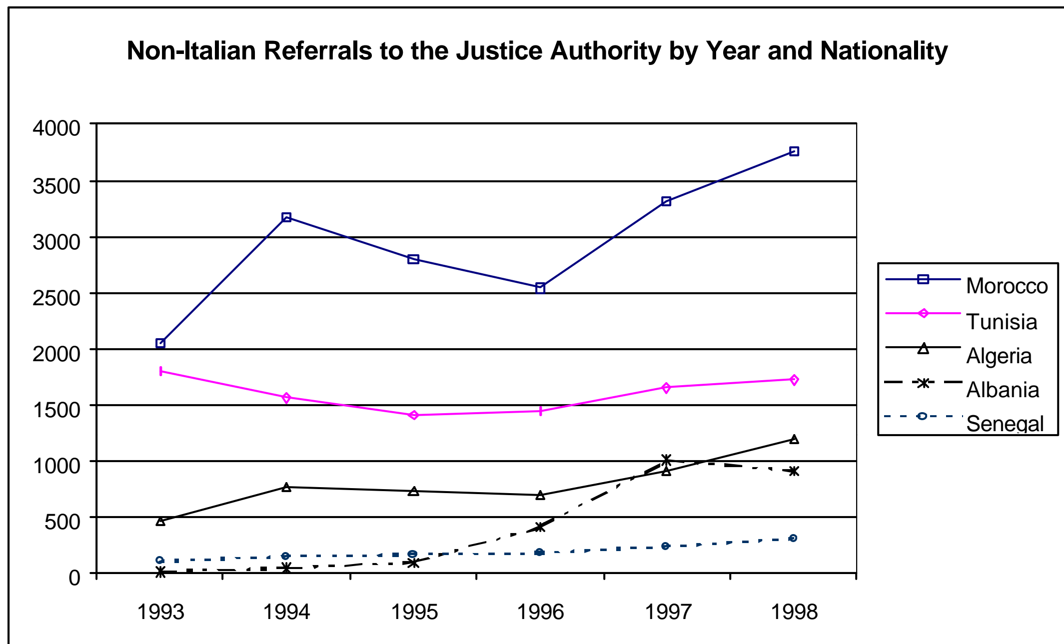
contrast, foreign drug dependents represented one third or more of all drug dependent prisoners convicted of other crimes in only 6 Regions and in only 3 of them did they represent more than 50% of such prisoners.

9.7. DRUG MARKETS

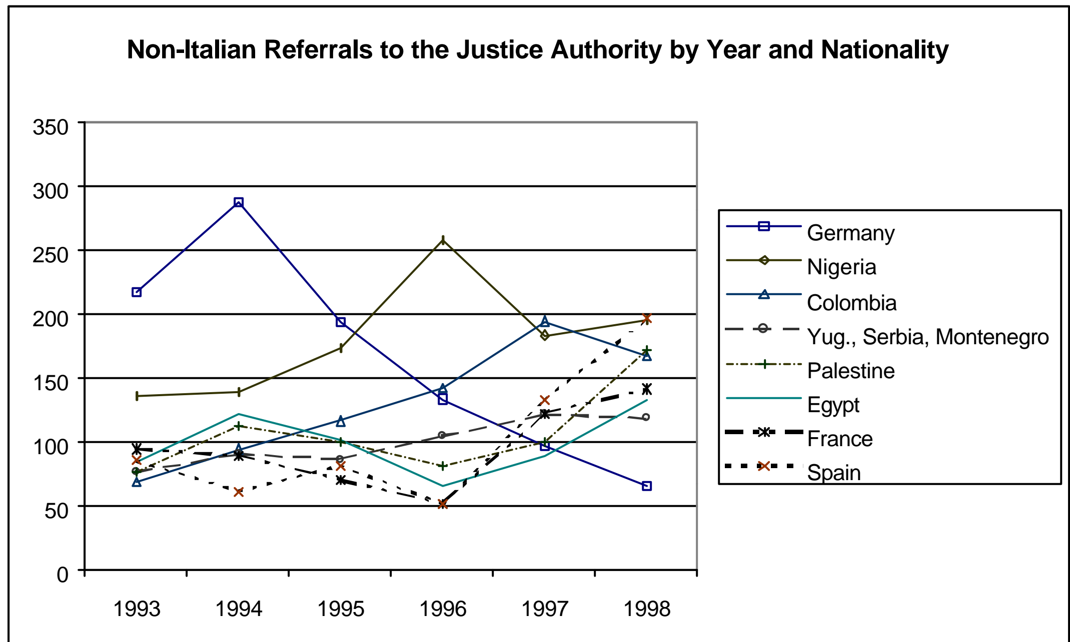
9.7.1. In 1998, the vast majority of seizures for all drugs were made within the Italian borders. Seizures at land borders most frequently involved amphetamines and LSD, at air borders most frequently involved cocaine and at sea borders most frequently involved cannabis.

9.7.2. The source and transit routes of drugs varies considerably for different drugs. For heroin, the majority of seizures were from Turkey, followed some way behind by the Czech Republic and then Croatia and Albania. For cocaine, the main sources were Colombia, Brazil, Venezuela, Ecuador and Spain. For hashish, Spain and Morocco were the main sources, followed by Albania whilst for marijuana Albania and Ghana were the principle sources. Amphetamines (including amphetamine analogues) came principally from the Netherlands, as did LSD.

9.7.3. Of the 33,179 persons referred to the Judicial Authority for drug offences. 10,525 were non-Italians. The nationalities (other than Italian) most represented in indictments for drug law offences were Morocco (35.7%), Tunisia (16.4%) and Algeria (11.3%), followed by Albania (8.7%). Together, these nationalities represented 72% of the total. Graph 19 shows the trend in referrals of non-Italians by nationality and year for the five countries with the highest number of nationals involved in drug law offences whilst Graph 20 shows the trend for nationals of other countries which are significantly represented in referrals to the Judicial Authority.



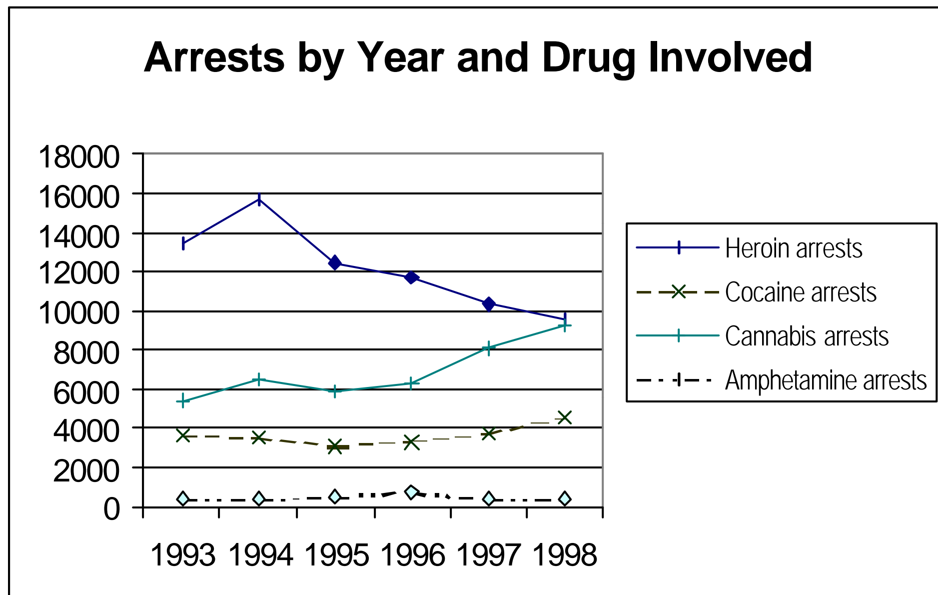
Graph 19



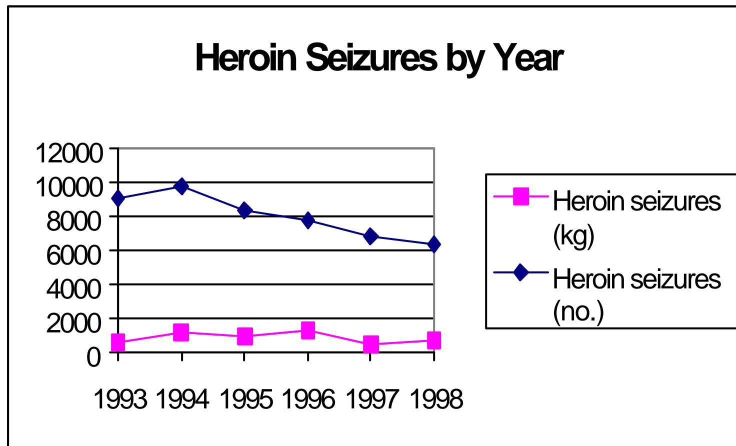
Graph 20

9.7.4. Graphs 21 - 26 show the number of arrests for the principle drugs and the relationship between the quantity seized and the number of seizures for each drug.

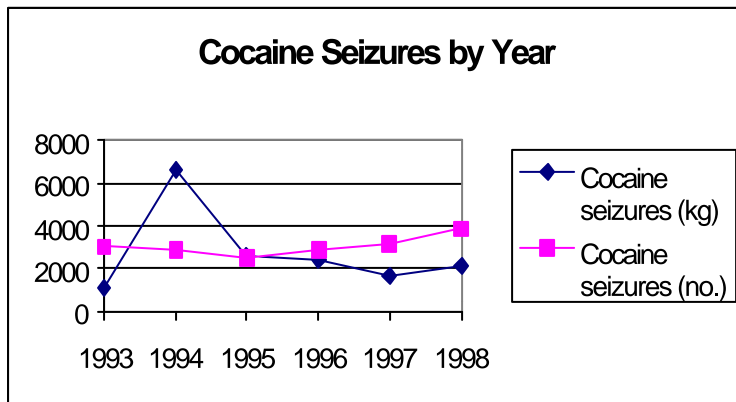
9.7.5. The number of arrests where heroin and amphetamine (including ecstasy) were involved has fallen whilst arrests for cocaine and cannabis have continued to rise. Only with heroin is there any consistent pattern, with the number of arrests and seizures declining over time whilst the quantity seized has remained broadly steady with only small fluctuations.



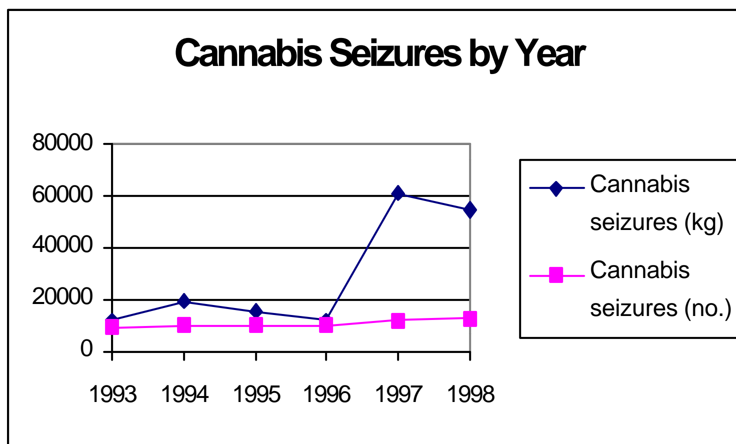
Graph 21



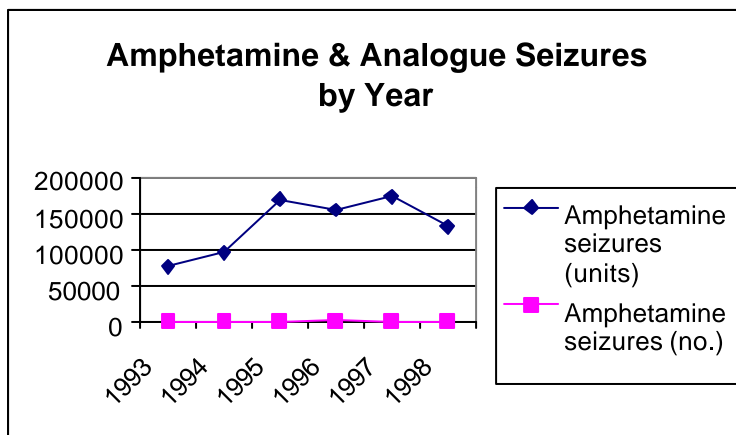
Graph 22



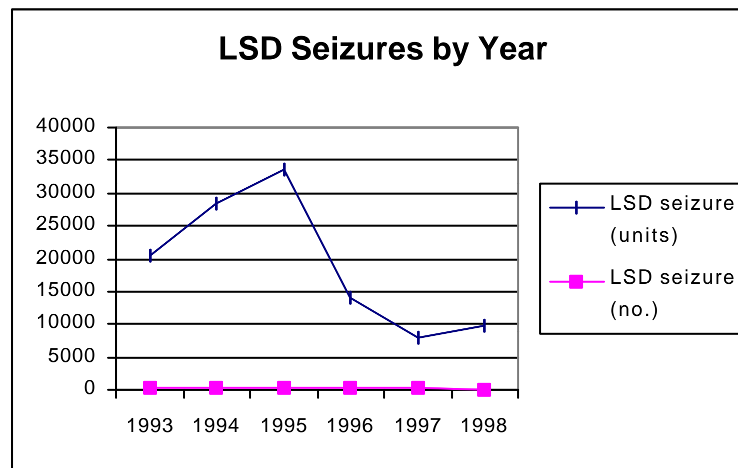
Graph 23



Graph 24



Graph 25



Graph 26

9.7.6. For all other drugs, there have been considerable fluctuations in the quantities seized whilst with the exception of cocaine, the number of seizures have changed little. The situation with cocaine is particularly interesting in that the number of seizures has shown a steady increase although the quantity seized has a broadly downward curve.

9.7.7. The pattern of drug law offences is also of some interest. Production and trafficking offences predominate in the northern Regions of Italy, dominated by Lombardia, Veneto, and Emilia Romagna. Offences of selling drugs also predominate in the northern Regions, with Lombardia, Piemonte, Emilia Romagna and Veneto being most affected. Involvement in the financing of drug trafficking and in the financing of the drugs market, however, is dominated by the southern Regions, notably Campania, Puglia, Sicilia and Calabria. These patterns are not surprising in that drug use is highest in the northern and central Regions whilst the southern Regions are less populated and have substantial coast lines and physical areas which cannot readily be policed. They are also the Regions, especially Puglia, where illegal immigration has been a problem and in which criminal groups from the Balkan countries appear to have become established.

9.7.8. In terms of availability, based on seizures,

- For heroin, Lombardia, Abruzzo, Puglia and Lazio were the main Regions
- For Cannabis, Puglia, Friuli-Venezia Giulia, Toscana and Lombardia were the main Regions
- For Amphetamines (including ecstasy), Veneto, Lombardia and Emilia-Romagna were the main Regions
- For LSD, almost all seizures were in the northern Regions.

9.7.9. By contrast, in terms of drug sales and trafficking, the northern Regions were dominant. Piemonte, Lombardia, Emilia-Romagna, Toscana, Lazio and Campania all had more than 2,000 people referred to the Judicial

Authority concerning offences of drug sales and Vento, Liguria, Puglia and Sicilia had over 1,000 people referred for this offence.

9.8. SOCIAL PROBLEMS LINKED TO DRUGS

9.8.1. There is, at present, no additional information on this topic. In a number of Regions there are or have been programmes designed to re-integrate drug users into employment or to reach drug users early in their drug use to offer assistance and to avoid social exclusion. These are dealt with more fully in the Demand Reduction section as little epidemiological information is available. It is expected that fuller information on this topic will be available for future annual reports.

9.8.2. Information in other sections of this report provide some indication of the public nuisance issue, notably offences against property and persons committed by minors involved with drug use and that almost 50% of the offences for which drug dependents were imprisoned were not drug law offences.

9.9. GEOGRAPHICAL/REGIONAL DIFFERENCES IN TRENDS AND INDICATORS

9.9.1. Throughout the report, geographical and regional differences have been noted. The trend has remained that drug misuse is most prevalent in the major metropolitan areas. All the basic indicators in terms of treatment demands, direct drug-related deaths and arrests for drug offences show that the northern Regions of Italy have the highest level of drug problems and that within these regions the concentration of problems is within the large metropolitan areas. Lombardia is the Region which comes first in nearly all of the indicators. Piemonte, Veneto and Emilia-Romagna are the three other regions with high levels of drug problems. In the central Regions, Lazio and Toscana have the vast majority of drug problems although Umbria and Marche have a large number of people in treatment within residential services. This perhaps reflects the tendency to place such services in more rural areas where drug problems are believed to be less prevalent. Of the southern Regions, Puglia has the second largest number of drug users in treatment in Ser.Ts in Italy and also has a large number of people attending social-rehabilitative services. Campania has the fourth largest number of people in treatment at Ser.Ts but a relatively low level of social-rehabilitative services.

9.9.2. There are indications that drug use rather than drug dependence is more widespread and that drug problems are beginning to emerge in the less densely populated areas. It is anticipated that the school survey mentioned earlier will provide valuable information about the broader pattern of drug use and possible implications for drug problems in the future.

9.10. RISK AND PROTECTIVE FACTORS

9.10.1. There is limited evidence available outside that drawn from the international literature about the risk and protective factors. Research carried out in Rome (1998), Parma (1998) and by ESPAD (1995), all found that there was a correlation between the use of alcohol, the use of tobacco

and the use of drugs. This is a matter of concern for Italy because of changing patterns in the use of alcohol amongst young people. Historically, alcohol consumption has been associated with eating. However, amongst young people this association appears to be of less importance and the level of problem drinking is rising, along with cigarette consumption amongst those who drink.

9.11. SOCIAL PROCESSES AND CULTURAL CONTEXT

9.11.1. As mentioned above, changing patterns to the consumption of alcohol are important and may have implications for drug use. Curiosity about drugs and novelty seeking are already present and the desire to participate in a wider youth culture appears likely to further diminish the traditional constraints on intoxication, whether from alcohol or from other drugs.

9.12. ATTITUDES AND PUBLIC OPINION

9.12.1. There is no additional information available on this topic. As reported above, the general level of concern about drug misuse appears to have diminished over time. This may reflect a situation in which drug use is seen as less dramatic and where media coverage is relatively low. At the same time, individual incidents can lead to considerable media coverage. This was the case with regard to the death of a young man in Brescia. Initial reports attributed the death to 4 MTA and many newspaper and television reports examined the use of the new drugs. In fact, the death was not due to 4 MTA but there was relatively little reporting of this.

9.12.2. The incident is illustrative of the general trend within Italy where drug misuse, whilst still a matter of concern, is not a major issue. However, dramatic events, which appear to involve a relatively new phenomenon, can still raise the profile of drug misuse and reflect the underlying unease about drug misuse by young people.

10. TRENDS PER DRUG

10.7. CANNABIS

10.7.1. There is limited information available on trends in terms of the use of cannabis as users tend not to seek treatment. It is noteworthy, however, that there has been a continued increase in the number of people seeking assistance from the Ser.T where the primary drug of use was cannabis. This has now risen from 5.1% of treatment demands in 1994 to 7.6% of treatment demands in 1998.

10.7.2. From other sources of information, it is clear that cannabis use remains extensive with increases in cases of unlawful possession and in telephone enquiries to Drogatel. A study carried out in Parma (Emilia-Romagna) in 1998 amongst 843 students between the ages of 14 and 19 found that 27% of them had used cannabis at least once in their life and that 21% of those between 14 and 16 had tried it at least once. There is no comparative data from previous years to show whether this level of use represents any change from previous years nor is there information on continued use as opposed to ever used.

10.7.3. Interestingly, whilst the percentage of people seeking treatment at the Ser.T whose primary drug use was cannabis has continued to increase each year for the last 5 years, cannabis use as a secondary drug has declined.

10.8. SYNTHETIC DRUGS

10.8.1. The use of synthetic drugs appears to be concentrated in the northern regions of Italy and in the metropolitan areas of Toscana and Lazio. There are few reports of its extensive use in the southern regions. This appears to be confirmed by the location of seizures and the location of persons referred to the judicial authorities for drug law offences.

10.8.2. The reports from those regions which have relatively high levels of ecstasy compared to the rest of the country suggest that there has been no significant increase in use in the last year. However, information from a number of sources indicate that ecstasy use and the use of other synthetic drugs continues to be an important aspect of drug use even if the demands upon treatment services are, at present, small.

10.8.3. The Parma survey referred to above found that 5.6% of the students had used ecstasy and that 3.6% of those between the ages of 14 and 16 had experimented with ecstasy. Another study in Rome looked at drug use amongst 2,800 students between the ages of 16 and 19. It found that ecstasy use was reported by 21.7% of the students. LSD use was reported by 16.9% of the students. Finally, information from Drogatel for 1998 found that ecstasy use was most common amongst young people in the age range 10 - 20. Of the users who telephoned, 60% had used ecstasy for between 1 and 2 years and 22% had used for 3 to 4 years.

10.8.4. Amphetamine use appears to be relatively low within Italy. The vast majority of seizures of amphetamine and its analogues are of ecstasy with very small quantities of amphetamine itself being seized. A number of possible reasons for this apparently low level of use can be put forward.

10.8.5. Synthetic drug use appears to be centred on the metropolitan areas of, in particular, Piemonte, Lombardia, Emilia-Romagna, Toscana and Lazio and in those towns where people go at the weekends. The metropolitan areas of these regions tend to have established youth cultures, to be more attuned to a wider European youth culture and to attract a larger international tourist population. Together, these factors might create a setting in which the use of 'leisure' drugs might develop.

10.9. HEROIN/OPIATES

10.9.1. Heroin remains by far the most common drug of choice amongst people seeking treatment at the Ser.T. It is believed that only about half of those who use heroin and are in need of treatment are at present attending the Ser.T and this appears to be confirmed by several regional studies.

10.9.2. At the same time, there has been a continued decline in the percentage of drug users attending the Ser.T whose primary or secondary drug is heroin, whilst the mean age of those seeking treatment has continued to increase.

10.9.3. In some regions heroin use as a primary drug remains very high (at least 90% of those approaching the Ser.T for treatment). It is difficult to interpret these figures. They may reflect the high prevalence of problematic drug use with heroin as the primary drug, but these are also, in several cases, the regions which have significant levels of other kinds of drug use. They may, therefore, more reflect the treatment focus in the region with concentration on the most problematic drug users.

10.10. COCAINE

10.10.1. Cocaine in the form of crack appears to be a relative rarity within Italy. On the other hand, there are indications that cocaine use is continuing to increase.

10.10.2. Of those approaching the Ser.T for treatment, the percentage reporting cocaine as either their primary or secondary drug has increased each year for the last four years.

10.10.3. Information from Drogatel for 1998 shows that 15.5% of the calls related to cocaine and that 42.4% of the users were between the ages of 18 and 35. Of the users, 43% had been using cocaine for 1 - 2 years, 20% for 3 - 4 years and 14.4% for 5 - 6 years. 17% of users had been taking cocaine for at least 9 years.

10.10.4. The study in Rome referred to above found that 29.8% of those included in the study had used cocaine. This is higher than the percentage reporting use of either ecstasy or LSD.

10.10.5. Cocaine use appears to be more widespread throughout the country and to broadly reflect the general prevalence of drug use in Italy. This seems to be confirmed by the continuing increase in the number of people found in unlawful possession of cocaine and the number of people referred to the Justice Authority for a drug law offence involving cocaine.

10.10.6. The broad trend appears, therefore, to be a continued increase in the use of cocaine throughout the country. Whilst no certain explanation for the relative popularity of cocaine can be offered, availability is clearly a factor and availability may reflect the fact that cocaine is within the framework of more 'traditional' patterns of trafficking where the newer synthetic drugs reflect a different pattern.

10.11. MEDICINES

10.11.1. The use of pharmaceutical drugs appears to be increasing amongst the younger population, although it is still at a low level.

10.11.2. Between 1997 and 1998 the number of people referred for unlawful possession of "Other drugs", primarily the benzodiazepines, rose from 847 to 1,343, an increase of almost 59%. The increase was most noticeable in males (60%) whilst the increase in females was only 46%.

10.11.3. At the same time, use of pharmaceutical products as either a primary or secondary drug amongst those in treatment at the Ser.T has declined as a percentage over recent years.

10.11.4. It would seem that the use of these drugs is continuing to rise, often in combination with other drugs, whilst treatment provision is more focused on the most problematic drug users with a consequent decline in the number of people seeking help as a result of their use of pharmaceutical drugs from the specialist services.

10.12. MULTIPLE USE

10.12.1. Multiple drug use appears to be widespread. A major concern is the combined use of synthetic or pharmaceutical drugs with alcohol. As noted earlier in this report, especially in the northern regions, there has been an increase in the use of alcohol amongst young people outside the traditional framework of alcohol consumption associated with meals.

10.12.2. Amongst regular and problematic drug users, multiple drug use is also common. This has been particularly noted amongst drug users with dual diagnosis although whether this is a pre-existing condition or one arising from multiple drug use is not so clear.

10.13. SOLVENTS

10.13.1. No additional information is available about the use of solvents. In general, solvent misuse appears to be a relative rarity within Italy.

10.14. DOPING

10.14.1. Drug use to enhance performance continues to be an issue of concern. There is little information available to indicate the trends in this type of drug use. However, there does appear to be a developing attitude amongst young people that the use of performance enhancement drugs is necessary and acceptable.

11. CONCLUSIONS

11.7. MAIN TRENDS AND NEW DEVELOPMENTS IN DRUG USE AND CONSEQUENCES

11.7.1. Without any general population surveys it is difficult to make any definitive statement about the main trends and new developments in drug use.

11.7.2. From the available information, it is clear that cannabis remains the most prevalent drug based on drugs unlawfully possessed, local surveys, calls to Drogatel and drug use within the military services.

11.7.3. There is little information about the use of amphetamine and its analogues. Data from several different sources does not show a high level of prevalence. However, data from special projects designed to work specifically in youth settings and discotheques suggests that ecstasy and similar drugs are prevalent, especially in the north of Italy.

11.7.4. The use of cocaine continues to show an upward trend although cocaine in the form of crack is extremely rare.

11.7.5. An area of particular concern has been the changing patterns of alcohol consumption, especially among young people in the north and central

regions. This is associated with increased tobacco consumption and a higher level of experimentation with controlled drugs. This may also be reflected in the figures for unlawful possession where for both males and females the largest number of referrals have been amongst young people between the ages of 18 and 20. It may also be reflected in the increasing number of drug using juveniles passing through the juvenile justice system.

11.7.6. In terms of problematic drug use, for the first time for many years there has been a slight decline in all treatment demands. There was a very small increase in first treatment demands but the overall trend is still downwards.

11.7.7. The mean age of the drug using population attending the Ser.T continues to rise as has the male:female ratio. There have, however, been slight increases in first treatment demands from the 24 and younger age ranges although the larger increases in all treatment demands have come from the 30 or older age ranges.

11.7.8. Amongst new clients, HIV, Hepatitis B and Hepatitis C infection remains at a lower percentage than is the case for clients already in treatment. Female clients, whether new or existing clients, have significantly higher rates of HIV and Hepatitis C infection than male clients but Hepatitis B infection is at a similar percentage for male and female clients. This continues the historical trend of a general decline in the percentage of clients infected whilst infection in females remains higher.

11.7.9. Direct drug related deaths show an upward trend in the 30 and over age groups whilst for the 29 and under age groups the historical trend has been downwards.

11.7.10. For drug markets, whilst arrests for offences involving heroin and amphetamine have declined over time, arrests for cocaine and cannabis have continued to rise. In terms of seizures, it is noticeable that only in the case of cocaine do the number of seizures exceed the quantity seized. This supports the assessment that cocaine prevalence is continuing to rise.

11.8. POSSIBLE REASONS AND HYPOTHESES FOR MAJOR TRENDS OBSERVED

11.8.1. There are major geographical differences in the trends observed. The northern regions and especially the large metropolitan areas of the north and central regions appear to reflect more 'northern European' patterns, not just in terms of controlled drug use, but also in alcohol consumption and other social behaviours. The southern and rural regions of Italy appear to reflect a continuation of historical cultural patterns which have been significantly less affected by the use of synthetic drugs.

11.8.2. The main indicators all suggest that drug use, and in particular problematic drug use, is primarily a male activity. However, other data, especially that from ambulatory services and from 'dance' projects, seems to suggest that drug use amongst females is higher than officially recorded. This may reflect both the focus of services, which has been primarily upon opiate

users, whilst female drug using patterns include a wider range of drugs. It may also reflect different cultural traditions between the north and the south of the country. The latter still reflects to a large degree a male dominated society in which deviant behaviour by women is not accepted and in which such behaviour remains hidden by the family or the partner. The levels of HIV and Hepatitis infection amongst female drug users may also reflect dependence on drug using male partners for drug supply and injection equipment, and the possibility that female drug users have a higher number of sexual partners both with drug users and through prostitution.

11.8.3. In terms of treatment demand, historically, first treatment demands showed a large increase between 1990 and 1991, probably reflecting the implementation of 309/90 and the establishment of the Ser.T, and then a relatively stable pattern with a decline in numbers in recent years. The slight increase in 1998 does not at present seem to indicate any upsurge in new treatment demands. By contrast, the trend for existing clients has been for the number in treatment to rise annually. The slight decline in the number of people still in treatment does not appear to reflect any significant change in this trend. Rather, it suggests that an increasing number of people are remaining in treatment over a longer period with consequent implications for service capacity to meet new treatment demands or changing patterns in drug use.

11.8.4. All the figures relating to drug users and the criminal justice system show an upward trend, although the figures on drug seizures show a more variable pattern. This would seem to confirm the evidence of local studies and of observations by 'dance' projects that drug use is widespread at least at the experimental and occasional level, even if such drug use does not at present lead to a specific demand for services.

11.8.5. The increase in drug use among young people is a cause for some concern. This rise is reflected in first treatment demands from the younger age groups, the increase in the number of drug using juvenile offenders and the predominance of the younger age groups found in possession of controlled drugs. It is not possible to identify any specific reasons for this continuing rise outside that of a general pattern within youth culture. On the other hand, the increase in first treatment demands may indicate an earlier recognition of a drug problem and a willingness to seek help before it has become a chronic problem. Further investigation is necessary to examine this situation.

11.8.6. The increasing proportion of direct drug-related deaths among the older age groups is an interesting phenomenon. It may reflect the poor general health of this population and less resistance to disease. It may also reflect a population which has completed drug treatment or been abstinent as a result of imprisonment which, on re-commencing drug use has done so at their previous dose level. Again, further investigation is needed to correlate treatment data and the register of direct drug-related deaths.

11.9. Methodological limitations and evaluation of data quality

11.9.1. 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.

11.9.2. Data from the Ministry of Defence is also of good quality, providing a useful indicator of drug use within the younger male population. However, from the year 2000 this data set will be more limited as male conscription will have ended.

11.9.3. Data from the Ministry of the Interior and, to a much lesser extent, from the Ministry of Justice, is more variable and is not always available in comparative form from year to year. Work is being undertaken to develop more consistent data over time, facilitating greater comparability and the analysis of trends.

11.9.4. There is very limited data from the socio-rehabilitative services and there are reservations about the quality of some of the data supplied. Work is currently planned specifically designed to improve the data from these services.

11.9.5. Similarly, reports from the Regions and Autonomous Provinces is 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.

11.10. Relationship between indicators

11.10.1. At present there is limited relationship between the different indicators and the different methodologies used for data collection, along with the different focus of those collecting the data, makes cross analysis only possible through special studies.

11.10.2. The epidemiology sector in the new National Drugs Observatory will be examining how data collection may be made more consistent and how cross analysis between different data sets might be achieved. To this end, work on implementation of the treatment demand and drug-related deaths indicators will be of considerable value for reviewing other data sets.

11.11. Relevance of data to policy issues

11.11.1. The data from the Ser.T is used extensively to identify changing patterns and needs and to inform guidance from the Ministry of Health.

11.11.2. Data from the Ministry of the Interior, especially unpublished data, is used to inform both policy and operational development.

11.11.3. For emerging trends, policy is inevitably affected by less rigorous data collection, based on observation and behaviour patterns. This is likely to continue if proactive policy is to be carried out. The Joint Action, as it continues to develop, could be of particular value to proactive policy work.

11.12. NEW INFORMATION NEEDS, GAPS AND PRIORITIES FOR FUTURE WORK

11.12.1. As has already been stated above, there are a number of gaps in the epidemiological data. The National Drugs Observatory, advised by the Scientific Committee, is currently examining gaps and priorities.

11.12.2. A particular gap relates to general population surveys and surveys of specific population groups. This is to be addressed in 2000 by a contract to develop this area of work.

11.12.3. A second priority is the effective implementation at a wider level of the available key indicator protocols.

11.12.4. The third priority is to improve the standards and comparability of data collection from different sources in order that a clearer picture of drug use patterns, problems and trends might be drawn.

PART IV

DEMAND REDUCTION INTERVENTIONS

12. NEW DEVELOPMENTS AND INFORMATION NEEDS

12.1. NEW DEVELOPMENTS DURING THE REPORTING YEAR

12.1.1. A development during the year has been the approval of project financing through the National Drugs Fund. As reported earlier, the funds retained for allocation to national projects submitted by the Ministries have been dispersed and the Regions are in the process of approving applications.

12.1.2. A second important development has been the establishment of the National Drugs Observatory and a section within that specifically focused on drug demand reduction. The Department of Social Affairs, advised by the Scientific Committee, is now in the process of establishing priorities for the work programme of the Observatory.

12.1.3. The third major development has been the inclusion of 'harm reduction' as a specific approved modality within national legislation. Although in practice harm reduction programmes have been operating for many years, this was at the discretion of treatment services and of funding bodies, with the result that such services were often unavailable to drug users who might benefit from them. As a result of the legislation, Regions have now included 'harm reduction services' as a specific category for funding through the resources provided to them from the National Drugs Fund. It is anticipated, therefore, that in 2000 there will be an expansion of these services to provide a more comprehensive range of treatment options throughout the country.

12.2. SPECIFIC EVENTS OR PROGRAMMES DURING THE REPORTING YEAR

12.2.1. These have been included elsewhere in the report, but include:

- Presentation and exploration of the EMCDDA Guidelines for the Evaluation of Primary Prevention in the Italian context
- The establishment of the National Drugs Observatory and the allocation of the National Drugs Fund
- National, Regional and local conferences and training events with an increasing focus on monitoring and evaluation of services and treatment interventions

12.3. MAIN ISSUES AND FUTURE INFORMATION NEEDS

12.3.1. As indicated above, the priorities of the work programme for the Drug Demand Reduction Section of the National Drugs Observatory are at present being established. Amongst the likely priorities are improved information on the typology of treatment offered through the public treatment services, fuller information on the services provided by

private/NGO organisations, improvements to the monitoring, evaluation and reporting systems on drug demand reduction.

12.3.2. In this context, the Ministry of Health, through funds from the National Fund, plans several projects to be implemented in 2000. These include:

- Provision of hardware and software where needed to public treatment services and training of staff in a monitoring and evaluation system based on European standards
- Standardisation of information on drug related deaths at the national level and a longitudinal study of cohorts of addicts to evaluate mortality and morbidity and the effectiveness of treatment interventions
- Implementation of national studies of drug use prevalence based on European standards. This will be based on more local studies, all conducted to a common standard, thus providing a representative national picture
- Development of a national data bank on drug demand reduction programmes based on the EDDRA system, aimed at collecting information on the private/NGO services as well as on the public services
- Piloting of a monitoring and evaluation system, including European standards, in the private/NGO treatment sector

13. ORGANISATION, STRUCTURES AND RESPONSIBILITIES RELATED TO DRUG DEMAND REDUCTION ACTIVITIES

13.1. CHANGES IN NATIONAL STRUCTURE

13.1.1. As reported above, under Law 45 of 18 February 1999 and the Decree of the Minister of Social Affairs published on 3 November 1999, the National Drugs Observatory has been re-located to the Department of Social Affairs from the Ministry of the Interior. In consequence, relevant Ministries and Departments, the Regions and the Autonomous Provinces will now submit reports to the Observatory at the Department of Social Affairs.

13.1.2. Responsibilities for drug demand reduction activities, however, remain largely unchanged. The Department of Social Affairs administers the National Fund for the Fight against Drugs, 25% of which is retained centrally to finance projects submitted by the Ministries of Health, Education, Interior, Justice, Defence and Labour and which will support national policy and strategy to tackle drug problems.

13.1.3. Individual Ministries have retained specific responsibilities for aspects of drug demand reduction. Thus, the Ministry of Health has responsibility for health service provision and for the development and implementation of quality standards within such provision. It has also introduced measures designed to support quality improvements in demand reduction services provided by NGOs and private organisations. The Ministry of Justice has responsibility for alternatives to prison or to continued imprisonment and

for the care of prisoners. The Ministry of Education has responsibility for prevention within the school system. The Ministries of Defence, Labour and Interior all undertake some drug demand reduction related activities within the general framework of their prime responsibilities.

13.1.4. Within Italy, considerable responsibility has been devolved to the Regions and Autonomous Provinces. 75% of the National Fund for the Fight against Drugs has been allocated to the Regions with specific guidance on how the resources should be used and how applications should be invited and determined. They also provide the core funds for local health provision, including drug treatment services and act to ensure that services meet national guidance. The Regions have similar responsibilities with regard to schools and the development and implementation of drug prevention within the schools and with regard to social service provision. This latter role has particular importance with regard to community provision of drug demand services, most commonly offered by NGOs and private organisations.

13.1.5. NGOs and private services have a significant role in the provision of drug demand reduction activities. No full census of all such organisations in Italy is available. It is known that in 1998 there were 1347 residential, semi-residential and ambulatory treatment services for people with drug problems. However, no figures are available for the non-specialist community services providing advice, counselling and prevention which might include drug using clients amongst their service users. Such services include those working with homeless people, youth consultation services, and the like.

13.2. INVOLVEMENT IN EUROPEAN ACTIVITIES DURING THE YEAR

13.2.1. Other than the activities and involvement reported elsewhere and the regular participation in specific European Union, Council of Europe and WHO (Europe) activities, there has been no major involvement in European activities during the reporting year. Regions, Communes, research and scientific centres and private organisations may have attended or contributed to such activities but there is no data currently available to the Focal Point on this involvement.

14. DEMAND REDUCTION ACTIVITIES IN THEIR SOCIO-CULTURAL CONTEXT

14.1. There is no single socio-cultural context for Italy. Rather many Regions and geographical areas have their own long established cultures.

14.2. Broadly expressed, the northern Regions of Italy have moved towards a more 'European' culture based more on the nuclear family and with higher proportions of people living alone. They include the richest Regions of Italy and per capita income is significantly higher than that for the southern Regions. These Regions have also seen the development of a more specific 'youth culture', which is perhaps reflected in the higher levels of synthetic drug use. Demand reduction activities have, therefore, tended to develop higher levels of outreach work and harm reduction activities in addition to their more traditional services, to work closely with families in primary prevention but to have less family involvement in treatment services and to have a higher concern with the relationship between

smoking, alcohol consumption and drug use. It should, however, be noted that some Regions are much more rural, with relatively small populations and they have their own distinct characteristics.

14.3. The central Regions may be divided into two. The Regions of Tuscany and Lazio in the west have greater similarities to the northern Regions. They also attract large numbers of tourists throughout the year. To this extent they have developed a 'European' culture with strong international influences. This is reflected in the patterns of service provision. At the same time, family involvement in both prevention and treatment services remains strong. The eastern Regions, on the other hand, have greater similarities with the southern Regions of Italy.

14.4. The southern Regions of Italy are the poorest with relatively low levels of per capita income. Broadly expressed, they reflect a popular image of Italy with extended families, a male centred culture in which male and female roles are clearly delineated and close knit communities which are capable of being highly supportive but also capable of intolerance of difference. Youth culture as such has not developed significantly and drug use has remained largely with traditional drugs such as heroin and cocaine. In some of the Regions there has also been established criminal organisations which have had an involvement in drug trafficking. For the south eastern Regions in recent years, there has been a high level of illegal immigration, mainly from the Balkan countries. There are some indications that they may also now be involved in criminal organisations. Together, these factors have focused demand reduction activities on more traditional prevention and treatment interventions with a high family involvement. They may also have led to a more cautious approach to innovations.

15. MAJOR STRATEGIES AND ACTIVITIES IN DEMAND REDUCTION

15.1. The major demand reduction strategies within Italy stem from the main objective of drug demand reduction policy. This objective can be simply stated as:

- A reduction in the number of people who experiment with or regularly use drugs and assistance to abstinence for those who develop problems as a result of their drug use.

15.2. The major strategies which have been implemented have, therefore, identified target populations and specific activities to reach these populations. These include:

- primary prevention at all levels of schooling
- advice and counselling for young people using drugs
- outreach programmes and telephone help lines
- harm reduction services
- treatment and rehabilitation services
- treatment as an alternative to punishment or to imprisonment
- national contractual arrangements to facilitate treatment and a return to work

- training and support for parents both to support prevention and to contribute to treatment

15.3. It is recognised that there are still gaps within the strategy and the activities which flow from the strategy. The specific inclusion of harm reduction in 45/99 represents one development to address a missing element. Through the new National Drugs Observatory and its integrated epidemiological and drug demand reduction sections, it is anticipated that other gaps, based on evidence, will be identified and that it will be possible to initiate activities to tackle these gaps.

15.4. At the same time, it is expected that experience from other countries and innovative ideas developed in or adapted for Italy will continue to be introduced and that these themselves may attract demand from presently under-served populations.

16. SPECIFIC INTERVENTION AREAS

16.1. FIRST CHILDHOOD INTERVENTION

16.1.1. 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.

16.1.2. 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.

16.1.3. 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.

16.1.4. 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.

16.1.5. 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.

16.1.6. 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.

16.1.7. 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.

16.1.8. 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.

16.2. PREVENTION IN THE FAMILY

16.2.1. Research undertaken by IREFREA within four countries of the European Union has provided valuable insights into this area. Within Italy, the research was focused on northern Italy and the findings are discussed within the special topic "Women, Children and Drug Use".

16.2.2. For Italy, prevention in the family is an area of activity subsumed within the topics of first childhood interventions, school programmes and youth/community programmes. It is becoming an important area as changes are occurring in the traditional family structure, rooted in the culture and traditions of the country. This is particularly observable in the northern Regions of Italy, but can be noted in other major urban areas.

16.3. SCHOOL PROGRAMMES

16.3.1. 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 in the reporting period.

16.3.2. Directive n.463 of 26 November 1998[3] 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.

16.3.3. 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

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.

16.3.4. 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 the resistance to peer group pressure and a negative vision of the abuse of alcohol and other drugs.

16.3.5. 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.

16.3.6. 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.

16.3.7. 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 21st 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.

16.3.8. 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.

16.3.9. 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.

16.3.10. 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.

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

16.3.12. The core programmes operating are:

- Young People's Project for the upper secondary schools
- Project Youth 2000 for the middle and lower schools
- Rainbow Project for the elementary schools

16.3.13. Within these programmes and to support them, the key elements are:

Students:

- Students are encouraged to be active participants and contributors to the prevention programmes. Their involvement allows the programmes to be tailored more effectively to the specific situation of a locality and the realities of the students.

Information and Consultation Centres:

- Linked with the local health services, the centres seek to support protective factors and to identify and respond to risk factors to drug use. They aim to provide a link between the school and the community

and have a particular focus on working with students who have personal difficulties and who are most at risk to drug misuse.

Families:

- Work with families has the aim of actively engaging them in an overall system of community education in which they can play an active part in supporting educational strategies. It also seeks to orientate and offer training to them which can support them through the acquisition of additional parenting skills.

Teachers:

- Training for teachers focuses on the development of skills through the use of action research and through the promotion of effective strategies for learning and for recognising and responding to the needs of students with difficulties.

16.3.14. In addition to direct prevention and health education programmes, complementary and integrated activities within the higher secondary schools have sought to support processes of both personal and collective growth. The opportunity for young people to participate in the animation of the life of the school has been an important element in this, encouraging a more intense relationship with teachers, motivating pupils and engaging many who were at risk of abandoning school.

16.3.15. The Provincial Councils of Students consist of pupil representatives and have now taken on an important role. By bringing together representatives from all the schools of a Province, they have allowed:

- development and implementation of proposals and initiatives which could not be undertaken by a single school.
- a link, through formal accords, with Directors of Education, the local authority, the Region, associations of students, of former students and of volunteers and with employer organisations.
- the development of proposals for youth policy which could be submitted to the Directors of Education, the local authority, etc.
- the promotion of transnational activities

16.4. YOUTH PROGRAMMES OUTSIDE SCHOOL

16.4.1. This section has largely been dealt with above and will also be dealt with under some of the other headings. There are relatively few programmes specifically concerned with drug prevention for young people outside the school environment. More common is the provision of youth consultation services and cultural/leisure services which have as one of their objectives the prevention of drug problems amongst young people.

16.4.2. In a number of large urban areas, mobile youth consultation centres (Informagiovani) operate. These services provide information on a wide range of activities and opportunities for young people, including leisure,

education, employment and culture. They also provide advice and consultation about problems experienced by young people, including problems associated with drug use and misuse, and about services available for people who have drug problems.

16.5. MASS MEDIA CAMPAIGNS

16.5.1. In 1998 the Department of Social Affairs promoted a mass media campaign "Be smart: don't harm youself" (Fatti furbo, non farti male). This continued in the first half of 1999. It included the distribution of information material to drug treatment services, youth associations, local authorities, schools, discos and to youth counselling services.

16.5.2. 1.5 billion lire was available for the second half of 1999 and this was used to carry out projects with a number of key organisations aimed at reaching young people and teenagers in high risk situations. Four specific projects were implemented.

16.5.3. *The Blue Train*: a special train that, in the evenings of July and August, travelled along the coast of Emilia Romagna stopping at 13 stations close to the most popular discos and leisure locations for young people. The train allowed young people to move during the night in safety and has become an entertainment in itself, complementary to the other leisure opportunities available on the Coast Romagnola. A carriage was sponsored by the Department of Social Affairs with interactive games and the provision of information, brochures, T-shirts and other articles.

16.5.4. *Targetted national action plan on new drugs carried out be Group Abele*: Ten locations with high prevalence were chosen and in each the project guaranteed to be present and provide advice and information at at least three planned events: a 'trendy' disco, an open air pop concert and another medium sized event. Implementation was agreed with local authority services and social enterprises in each of the locations. In the course of the project, 100,000 young people were contacted. The objectives were: to reduce the use of new drugs, to contain abuse, to limit the risks arising from use and to challenge use, misuse and the recurrent practice of multiple drug use combining alcohol with other drugs. Two 'techno campers' were used with a monitor which allowed the projection of information spots and a video cabin inside which allowed young people to relate their experiences to the camera

16.5.5. *Dissemination of information through initiatives promoted by the CNCA*: In September and December 1999 regional and inter-city meetings were arranged to debate and inform about drug addiction, with a particular focus on prevention and social re-insertion. Material produced by the Department of Social Affairs was used with young people, especially in the contact with the middle and upper schools. Alongside this material, products from the project "Information at Work", funded by the European Social Fund, were used. These included a film and two guides on drug dependence and work. Some 50 initaitives were carried out througout Italy with participation from both the trade unions and employers associations and from workers in public and private services, students, journalists, young people and families. The events took the form of a

traditional conference over a day with training seminars and special events for young people. The central theme was prevention of drug use in the widest sense, including reduction of misuse of legal substances as well as reduction of illegal drug use.

16.5.6. *Targetted initiatives undertaken by Foundation Exodus*: The project sought to use a number of planned events which were already planned as vehicles to disseminate material prepared by the Department of Social Affairs. These included events with a high social impact as well as those which had lower significance for the target audience.

- Radioinpiazza ' 99, a road show promoted by the Radio 102.5 network. It included a very large disco travelling through 30 Italian cities over the summer months. This provided a valuable multimedia space which has strong visual and emotional impact.
- A football game to raise funds for the National Drugs Fund, played by a celebrity team (Nazionale Italiana Cantant) in the stadiums of Milan, Parma and Rome
- The National Sporting Assembly of the Therapeutic Communities, organised by the National Association for the Promotion of Community Sport and CONI, was held in the Foro italico di Roma and included sports events, music and a conference.
- The Concert for 1000 Guitars, which was held in Naples in November 1999 was a large event organised by the Foundation Exodus. It involved one thousand young people from the Campania Region and was extensively covered by TV, radio and the press.

16.6. TELEPHONE HELP LINES

16.6.1. The national drugs help line "Drogatel" has been based at and financed through the Department of Social Affairs since 1993. It provides a free and anonymous service of information about drugs and drug problems. It is open daily from 9am to 9pm staffed by psychologists, doctors, legal experts, social workers and drug experts. The service uses a national data bank which allows the most up to date information to be provided to those who seek its assistance.

16.6.2. Drogatel aims to provide information on all aspects of drug problems, to direct those who call it to appropriate prevention, treatment and rehabilitation services and to collaborate in the creation of a network of operators in the sector to exchange information and improve services to the general population.

16.6.3. Two Communes (Milan and Naples), three Regions (Calabria, Lombardy and Veneto) and the National Institute of Public Health (Istituto Superiore di Sanità) have also established helplines which complement the national service. They form part of the Italian section of F.E.S.A.T. and have collaborated together on a number of occasions, most notably for activities associated with European Drug Prevention Week. Unfortunately, no data is available from these services and even if it were, it would be extremely difficult to avoid double counting.

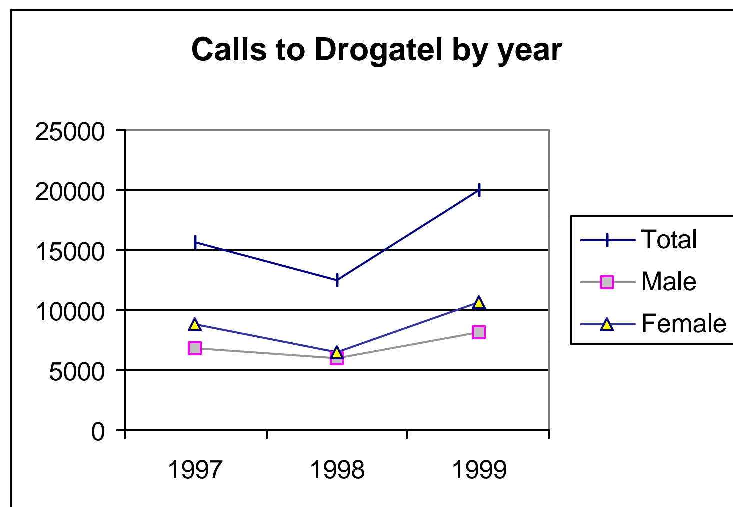
16.6.4. In addition to the service provided by Drogatel and the other dedicated services, telephone advice and counselling is provided by the majority of local specialist drug services and by the office of the Regional Assessor for Drug Dependence. In general, these are not dedicated helplines and no data is readily available on utilisation of these services.

16.6.5. The services of Drogatel are advertised through the web site of the Department of Social Affairs and in all telephone directories in the section "Emergency Services and Useful Numbers". It is also included on teletext pages, advertised through relevant publications and regularly included in newspapers when there are major stories concerning drug misuse.

16.6.6. In 1999, there were 20,001 calls to the help line, 8,218 (41%) from males, 10,736 (54%) from females and in 5% of cases the sex of the caller was not recorded. The majority of calls came from the 26-35 age group (23.4%), followed by the 19-25 age group (19%) and the 36-45 age group (16%). 45.3% of callers were relatives of drug users, of whom 20% were mothers of drug.

16.6.7. With regard to the subject of the calls, heroin (27.7%), cannabis (21.3%) and cocaine (15.5%) were the drugs most frequently mentioned. This represent a decline in calls about heroin and cannabis from 1998 but an increase in calls concerned with cocaine.

16.6.8. The number of calls to Drogatel was considerably higher than for 1997 and 1998 as shown by Graph 27. At present it is not possible to say if the increase in calls was related to any specific events but it is reasonable to assume that the higher profile given to drug misuse in the media, and especially the publicity about the death in Brescia, may well have raised awareness and resulted in increased demand on the anonymous services of Drogatel.



Graph 27

16.7. COMMUNITY PROGRAMMES

16.7.1. This is covered in other sections of the report and no additional information is available outside that provided there

16.8. OUTREACH WORK

16.8.1. There has been continued development of outreach work with drug users, although much of this has been in the northern and central regions with large urban populations. The services may be provided by public or private organisations but in virtually all cases they are a joint public and private service provision.

16.8.2. Health services and services for young people as well as organisations specifically established to work with drug users are involved.

16.8.3. The approaches taken are varied as are the target groups. General youth service provision aims to give advice and information and to direct young people to other more specialist services, where this is appropriate. Services for homeless people include drug users in their client group and seek first to develop a relationship with the client and to provide immediate practical assistance before guiding them towards specialist facilities.

16.8.4. Street work specifically with drug users varies considerably from harm reduction services, with the provision of sterile injection equipment, drug information and practical assistance to support the drug user until such time as s/he is ready to seek more intensive help through to outreach work as a means of contacting drug users and trying to draw them into treatment services.

16.8.5. At the national level, in January 1999 the National Institute of Health organised a conference concerned with drug use in discotheques. Speakers came from the Institute, the Ministry of Health, the Department of Social Affairs, the Union of Local Dance Halls and services working specifically in the discotheque setting.

16.8.6. There have been a number of local initiatives, again predominantly in the northern regions of Italy, to work in collaboration with discos and similar centres to provide accurate information about the newer synthetic drugs to young people. The national conference mentioned above provide more detailed information about services in Rome, Genoa, Milan, Florence, Belluno, Verona and Perugia.

16.8.7. Progetto Mosaico is based in Rome and is concerned with information, prevention and research on new drugs. It is financed by the Commune of Rome and is a collaborative service between the Co-operative " Il Cammino" and the Associations " Il Caleidscopio", "Parsec" and "La Tenda". Its objectives were to change risk behaviour and risky drug use, to provide training to health and social workers, to increase knowledge about new drugs and to work with schools to promote a culture of prevention.

16.8.8. Between June 1997 and May 1998, there were 35,630 contacts wit 8,761 users. Just under one third were under 18 and two thirds were male.

16.8.9. Two training courses were held with a total of 176 participants. Moreover, 200 teachers and 3,500 pupils were contacted and 120 pupils were trained as animators. Additionally, substantial amounts of material were

distributed, including 115,000 brochures on ecstasy, 160,000 "anti-panic" cards and 100,000 brochures explaining the drugs and terms related to them.

16.8.10. In Genoa, a collaborative project between public and private services and the schools has developed a prevention programme which worked first with adults and young people to identify the best health promotion messages. Subsequent work was undertaken in the middle and senior schools based on comparison of the images and reality of the new drugs in order that the work might be more precisely defined. From this, audio-visual material was prepared working with young people in the places where they met. This material is now being used in both the middle and senior schools.

16.8.11. Also in Genoa, specific work within the discotheques has been undertaken. This has focused on young men and has included providing information on the dangers associated with the use of ecstasy and other drugs, how HIV is transmitted and how infection might be avoided. A questionnaire was also used to collect information on the level of knowledge about the relationship between risk behaviours and possible health damage. Some 1,100 anonymous questionnaires were completed in 1999 and the information is now being analysed.

16.8.12. In Milan, Progetto Kimbanda has operated street based prevention. As with other projects, its aims have been to provide information and guidance to young people and to collect further information in order that its might target its work most effectively. It has developed an interactive video game (Rave City) on the theme of synthetic drugs as well as providing leaflets, t-shirts and a telephone advice line.

16.8.13. Three projects have operated in Veneto, in Belluno, San Donà di Piave and Legnago. As with the other services, they combined research with the provision of information and advice to young people. All worked in discotheques and meeting places for young people. The project in San Donà di Piave has comparative figures for 1998 and 1999 which shows that they substantially increased their contacts with young people between the two years. They also worked in close co-operation with the Regional President of the Union of Dance Hall Operators and were provided space within the discotheques to supply information and advice.

16.8.14. Similar projects to those described above were also operating in Perugia, Florence and Valdarno (Tuscany). Again, these were co-operative projects between a number of organisations, both public and private, and with the co-operation of the discotheque owners.

16.8.15. It is clear from the available reports that young people using ecstasy and other synthetic drugs do not see themselves as in need of the kind of services most commonly provided by the Ser.T and the private organisations. It is equally clear that their knowledge about the drugs which are available to them is limited and that they are engaging in high risk behaviours.

16.8.16. By working outside their institutional settings and by working in co-operation, public and private specialist drug services have been able to reach a significant population. Where they have worked with the active support and participation of the discotheque operators they have been able to provide a valuable service which is relevant to their target population. The available figures, although not scientific, indicate that targeted services readily accessible will be well utilised and are likely to have considerable benefit both for prevention and for limiting drug-related harm.

16.9. LOW THRESHOLD SERVICES

16.9.1. As with other initiatives linked to harm reduction, a number of low threshold or drop-in centres have opened. These have been financed locally and there is little information available about them, with few regions supplying detailed reports. It is anticipated that, with new funding now available from the National Drugs Fund, specific support for harm reduction approaches and the establishment of the National Drugs Observatory within the Department of Social Affairs, it will be possible to gather fuller information and present this in future years.

16.10. SUBSTITUTION AND MAINTENANCE PROGRAMMES

16.10.1. To avoid repetition, this subject is dealt with fully in the special topic (para 18). This section, therefore, concentrates solely on significant developments in the reporting period.

16.10.2. Use of methadone within the public drug treatment services (Ser.T) increased in 1998 and the indications are that there has been no diminution in 1999. There has also been a small increase in the use of naltrexone and clonodine.

16.10.3. In 1999, permission was given for the use of bupremorphine in the treatment of drug dependence. This followed pilot testing in Italy and evaluation of the results. It was found that bupremorphine was a valuable addition to the pharmacological treatment options and it is now available. Information on its use in Italy will become available as the treatment information for 1999 becomes available.

16.10.4. There has been a further increase in the number of drug users attending both the Ser.T for methadone treatment and a social-rehabilitative centre, usually residential, for more intensive social and psycho-therapeutic interventions.

16.11. PREVENTION OF INFECTIOUS DISEASES

16.11.1. No new legislation has been introduced relevant to this topic during the reporting period.

16.11.2. There have been no substantial changes in the organisation and strategies related to the prevention of infectious diseases. The majority of harm reduction programmes were initiated in response to concerns about the spread of HIV infection and have been continued and developed in

light of the high prevalence of Hepatitis (B and C) infection amongst drug users. Methadone treatment, needle and syringe replacement and street programmes have been the major reponse. Within the public services, there has been official encouragement to test those attending the Ser.T for HIV and Hepatitis infection. Where it is considered clinically appropriate, drug users may receive a Hepatitis vaccine.

16.11.3. Services may be provided by the local health authority through the Ser.T, by the Commune, by the Region, by NGOs or by services concerned with sexual health and health promotion. Commonly, two or more of these bodies work jointly in the provision of services.

16.11.4. The national focus has been on risk reduction for all drug users, whether in treatment or not. The objective has been that prevention should support non-drug use and treatment should seek to achieve abstinence but that intermediate objectives needed to be developed as steps towards the main objective. To this end, the aim has been for the development of initiatives which can reach users in a wide range of settings: young people's meeting points, discos, pop concerts, etc; first intervention centres; Ser.T; therapeutic communities: prisons. A number of these initiatives are dealt with under the appropriate headings elsewhere in this report.

16.11.5. A development of particular interest during the reporting period has been the work of Project PESESUD-1. The CNR of Milan, together with a range of public and private services, has been carrying out an evaluation of needle and syringe replacement schemes. One result has been the creation of an Italian Register of Needle and Syringe Programmes which is available on the internet at WWW.ITBA.MI.CNR.IT/EPIDEMIOLOGY/SYRINGE.HTML .

16.11.6. The site lists 78 such schemes in 14 of the 20 Italian Regions. The vast majority are in a few regions: Lombardia (19), Emilia-Romagna (16), Toscana (11), Lazio and Piemonte (7 each). The southern regions between them have only 5 such schemes. It is not clear how fully representative of all such schemes the web site is but it is likely that it does represent the national profile for such schemes.

16.11.7. The information provided includes the type of provision made, the organisation operating the service and the location of the service, the year it was opened and telephone and fax numbers. It also provides information about the number of syringes distributed but only in a few cases is there any explanation of the time period covered.

16.11.8. It is clear from the information provided that, in a high proportion of cases, the service is an impersonal one, with a machine installed to dispense injection equipment. Those services which have a mobile unit for taking sterile injection equipment to public locations, or which operate a dispensing system in fixed locations, tend to have a wider range of services, including information, advice and counselling, supply of contraceptive sheaths, referral to appropriate health, social or drug treatment services. Three services report that they also provide naltrexone. Other services provided by at least one of the reporting

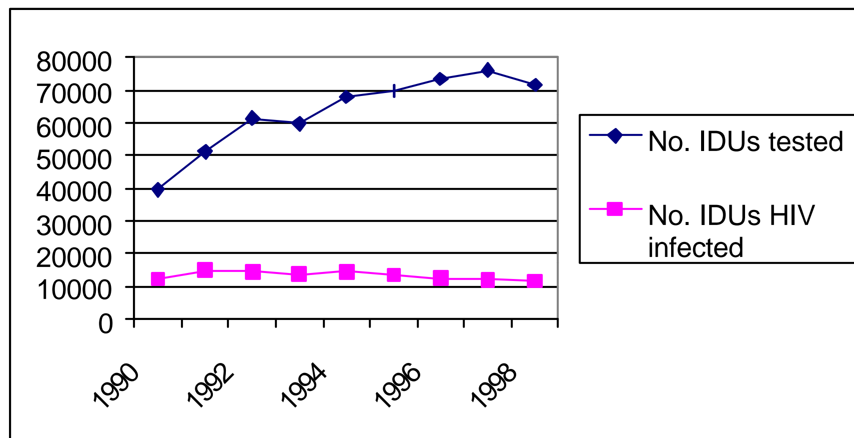
organisations include: physical health care; training to deal with overdoses; supply of bleach to clean equipment; food.

16.11.9. There is little information available about the staffing of these services, or about their training. Where the service is provided through the Ser.T and it is a direct contact service, it is likely that the staffing reflects that of the Ser.T, with an emphasis on social operators. In other instances, staff are volunteers in a part time provision and no specific information is currently available.

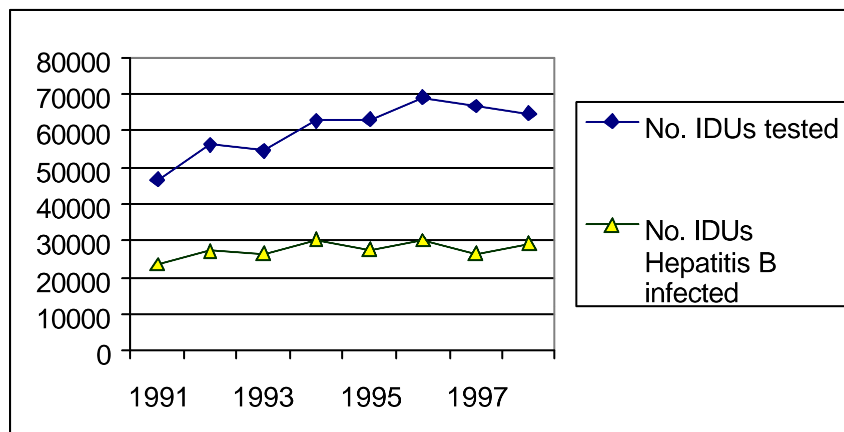
16.11.10. Further funding has been provided to develop the evaluation and information programme and it is anticipated that this will be available for the next report.

16.11.11. With regard to the statistics for infectious diseases, the information available solely relates to HIV and Hepatitis infections. As mentioned above, testing is offered to all those who attend the Ser.T. The general trend has been a decline in HIV infection but a continuing rise in Hepatitis B infection. Data on Hepatitis C infection is only available for the last two years but the trend has been upwards.

16.11.12. Graphs 28 - 29 below show the number of people tested against the number of people found to be infected. As can be seen, there has been a reduction in the number of people tested for both HIV and Hepatitis B infection. Whilst there has also been a slight decrease in the number of people found to be HIV infected, there was an increase in those found Hepatitis B infected.

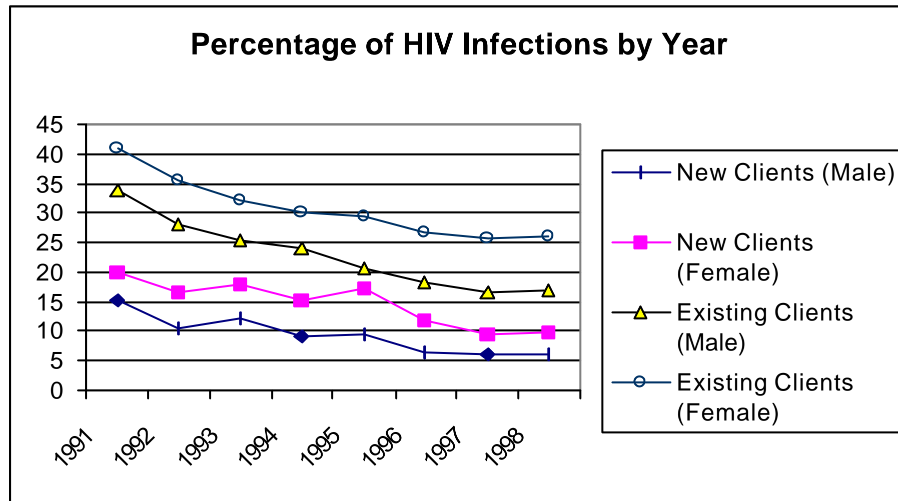


Graph 28

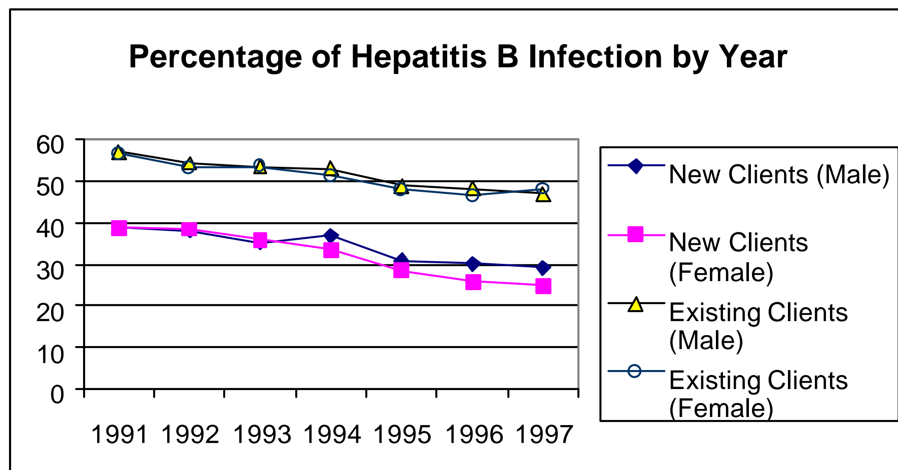


Graph 29

16.11.13. When the data is examined by sex and new and existing clients of the Ser.T a slightly different picture emerges (Graphs 30 - 31). For HIV infection, female clients, both existing and new, have higher rates of infection than their male counterparts. In 1998 there was a slight rise in the percentage of existing clients infected with HIV whilst the percentage of new clients HIV infected remained stable. For Hepatitis B infection, the gap between existing and new clients is more marked although there is no significant difference between male and female clients.



Graph 30



Graph 31

16.11.14. For Hepatitis C infection, the pattern is broadly similar to that for Hepatitis B, although the percentages of those infected with Hepatitis C are considerably higher, with around 73% of existing and 45% of new clients so infected.

16.11.15. There is also limited information from the Ministry of Justice concerning HIV infection amongst prisoners. Of 47,650 prisoners, 1,546 (3.35%) were HIV positive. Of these, 86.3% were drug dependent.

16.11.16. There are regional differences in the percentage of drug-related infections. Whilst the majority of Regions and Autonomous Provinces reflected the national picture, some regions showed a marked difference. In HIV infection, the Regions of Emilia-Romagna, Puglia and Basilicata and the Autonomous Province of Bolzano registered significant increases

in the percentage of clients who were HIV positive. For Hepatitis B infection, the Regions of Valle d'Aosta, Toscana and Lazio and the Autonomous Province of Trento registered significant increases and for Hepatitis C infection, Valle d'Aosta, Molise and the Autonomous Province of Bolzano showed significant increases. Comparative figures for Hepatitis C infection were not available for Emilia-Romagna and the Autonomous Province of Trento, but in 1998 both recorded a higher level of infection than the national average.

16.11.17. The reason for these variations is not entirely clear. It may reflect a higher level of testing in some cases. In others, where the number of drug users is relatively small it may reflect rapid spread of infection through the small population of drug misusers. It might also reflect a return to higher risk behaviours by drug users. Further exploration of the figures is necessary to explain the changes.

16.12. TREATMENT SYSTEMS

16.12.1. Within Italy there is a wide variety of treatment services, ranging from those provided by the public services to those provided by NGOs, social enterprises and private organisations.

16.12.2. At a national level, the Department of Social Affairs and the Ministry of Health have the main responsibilities for policy and for guiding, monitoring and reporting on demand reduction interventions. These roles have already been described in other sections of the report and will not be repeated here.

16.12.3. The Regions and the local health authorities (ASL) have a major responsibility in the provision of treatment services. The Regions allocate 75% of the National Drugs Fund for services in their Region, which may be proposed by the communes, local health authorities or private organisations. The local health authorities, as well as providing the Ser.T, also finance treatment within residential, semi-residential and day services provided by non-public organisations. Again, these roles have been more fully dealt with elsewhere.

16.12.4. As reported under the section "Special Topics", there has been an increase in combination treatments where a drug user has been resident in a treatment centre operated by a non-public service whilst receiving methadone treatment from a Ser.T. The Ser.T may also have agreements with non-public services for the provision of day programmes and psycho-therapeutic treatments to clients of the Ser.T. In practice, therefore, there are close and practical links between the public and private services in order that a full range of treatment options might be offered to clients on an individual basis.

16.12.5. There is no single therapeutic emphasis operating within Italy. In general, residential communities have as their objective that the client should become and be able to remain drug free. Most operate as modified therapeutic communities. Day programmes are focused in general on interventions aimed at containing and reducing street drug use and in developing personal and social skills for the individual. Within the

Ser.T there are a variety of therapeutic approaches ranging from harm reduction through to detoxification and abstinence. Many will have such a range available within their own service and through agreements with private services.

16.12.6. In 1999 harm reduction was given a specific emphasis in Law 45 of 18 February, although it had been practice within treatment services for many years. In the earlier period, there was a substantial amount of local and regional resources allocated to harm reduction programmes. There is no specific definition of harm reduction as it applies to Italy, rather, it is within the overall national policy of reducing the likelihood that people will use drugs, limiting the harm which might arise from drug misuse and assisting those who do misuse drugs to achieve and sustain abstinence. At the treatment level, this has resulted in the development of needle and syringe replacement programmes, an increase in the number of services available, an increased use of methadone and other pharmacological treatments, new initiatives to work with drug dependent prisoners, further development of alternative to custody measures, etc. Central to this has been the view that harm reduction should be an active, not a passive, approach, supporting the national objectives.

16.12.7. The range of services available has already been described elsewhere in this and previous reports. Apart from pharmacological interventions to assist retention, stabilisation and detoxification, they include, amongst others:

- Individual counselling
- Psychotherapy
- Group work
- Motivational and behavioural therapies
- Family counselling and support
- Day care
- Education and training for employment
- Residential and semi-residential treatment
- Injection equipment replacement and the provision of contraceptive sheaths
- HIV and Hepatitis testing with counselling, information and support
- Street work

16.12.8. Not all these services are necessarily available in every part of the country. Depending on the treatment philosophy of the service, and to some extent the culture of the locality where the service is based, the focus may be on particular services. However, most of the services are accessible to people with drug problems.

16.12.9. At present it is difficult to provide accurate information about the duration of treatment. In terms of methadone treatment, it is possible to say that the trend has been towards longer treatment and there has been a trend away from purely psycho-social and/or rehabilitative treatments within the Ser.T. For residential treatment services, length of stay is an individual decision but in general they provide long term treatment of 18 months to two years.

16.12.10. Information about the staff of the Ser.T can be found later in this report. There is limited information at present available about the staffing of the services provided by social enterprises. It is not uncommon for former clients to be staff members, although in many enterprises they have resumed their education and gained qualifications which makes them suitable as staff members. Many of the social enterprises also have substantial numbers of volunteer staff drawn from the community.

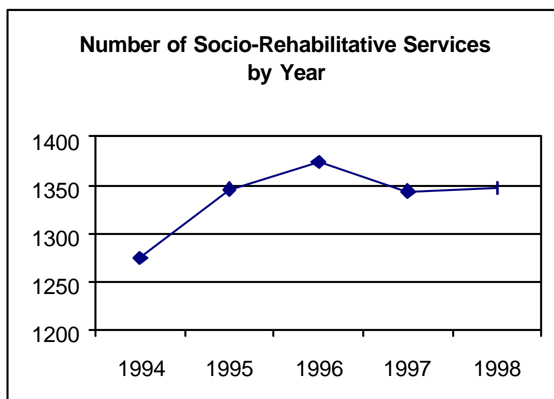
16.12.11. As covered extensively in the special topic, drug users may attend for treatment voluntarily or as part of an alternative to detention programme. In the latter case participation is compulsory and failure to attend may result in the imposition of a prison sentence or a return to prison to serve the balance of the sentence.

16.12.12. In 1998, 137,657 drug users attended for treatment at the Ser.T. Of these, 36.2% received psycho-social and/or rehabilitative treatment exclusively and 63.8% received a pharmacological treatment.

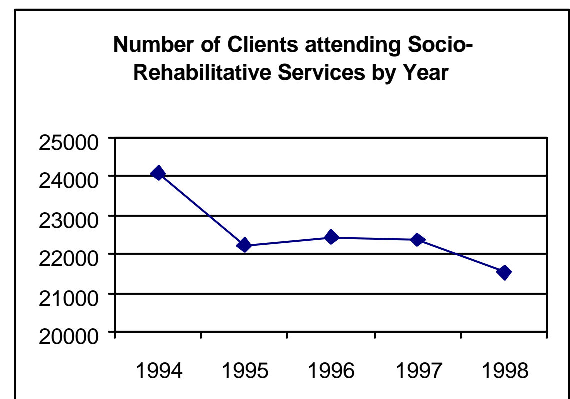
16.12.13. Of those receiving psycho-social and/or rehabilitative treatment, 15.5% were attending rehabilitation services and 12.1% were in prison.

16.12.14. Of those receiving pharmacological treatment, 2.7% were attending rehabilitation services and 3.8% were in prison.

16.12.15. With regard to the socio-rehabilitative services, there is limited data available. In 1998, the average number of clients attending them was 21,531, a reduction from 1997. The trend over recent years, moreover, has been a steady decline in the average attendance at these services although the number of services providing information has risen (Graphs 32-33).



Graph 32



Graph 33

16.12.16. Around 50% of all socio-rehabilitative services are based in the northern regions of Italy, with around 20% in the central regions and 25% in the southern regions and the islands. Around 44% of all drug users attending these services are in Lombardia, Emilia-Romagna and Lazio.

16.12.17. The male:female ration for residential services is 6.3:1, for semi-residential services 5.3:1 and for day services 3.7:1. Thus residential services have the same ratio as the national one for the Ser.T whilst semi-residential and day services have substantially lower ratios. There are also significant regional differences but it is difficult to draw any conclusions from this because the vast majority of services are residential (63%) and residents may come from other regions. It may, however, be reasonably concluded that the semi-residential and day services have been more successful in providing services which are attractive to female drug users.

16.12.18. Further statistical data is already included in either the special topics or in the epidemiological tables previously submitted and is not, therefore, repeated here.

16.13. AFTER-CARE

16.13.1. This topic has partly been covered by the section on Treatment and the data will not, therefore, be repeated.

16.13.2. From September 1997, research was undertaken concerning drug use and the workplace and 57 services were invited to furnish information. 39 services (17 Ser.T, 13 first intervention centres and 9 therapeutic communities) responded, providing a good representation of the services.

16.13.3. 90% of the respondents indicated that they had an active programme of support and social re-insertion, especially into employment, focused on clients who had been detoxified or were in the final phase of a residential programme.

16.13.4. Between 1993 and 1997, 2,122 people (1,697 male, 425 female) were assisted and the annual number assisted has risen each year, almost doubling between 1993 and 1997. Around 20% of people assisted were attending the Ser.T and around 80% first intervention centres and therapeutic communities.

16.13.5. Almost one in three organisations stated that the activity was carried out within their own service and about the same number worked with social co-operatives of type B, private firms, local producers (mainly in handicrafts, commerce, building and nursery gardens) and local authorities. There was a clear synergy between the services and the external world in the realisation of these programmes. The plans were often developed with external support for activities conducted within the service.

16.13.6. A second element was providing training to clients to assist them develop skills which would be of value in obtaining employment. In 44% of cases the training was conducted by the service itself with the support of

external organisations such as professional training centres, local authorities and local firms. In 24% of cases the services were largely self-sufficient and in 32% of cases the services were entirely dependent upon external organisations.

16.13.7. In terms of the employment available, in 72% of cases it was with organisations employing up to 20 people, and in 18% of cases with organisations employing 20 to 200 people. In no instance was employment found with an organisation employing more than 200 people. The most common employment settings were social co-operatives, followed by handicraft firms and private firms.

16.13.8. In 28% of cases, the contract offered was time-limited for between 3 and 12 months. In 23% of cases it was a trainee contract for 6 - 12 months and only in 8% of cases was a permanent contract offered.

16.13.9. Surprisingly, the opportunity to use part-time and flexible time working was scarcely used. There was also, in around one quarter of the firms, a lack of planning and practical understanding of the particular needs of those employees who had had drug problems.

16.13.10. In 74% of cases, a member of staff of the drug service acted as a mediator to support re-entry into employment. In some services, a social worker followed individual clients. The role of the mediator was largely psycho-social tutoring (support, advice, strengthening of motivation), orientation to work, support in searching for employment, etc.

16.13.11. Around 35% of clients relapsed, around 15% were absentees from work and around 10% were considered insufficiently productive.

16.13.12. Further work is being undertaken which will provide additional information about the experience of assistance into employment of people with drug problems. It is hoped that this will be available for the next report.

16.13.13. Another feature of after-care relates to work undertaken in the treatment phase, especially in residential treatment, and this is work with the family of the drug user. Direct work with individual parents, as well as self-help groups for the families of drug users, have helped to achieve changes in which the home conditions for the drug user have improved and the family is in a stronger position to support treatment and after-care. However, the gradual ageing of the drug user population in treatment, with a consequent greater separation from the family, may require additional strategies to be developed to support after-care.

16.14. SELF-HELP GROUPS

16.14.1. The use of self-help groups has become part of the normal practice in a majority of the public and private services for people with drug problems.

16.14.2. As mentioned above, self-help groups for the parents of drug users are found in both the public and private services for drug users.

16.14.3. The number of Narcotics Anonymous groups has grown in recent years. There is limited information available about them at a national level as they are largely dependent upon the enthusiasm of the members and staff of treatment services rarely participate.

16.14.4. Particular note might be made of the role of self-help groups as a means of supporting drug users and former drug users who are HIV positive. These groups have been able to help members face their own death or the death of people close to them and to share the problems of and possible solutions to living with HIV infection.

16.15. GENERAL HEALTH CARE

16.15.1. There is no additional information to provide for this section

16.16. CRIMINAL JUSTIC SYSTEM

16.16.1. This section only considers drug dependent prisoners, as the special topic (see section 19) deals in detail with non-custodial responses to drug using offenders.

16.16.2. The Prison Administration supports the use of the period of detention either to continue treatment or to initiate treatment for drug using prisoners. In this, they rely on specialist drug treatment services with whom they have established service agreements. The activities of the Ser.T within prisons is the subject of a survey by the Ministry of Health and the results will be provided as soon as possible.

16.16.3. In practice, the Prison Health Service provides general health care and is able to call upon specialist staff to provide consultation and treatment where this is considered necessary. From the year 2000, health care of prisoners will become the direct responsibility of the Ministry of Health covering both general health care and treatment for prisoners with drug related problems.

16.16.4. Local training activities have been conducted with the health service, Universities and NGOs whilst the Prison Administration has continued to provide training to staff working with drug using prisoners. Those trained have been not only prison staff but also staff from other organisations involved in the treatment and social re-insertion of drug using prisoners (Ser.T, therapeutic communities, local authorities). The result of these activities has generally been positive in terms of competence, strengthening the links between different services and an improvement of the relationship between the staff, clients and the environmental context.

16.16.5. In 1998, the Ministry of Justice reported that out of a total of 45,732 prisoners, 13,567 (28.5%) were drug dependent. Approximately half the drug dependent prisoners were convicted of an offence against the drug laws and half for other offences. The vast majority of drug dependent prisoners were male (96%).

16.16.6. Based on data reported from the Ser.T, in 1998, 9,361 drug using prisoners were in treatment of whom 64.7% received psycho-social

treatment, 29.4% received methadone treatment and 5.9% received pharmacological treatment with a non-substitution drug. Of those receiving methadone, 70% received short term treatment, 15% received medium term treatment and 15% received long term treatment.

16.16.7. Information and health education to prevent the spread of infectious diseases has continued to be provided. This work has had good results in terms of knowledge and awareness of risk activities. However, there have been problems with regard to non-Italian prisoners in terms of communication and in terms of diagnosis. For the former problem, cultural mediators have been used between the institutions and the different groups. For the management of infectious diseases, a network of interventions is planned in co-operation with local specialist services.

16.16.8. Information on the number of prisoners who were HIV positive is available from the Ministry of Justice. In 1998, 3.25% of the prison population was HIV positive. Of these people, the vast majority (86.3%) were drug dependent prisoners. 70.9% were asymptomatic, 21.5% were symptomatic and 7.6% had AIDS related illnesses.

16.17. GENDER-SPECIFIC ISSUES

16.17.1. (SEE SECTION 20)

16.18. CHILDREN OF DRUG USERS

16.18.1. (SEE SECTION 20)

16.19. PARENTS OF DRUG USERS

16.19.1. As noted in the sections concerned with self-help groups and with after care, parents of drug users have been involved in the treatment programme in many of the services. There are two elements to this. First, to assist the family to identify ways in which it might function more effectively and to support changes within the family. Second to engage parents as contributors to and supporters of the treatment programme for their child.

16.19.2. It has been found beneficial to engage the parents of drug users in the treatment programme from the start of the programme. In fact, it is not uncommon for the parents (especially the mother) to be the one who makes first contact about a possible drug problem in the family. This involvement allows the opportunity to manage the whole family dynamics, recognising that the non-drug using members of the family may have relational or behavioural problems which need also to be addressed and may also inadvertently act in ways which support continued drug misuse rather than support treatment. There are problems with this approach which have to be guarded against, in particular, that the treatment service staff might by drawn into subjective responses to family situations rather than retain an objective assessment.

16.19.3. Work with parents includes; counselling; support of parent self-help groups, often managed by the psychologist in the Ser.T and providing a

link between the parents and the treatment programme; family therapy; involvement as volunteers within programmes, especially in those run by NGOs.

16.19.4. In those cases where there are major problems within the family of a drug user, for instance, abuse, violence, etc., it is normal to develop a co-ordinated intervention between the Ser.T, the mental health and the social services.

16.19.5. Some Ser.T have developed specific groups for the mothers of drug users. It has also proved necessary to involve grandparents in some situations. This reflects the continued strength within parts of Italy of the extended family where grandparents are still closely attached to the family and become actively engaged where there are problems within the family.

16.19.6. Support for the family of drug users is also commonly provided before the drug user enters into treatment. It is not unusual for such support to be provided for several months to assist the family to effect the changes which will persuade the drug user to seek treatment.

16.19.7. One change which has been more recently noticed is the reduction of involvement of parents in the treatment of their children. There are two possible explanations for this. First, that drug use is no longer such a dramatic event within the family, that it has become more normalised and the parents have become resigned to a chronic, relapsing condition. The second relates to demographic and social changes, with greater separation between families and an older population in treatment which is more distanced from the family. This latter explanation does not, however, apply to use of the newer synthetic drugs where the users tend to be younger and still close to their home in comparison with the users of opiates who form the majority of the treatment population.

16.20. DRUG USE AT THE WORKPLACE

16.20.1. As reported above, a survey was conducted on the activities of drug services with regard to the workplace. The main areas of activity which were reported concerned the preparation of clients for re-entry into the work force. However, information was also gathered about activities aimed at preventing drug misuse in the workplace and with employees with drug related problems.

16.20.2. In the survey, of the 39 organisations replying, 16 (41%) had undertaken some form of prevention activity within the workplace. This commonly involved lectures and the provision of information. Other activities which some have carried out have included: health education courses; meetings with the trade union representatives; training of the executive committee of the trade union; training courses on primary prevention for teachers and; small groups on the theme of interpersonal relations.

16.20.3. Between 1993 and 1997, almost 5,000 people have been involved in these programmes, the majority of whom were male (3,208). The trend has been for an increasing number of people to be involved each year.

16.20.4. In the same period, the services which responded indicated that they had had contact with 5,606 workers, 4,660 (82%) of whom were male. The number of male workers in contact with services increased annually throughout the period. The number of female workers moved up and down but peaked in 1997. The majority of contacts were with the Ser.T (91.7%) but for all services there was an annual increase in the number of contacts.

16.20.5. The assistance to and/or rehabilitation of employees is provided for between one and three years with some programmes which last for a maximum of six months.

16.20.6. An examination of the National Collective Contracts for Employees (Contratti Collettivi Nazionali di Lavoro [CCNL]) provides useful data about arrangements which favourably treat drug dependents.

16.20.7. Circular n. 164 of 6 December, 1991 issued by the Ministry of Labour provided operational guidance on the implementation of article 124 of the Decree of the President of the Republic 309/90 for both workers and employers. This covered a number of areas:

- *Maintenance of employment*

  Where an employee is confirmed as drug dependent, and enters a therapeutic programme, his/her return to work is guaranteed for a maximum period of three years from ceasing work to the completion of treatment (or longer if their contract permits).

  Confirmation of drug dependence must be provided by a public health service, defined in the circular as the Ser.T

  The treatment programme may be provided in separate blocks, if this is appropriate, provided that the absence from work does not exceed 3 years.

  The law on maintenance of employment for drug dependents is thus designed to aid re-insertion and is more favourable than that relating to maintenance of employment for employees who are ill or who have had an accident. In 1984, the National Institute of Social Security decided that Law 833 of 1978 (indemnity for illness) also applied to illness as a result of drug dependence. In combination with the special contractual arrangements described above, this provides a wide range of options for treating drug dependents in employment.

  All the collective contracts which were examined took into account the requirements of the law concerning maintenance of employment, although the majority simply applied the letter of the law.

- *Measures to support a return to work*

  Some contracts which were examined contain measures designed to facilitate the return to work of the drug dependent during the final phase of treatment/rehabilitation. These include:

- The opportunity of changing to a new post at work which is considered more suitable by the treatment service
- Allowing flexible hours of employment
- Allowing part time working
- Allowing short periods of unpaid leave
- Transfer to a work location nearer to the treatment/rehabilitation centre
- Economic measures of support
- Payment of part of the wages/salary in the first period (time of unpaid leave)

The CCNL seems to have taken into account that the economic hardship for the drug dependent and/or his family created by the period of unpaid leave might have a detrimental effect on the implementation of the treatment programme.

- *Replacement of staff during absence for treatment*

To replace drug dependent staff absent whilst in treatment, staff may be employed on fixed term contracts. If treatment is not completed in the expected time and a further period (within a 3 year maximum) of treatment is required, the fixed term contract is also extended for the same period.

- *Protection of the Family*

The right to unpaid leave with the maintenance of employment is extended to working members of the family of a drug dependent so that they can participate in the treatment programme where the competent service states that this is necessary. The law does not define the maximum period of absence for a working family member, but for coherence, it is considered to be for the same period as required for the treatment of the drug dependent (to a maximum of 3 years), provided that this is declared by the competent service. If no time period is given, the leave is decided on the basis of individual cases or the general arrangements for unpaid leave.

Circular 164 also allows a worker to take on, for a limited time, the role of the family member who is in treatment. Some contracts are limited to an explanation of the right to leave for a member of the family of a drug dependent. Others define the time limits for leave and the formal requirements to obtain leave.

- *Measures of promotion and access to treatment programmes*

The most effective approaches for dealing with drug problems in the workplace appear to be those which are not simply confined to

contractual arrangements on maintenance of employment and protection of the family, but which include additional elements in the contract.

These additional elements identify a more flexible intervention strategy more fully integrated contractually and include the construction of bilateral organisations. These organisations have the role, in conjunction with the treatment services, of providing orientation. support and access to treatment and for re-insertion and support programmes on return to work. They also propose interventions on drug dependence to the local authorities.

16.21. ETHNIC MINORITIES

16.21.1. In Italy ethnic minorities are not perceived as being significantly involved in the use and misuse of drugs. However, this perception may not be correct, as data is not available on this subject from the treatment centres. In general, it seems that they are not at present approaching treatment services for assistance to deal with a drug problem. A second problem is that the available data distinguished between Italian and non-Italian, but does not record ethnicity. It is not possible, therefore, to determine which ethnic groups comprise the non-Italian population in this data.

16.21.2. The lack of data cannot be taken to mean that there is no problem within the ethnic and illegal immigrant communities. Rather, it may be due to factors such as:

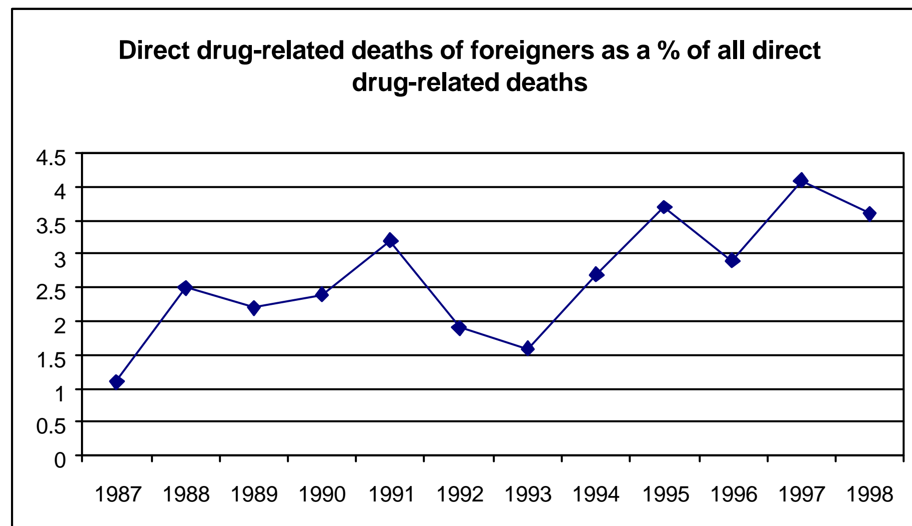
- A lack of trust in the available network of services which have been specifically established in terms of national and local culture
- A lack of accessible information about the available treatment services
- A concern about the implications of seeking treatment when an illegal immigrant

16.21.3. First intervention and street work projects have had experience of some contact with ethnic minority communities and have sporadically met people from these communities who have drug related problems. On the other hand, some communities are very closed to external contacts and seek to deal with problems within their own community.

16.21.4. By contrast with the experience of treatment services, 38.5% of those arrested for drug offences were non-Italians. Moreover, some 9,529 drug dependent non-Italians were received into prison at some time during 1998, representing a continuing upward trend. The corresponding figure for 1992 was 3,644.

16.21.5. Of the 10,525 foreigners referred to the Judicial Authority on suspicion of a drug crime, two thirds came from north Africa, in particular, the Magreb countries. The next largest groups were from eastern Europe (10.3%) and from sub-Saharan Africa (6.4%).

16.21.6. Another possible indicator of drug use in non-Italians is direct drug-related deaths. At present, data is not readily available on the nationality or ethnicity of non-Italians whose death was recorded as directly related to drug misuse. Graph 34 shows non-Italian deaths as a percentage of all direct drug-related deaths.



Graph 34

16.21.7. There is no consistency in the pattern, and a number of explanations might be offered for the variations year by year. However, the overall trend has been for a slow increase over time with reductions in any one year being overtaken by increases in later years. The implication of the data is that drug use amongst non-Italians is a problem but further exploration of the data, including additional data arising from the EMCDDA protocol, is necessary to determine more precisely whether the deaths are within particular ethnic groups and what implications there are for intervention services.

17. QUALITY ASSURANCE

17.1. RESEARCH

17.1.1. Some of the research which has been undertaken has already been described elsewhere in the body of the report and will not, therefore, be repeated here.

17.1.2. One major piece of research completed at the end of 1998 was carried out by the National Institute of Health. It used the First Treatment Demand protocol of the Pompidou Group and involved the public treatment services (Ser.T) in 13 different regions.

17.1.3. The research has produced very interesting results both in terms of knowledge of the epidemiology of the phenomenon and in terms of the methodology. From the latter perspective:

- It was the first multicentre research carried out in Italy on the basis of a European scheme

- It represented a first pilot model for the application in Italy of the Pompidou Group protocol and of the variations in the EMCDDA treatment demand protocol

- It provided an important opportunity to involve the Ser.T, particularly the staff who were normally engaged in clinical work, in a national scientific research project, sharing in the use of a model which it is hoped will become more frequently used

17.1.4. Other research which has been undertaken is as follows:

- The Department of Neuroscience of the University of Cagliari (Sardinia) is the leading centre for basic research and other university institutes have close links with it in this research

- A number of institutes of forensic medicine have been involved in research on forensic aspects of drug dependence

- In terms of epidemiology, the National Institute of Health has developed numerous studies on co-related pathologies

- The Epidemiological Observatory of the Lazio Region has developed specific studies on prevalence, risk behaviours and morality of drug dependents

- The Institute of Physiology of the National Research Council in Pisa has carried out national epidemiological studies of the youth population, which has identified new methodologies for primary prevention in schools and has developed a system for monitoring those who approach services based on Italian provinces.

- The Mario Negri Institute of Milan has carried out research on the typology of treatment and on the evaluation of public services.

- IREFREA has carried out a European study on Ecstasy use, with Italy as one of the selected countries. This has provided useful additional information.

17.1.5. Research in the field of drug use/misuse in Italy has been carried out in many institutions. The sources of funding for research are extremely diverse and at the moment it is not possible to construct a full national picture of the research which is being or has been carried out. The above represents only a small selection of the studies.

17.1.6. What can be said is that the institutes most active in clinical research are the Universities of Cagliari, Siena, Pisa, Modena, Firenze and La Sapienza and the Catholic Univerisities of Rome.

17.2. EVALUATION

17.2.1. Again, some of the major evaluations have already been referred to in the body of the report and will not be repeated here.

17.2.2. COST A6 (Italia) has undertaken a major series of evaluations financed by the Ministry for the Universities and for Scientific Research and Technology and the National Drugs Fund. The projects are implemented by IEFCoS.

17.2.3. The project overall aims to work in ways which support and are integrated with European activities. At the operational level there are three elements to the project:

- Evaluation of prevention programmes
- Evaluation of treatment
- Evaluation tools and methodologies

17.2.4. In terms if support for and integration with European activities, a series of meetings of the different working groups of COST A6 have been held in Italy with the logistical and organisational support of COST A6 Italia. As part of this process, a seminar was held during the year to introduce the EMCDDA Guidelines for the Evaluation of Primary Prevention. The aim of the seminar was to promote the Guidelines and to identify ways in which they might be adapted for use within an Italian context. It has also published a booklet containing national reports and various contributions on the theme of the evaluation of treatment.

17.2.5. For the evaluation of prevention, a working group has been established consisting of the leading Italian experts. The aim of the group has been to review the theme of prevention, to examine the material and experience available within Italy and to develop guidelines for the evaluation of prevention, starting from those already available from the EMCDDA. This work has been undertaken in collaboration with the Ser.T of Ferrara.

17.2.6. For the evaluation of treatment an expert group has also been established. The group has sought to review the available treatment evaluations in Italy and to develop guidelines for use within the country. In this, it has examined and extended the available material prepared by Working Group 3 of COST A6.

17.2.7. Both of the expert working groups have used meetings and electronic communications to develop the work.

17.2.8. The third project, concerned with the development of evaluation tools, has been focused on validation of the European Addiction Severity Index (EuropASI). This is within the framework of COST A6 and involves the adaptation, translation and testing of an instrument for describing treatment and the services. The adaptation and translation has been completed and the EuropASI is now being piloted. The indications are that it is a very useful tool which has been appreciated by treatment services.

17.2.9. For the project, a dedicated web site has been established within which can be found all the information relevant to the activities.

17.2.10. In addition to these activities, two other projects have been undertaken by COST A6 Italia. The first was concerned with the validation in Italy of the workbooks for evaluation prepared by the World Health Organisation. The operational project was undertaken through a contract between IEFCoS and the Ser.T of Ancona. The second was distribution of the Guidelines on the Evaluation of Primary Prevention of the EMCDDA within Italy.

17.3. TRAINING

17.3.1. There are few significant changes from those which have been reported in previous years.

17.3.2. There continues to be a lack of interest and specific commitment in the university and para-university structures for the development of a basic course on drug use/misuse interventions.

17.3.3. The Ministry of Health has carried out a project on updating, documentation and training for the staff of the Ser.T closely associated with the evaluation project described elsewhere.

17.3.4. The project was developed to:

- promote a common basis of clinical practice based on up-to-date technical and scientific knowledge
- provide a picture of the current practices within the services involved in the project
- establish objective knowledge and education which supports, between the participants, a culture of evaluation
- promote knowledge and adoption of direct and indirect indicators which have been validated in a European context
- give to operators minimal but comparable tools to carry out a stable and long-lasting self-evaluation of the activities of the service, with the intention of increasing professionality of the staff, improving the effectiveness of the whole intervention and to assess the cost/benefit return.

17.3.5. At the end of 1998, the first masters degree in the epidemiology of drug dependence was completed. This was organised and managed by the Epidemiological Observatory of Lazio.

17.3.6. In other Regions, the administrations have provided specific 'updating' courses aimed particularly at the staff of the private/NGO services, almost all from the therapeutic communities.

17.3.7. At the Regional and local levels there have continued to be many training courses and seminars dedicated to a range of topics, including new drugs, detoxification, work in prisons, psychotherapy, etc. These courses do not provide specific qualifications and much training remains based on the gaining of experience whilst working, through supervision and through shared working and supervision on individual cases managed jointly by public and private services.

PART V

SPECIAL TOPICS

18. HEROIN, METHADONE AND SUBSTITUTION TREATMENT

18.1. CRITERIA AND TARGET GROUPS FOR SUBSTITUTION TREATMENT

18.1.1. Guidelines for substitution treatment with either methadone or naltrexone are provided by the Ministry of Health, professional associations and scientific societies. There is no single document which brings all this guidance together but that which is provided is widely available. Substitution treatment with heroin is not available within Italy.

18.1.2. Substitution treatment is provided through the Ser.T, which are part of the Local Health Authority (ASL) and which are autonomous entities with power to determine their own policy and practice. The Regional Assessor for Drug Dependence may offer guidance and can influence policy and practice but cannot direct it.

18.1.3. In practice, the main criteria for the use of substitution treatment is as a means of assisting the drug misuser to be more amenable to additional therapies. Harm reduction, that is, retention of contact and reduction of recourse to illicit drugs and to drug injection, may also be a factor in the decision to offer substitution treatment.

18.1.4. The primary target group for substitution treatment is heroin and opiate dependents for whom it is considered that immediate detoxification would be inappropriate and ineffective.

18.2. LEGAL BASIS FOR SUBSTITUTION

18.2.1. The Law 309 of 1990 gave competence to the Ministry of Health to provide regulations for the administration of methadone. The legal base for substitute treatment was established under the Ministerial Decree Nº 445 of 1990 issued by the Minister of Health [4]. This Decree determined:

- which doctors could prescribe methadone,
- that prescription of methadone was to be carried out on the basis of the model for Table I drugs (a special form available to appropriate professionals which must be completed in duplicate),
- required the maintenance of a register of clients' entry into and exit from treatment,
- approved the prescription of methadone at a therapeutic dosage for 8 days to a maximum daily dose of 120 mg unless there were good reasons to exceed this in individual cases.

18.2.2. Technical guidance was also provided by the Ministry of Health in Circular Nº 20 of 1994 which proposed a limit to the reliance on substitution drugs and suggested limiting the power to prescribe to family doctors who had

an arrangement with the National Health Service. The Circular did not, however, have any legal authority.

18.2.3. In 1999, following trials within Italy and the evaluation of the available information, the Ministry of Health has approved the prescription of buprenorphine from the start of 2000.

18.2.4. The establishment of the Ser.T was promoted by Law Nº 162 of 1990 and detailed arrangements for them were defined in Ministerial Decree Nº. 444 of 1990. Local public treatment services were already in operation at the time of the law, but its publication resulted in an increase in these services. It provided for regulations for the organisational framework of the Ser.T and for their functions and also for the establishment of agreements between the Ser.T and social-rehabilitative organisations to provide integrated treatment for people with drug problems.

18.2.5. Further changes were made in 1998 as a follow-up to the reform of the National Health Service made by the Legislative Decree 502 of 1992 and successive modifications. It required that the Ser.T should be framed in the context of the reformed health service in terms of the competencies and internal organisation of the services, the quality standards and minimum levels of service to be provided, the type and number of professionals involved and the relationship between the public services and NGOs/private organisations providing services to drug misusers.

18.2.6. The new organisational model is based in the creation of departments, as entities of the local health authority, concerned with the health and social problems associated with the misuse of drugs. The departments are directed by an expert in the field and are responsible for managing the available resources and co-ordinating services and local agencies involved in the care of drug misusers. The new arrangements have also introduced rules on the role and minimum standards for the Ser.Ts and a redefinition of the collaboration with NGOs and private organisations.

18.3. ORGANISATION, REGULATION AND MONITORING OF DELIVERY SYSTEMS

18.3.3. Under the Presidential Decree 309 of 1990, the Ministry of Health was given the competence to collect and analyse data on the epidemiology, of drug dependence, on the related pathologies and on the activities and characteristics of the public services for drug dependence (Ser.T) in relation to the treatment and rehabilitation of people with drug problems.

18.3.4. The Ministerial Decree of 20 September 1997 [5]] introduced a new reporting system for the Ser.T, replacing the one introduced by the Ministerial Decree of 3 October 1991.

18.3.5. The Ser.T are asked to provide annual data to the Ministry of Health and to provide data as on the 15 June and 15 December. They also provide data to the Office for Drug Dependence of their Region which submits data for the Region to the Ministry of Health.

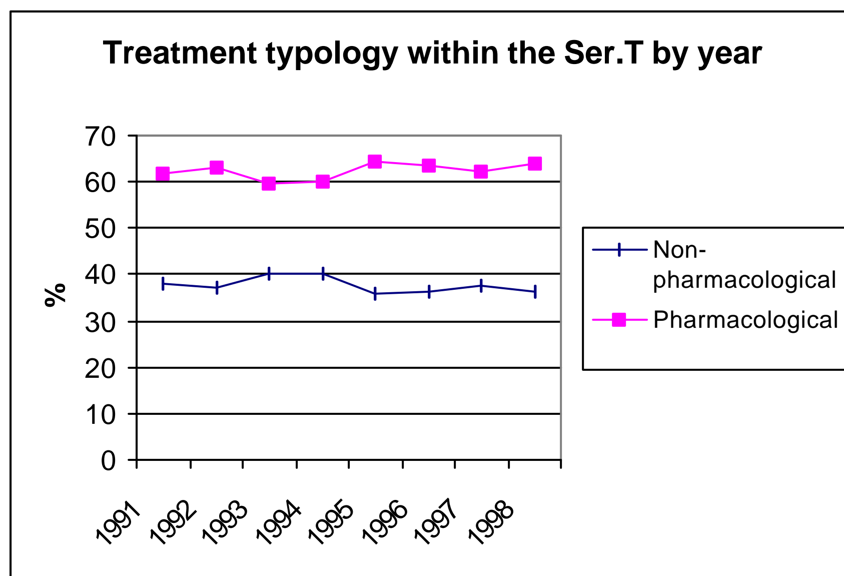
18.3.6. The forms used are as follows:

- SER.01: Anagraphical data of the Ser.T
- SER.02: Characteristics of personal working in the Ser.T
- ANN.01: Clients by age group and sex
- ANN.02: Clients by primary and secondary drugs of misuse
- ANN.03: Treatment provided
- ANN.04: HIV testing
- ANN.05: Hepatitis B testing
- ANN.06: Hepatitis C testing
- SEM.01: Half-yearly report

18.3.7. The Ser.T are asked to provide the annual data by the 31 January each year and the half-yearly data within 30 days of the end of the reporting period. The Regions and Autonomous Provinces are asked to check the data and to submit it to the Ministry of Health within 30 days from the reporting date for the Ser.T. The Ministry of Health is required, within 60 days of the deadline for receipt of data from the Regions, to analyse the data and provide a report on the national situation. This report is then sent to the Regions, Autonomous Provinces and to the Ser.T.

18.3.8. Not all Ser.T meet the reporting deadlines, but the data received represents around 95% of these services nationally.

18.3.9. The organisation, regulation and monitoring of delivery systems is largely the responsibility of the Ser.T guided by the relevant department of the local health authority and with oversight by the Office for Drug Dependence of the Region.



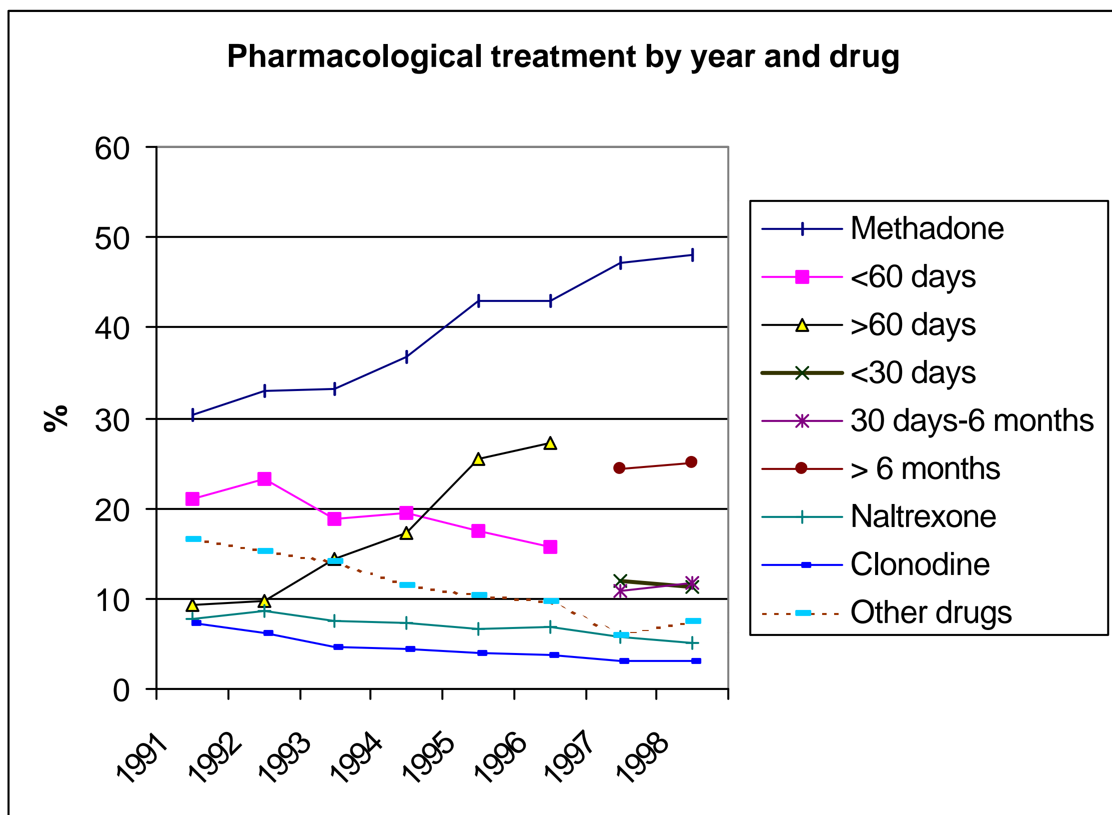
Graph 35

18.3.10. National guidance is that distribution of methadone should be a personalised medical action, accompanied by continuous monitoring of the client, the use of appropriate clinical controls and regular urine testing. Daily attendance at the service is common. However, some services now encourage attendance two or three times a week, rather than daily, with the aim of encouraging better adhesion to the recovery process and behavioural changes.

18.3.11. The use of naltrexone has developed as a means of achieving a drug free state for the client and permitting the more effective use of a range of other therapeutic tools. There is no specific guidance on the use of this drug but encouragement has been given to a wider use at the initiation of treatment to provide a space for more accurate diagnosis rather than use solely with patients who are already motivated to achieve abstinence. As with methadone treatment, clinical monitoring of the clients is expected, as is regular testing of the urine to identify the use of other drugs, especially those which may not be inhibited by naltrexone.

18.4. CHOICE OF DRUGS FOR SUBSTITUTION

18.4.3. The main drug used in substitution treatment is methadone, followed by naltrexone, clonidine and other drugs (Graph 36). Historically, psycho-social and rehabilitation interventions have declined over time whilst pharmacological interventions have risen.



Graph 36

18.4.4. Up to 1996, the reporting system was based on two typologies of methadone treatment, brief treatment of less than 60 days and protracted treatment of over 60 days. The new reporting system introduced in 1997

established three definitions: brief treatment (less than 30 days); medium term treatment (between 30 days and 6 months); long term treatment (over 6 months). It is too early to make any conclusion about the pattern of substitution treatment with methadone, but early indications are that long and medium term treatment is increasing and brief treatment is declining.

18.4.5. There are no clear figures about the length of time for which the other drugs used in substitution treatment are prescribed.

18.4.6. The decision on which drug, if any, should be prescribed to a client is a clinical decision. Increasingly the decision is made by the Ser.T team and not by a medical practitioner alone and it is part a clearly defined therapeutic programme and contract with the client.

18.4.7. There are Regional differences in the percentage of clients receiving substitution treatment and in the choice of drug. The national average of clients receiving methadone treatment in 1997 was 47.2% of all clients of the Ser.T. Eight Regions (Valle d'Aosta, Liguria, Toscana, Umbria, Lazio, Campania, Calabria and Sardegna) and one Autonomous Province (Trento), had a higher percentage than the national average, with Lazio providing methadone treatment to 77.1% of its clients, the majority of whom received long term (more than 6 months) treatment. 10 Regions had a higher than national average (12%) of clients receiving brief treatment (less than 30 days), including most of the Regions which exceeded the national average for methadone treatment. Medium term treatment (30 days - 6 months) was the least used methodology with a national average of 10.8% of all Ser.T clients.

18.4.8. In terms of other drugs used, the national average for naltrexone was 5.8% of all clients, for clonidine it was 3.2% and for other drugs it was 6%. Veneto, Friuli V.G., Emilia Romagna, Sicilia and Piemonte were the main users of naltrexone. The northern regions, Umbria and Sicilia were the main users of clonidine and these same regions were the ones most likely to use other drugs in treatment.

18.4.9. It is not clear why there are such differences between Regions and it may reflect historical practice, the treatment philosophy, levels of training, how treatment interventions are decided, the characteristics of the clients attending the services, etc.

18.5. EXTENT AND CHARACTERISTICS OF SUBSTITUTION PROGRAMMES

18.5.3. Substitution programmes are available throughout Italy in the Ser.T. In 1998 there were 545 such services which provided treatment to 137,657 clients.

18.5.4. In general, the Ser.T are based in urban and metropolitan areas with relatively few services located in rural areas. The Regions with the highest number of Ser.T are Lombardia (76), Piemonte (59), Puglia (57), Sicilia (46), Emilia Romagna (43), Lazio (41), Toscana (38), Veneto (37) and Campania (33). Between them, they account for 79% of the Ser.T

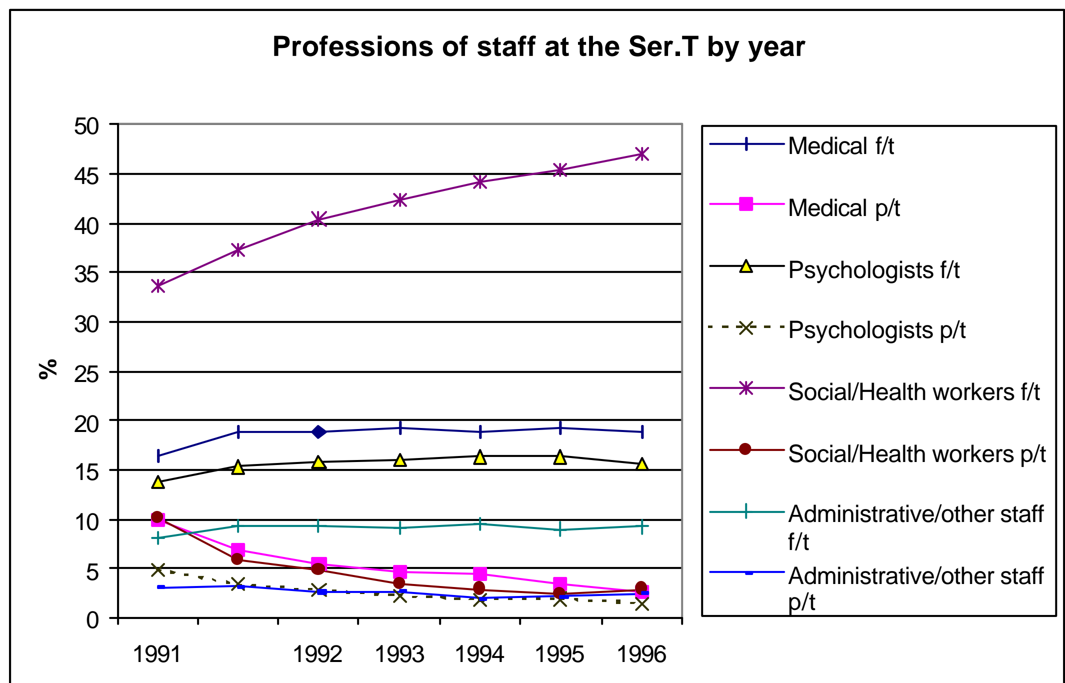
nationally whilst the remaining 10 Regions and two Autonomous Provinces have 21% of the Ser.T.

18.5.5. In 1997, there were 5,501 staff employed full time in the Ser.T, 573 part time staff and 602 staff available as required for specific interventions. Between 1991 and 1995 there was a significant increase in the number of full time staff assigned to the Ser.T, rising over that period by 61.5% and a decrease in the number of part time staff, which fell by over 50%. Since then, the balance between full and part time staff has remained stable.

18.5.6. Table 11 shows the number of full time and part time staff from the different professional backgrounds whilst Graph 37 shows the percentage of staff from the different professional backgrounds and changes over time.

	1991	1992	1993	1994	1995	1996	1997
Medical F/T	777	1028	1128	1199	1171	1196	1140
Medical P/T	470	375	330	290	282	216	155
Psychologists F/T	656	832	947	996	1012	1009	949
Psychologists P/T	231	184	169	145	109	115	93
Social/Health workers F/T	1598	2035	2420	2634	2741	2811	2852
Social/Health workers P/T	478	314	285	214	183	153	175
Administrative/other staff F/T	386	512	556	566	596	558	560
Administrative/other staff P/T	146	174	156	167	125	135	150

Table 11



Graph 37

18.5.7. In 1997, an additional group of staff were identified in the new reporting system. These were professional staff with whom the Ser.T established an agreement for the provision of specified services. Some 602 people were

recorded as operating with the Ser.T on this basis, of whom 46.3% were medically qualified, 19.4% were psychologists, 22.4% were health or social workers and 11.8% were administrative or other staff.

18.5.8. There are significant Regional variations in the staffing of the Ser.T. Those Regions which have a lower than average full time staff are also those Regions which have the largest number of agreements for the provision of services by external staff.

18.5.9. In Umbria, Lazio, Molise and Calabria the percentage of medical staff within the Ser.T is higher than the national average. In the Regions of Friuli V.G. and Basilicata, and in the Autonomous Province of Trento, it is the percentage of psychologists which is higher than the national average. The percentage of health and social workers is particularly high in Valle d'Aosta and Liguria.

18.5.10. There are significant differences between Ser.Ts. In some, where a clearly defined clinical approach has been developed and a range of therapies are involved, methadone treatment is a complement to other therapies. In others, where there are limited staff and additional training has not been available, methadone treatment has almost become an end in itself as a social control rather than a treatment modality.

18.5.11. There are also differences between those Ser.T which have focused on harm reduction for the most problematic drug users and those Ser.T which have concentrated on treatment aimed at achieving abstinence. In the former, the client often continues to receive substitution treatment despite multiple drug use in an effort to retain contact and create conditions where the client is amenable to therapeutic interventions. In the latter, drug use in addition to the prescribed methadone is an indicator for terminating substitution treatment in favour of other therapeutic interventions.

18.5.12. In many Ser.T there has been an increase in the integration of methadone treatment with psycho-social treatment. These have included group therapy, support to enter protected work environments, economic and social support. These approaches have been connected with clinical screening and regular urine testing and have supported behavioural changes. Individual psychological/psychiatric support has also been provided to patients as appropriate.

18.5.13. There has been some developing conflict over the increased medical role in drug treatment and the declining role of psychological and other non-pharmacological interventions. A better balance seems necessary which combines motivational counselling and interventions such as those based on the theories of Prochaska and Clemente and other interventions drawing on the clinical practices such as those used by Miller and Rollnik. The development of multi-approach treatments in an increasing number of Ser.T may allow this better balance to be established.

18.6. NUMBER AND PROFILE OF CLIENTS

18.6.3. Some 63.8% of all clients attending the Ser.T received a pharmacological intervention during 1998 of whom 48% received methadone. Of those receiving methadone, 23.5% received methadone for less than 30 days, 24.4% received methadone for between 30 days and 6 months and 52.1% received methadone for over 6 months.

18.6.4. There is no specific data available on the profile of clients who received a pharmacological treatment. It is unlikely that the general profile of clients attending the Ser.T is representative of the clients receiving methadone or other substitute treatment and it is not possible to identify the profile of clients who are considered suitable for a particular pharmacological intervention.

18.6.5. The general profile of clients may, however, offer some indication of the range of clients who might be considered for substitution treatment.

18.6.6. In 1998 the national ratio of male to female clients was 6.3:1. The northern regions in general had a much lower ratio at 4.9:1, the central regions a ratio of 5.2:1 whilst the southern regions had a high ratio of 11.4:1. The pattern over recent years has been for an increase in the male:female ratio, rising from 5.4:1 in 1994 to 6.3:1 in 1998 and for the southern regions always to have a much higher ratio than the national average.

18.6.7. In terms of the age of existing and new clients, the mean age of existing clients was 31.2 (male) and 31.1 (female) while the mean age for new clients was 30.6 (male) and 30.4 (female). This represents an increasing mean age for all clients, especially amongst new clients of the Ser.T.

18.6.8. Two aspects of substitution treatment which are of particular interest are treatment in combination with residence in a socio-rehabiliative service and treatment in prison.

18.6.9. In 1998, based on data collected by the Ministry of Justice, of 45,732 male prisoners, 13,020 (28.5%) were drug dependent. Of these, 558 (4.3%) were treated with methadone. Of 1,827 female prisoners, 547 (29.9%) were drug dependent and of these, 62 (11.3%) were treated with methadone. These national figures mask substantial variations between regions, with some having a substantial methadone treatment programme for prisoners and others having virtually no such treatment for prisoners. One region had no prisoners receiving methadone treatment and a further five regions had no female prisoners receiving methadone treatment. Methadone treatment for male prisoners was most likely to be provided in Toscana and Sardegna, followed by Lombardia, Friuli V.G. and Veneto. Methadone treatment for female prisoners was most likely in Friuli V.G. Toscana, Sardegna, Basilicata, Marche and Liguria.

18.6.10. Alternative information, based on data provided by the Ser.T to the Ministry of Health shows that 2,753 drug dependent prisoners received methadone treatment in 1998. The majority of those receiving methadone treatment in prison received brief treatment (less than 30 days), but

medium and long term methadone treatment was also provided to some 826 prisoners.

18.6.11. The difference in these figures is substantial. However, from 2000, health assistance to prisoners will be the sole responsibility of the Ministry of Health and the problems associated with data from two different and incompatible data collection systems will be removed.

18.6.12. The second aspect is methadone treatment combined with treatment in a socio-rehabilitative service. In 1998, some 1,789 clients of the Ser.T received this combined treatment. 825 received short term treatment, 551 received medium term treatment and 413 received long term treatment. A further 138 received combined treatment where naltrexone was prescribed. Using a different system for calculation, combined treatment increased from 6.8% of all clients of the Ser.T in 1997 to 7.3% of all clients in 1998, with a corresponding decrease in the percentage of clients treated exclusively in the Ser.T.

18.6.13. The openness of residential services and therapeutic communities to the acceptance of drug dependents whilst still receiving methadone in decreasing quantities has proved beneficial. The treatment options and the range of therapies available in such settings, combined with gradual detoxification, appear to have opened up new opportunities which were much more restricted in the ambulatory or out patient setting.

18.7. EVIDENCE ON IMPACT OF SUBSTITUTION

18.7.3. Two major evaluations, under the aegis of the Ministry of Health, are currently being undertaken which, whilst not solely focused on evaluation of substitution treatment, will provide considerable information about this type of intervention. The first, co-ordinated by the region of Emilia-Romagna, is concerned with an evaluation of the quality of the Ser.T. The second, co-ordinated by the Department of Public Health of Turin University and Lazio Region Epidemiology Observatory, is concerned with an evaluation of the effectiveness of treatment for heroin addicts.

18.7.4. For the first evaluation, two national seminars have been held at which the system of evaluation was defined and the first phase planned. Regions also presented information on their local situation concerning the operation of the services, the control systems operated and present and future perspectives. In 16 of the 21 Regions and Autonomous Provinces, regional expert groups have been established to appraise the application, adapted as necessary, of the national model for quality evaluation.

- The second evaluation is a national, multi-centre study aimed at identifying the effectiveness of treatment

18.7.5. The Italian study, which cannot use randomised selection for ethical reasons, is based on the following approach:

- *Objective:* the evaluation of the effectiveness of treatment by the Ser.T using specific criteria

- *Treatments:* the inclusion of the full range of treatments available: methadone reduction; methadone maintenance; detoxification with symptomatic drugs and/or antagonists; psychotherapy; admission to a residential service; counselling; advice, support and; information and orientation to the job market and into employment. The study will evaluate both single treatments and combinations of treatment.

- *Outcome:* the first phase will focus on retention in treatment and reducing mortality (accidents, overdoses, etc.). The future phases will consider the use of other substances, morbidity (e.g. overdose), re-socialisation and other possible results.

- *Control of the sample:* this will be based on a questionnaire administered at entry designed specifically to measure existing conditions

- *Duration of the study:* one and a half years for enrolment into the study and a survey of the treatments. A further six months for the follow-up on mortality.

18.7.4. A pilot study has been conducted to assess the feasibility of the study and the validity of the tools. 130 operational centres in 13 regions have been involved with an anticipated 20-30,000 clients. The protocol of the study, dealing with its methodological and operational aspects, has been provided to all the participating Ser.T and updates are disseminated through the Newsletter VEdeTTE, which also includes information about problems encountered and latest news from the study.

18.7.6. In Piemonte additional elements have been included in the study. The outcomes to be measured include retention in treatment, the use of illicit drugs both during and after treatment, HIV sero-conversion, morbidity co-related to overdose and social reinsertion. It has also established an ethical committee, composed of experts on ethical issues, psychiatrists, staff of the services, exponents of social privacy and client representatives. The committee is responsible for reviewing the study protocol and examining the ethical issues, especially with regard to conflicting requirements, e.g. the privacy rights of individuals versus the collective benefits of the study. This last initiative has been welcomed by clients and by the Ser.T staff.

18.8. RESEARCH RESULTS ON SUBSTITUTION

18.8.3. The region of Emilia-Romagna is conducting specific research on methadone treatment. The preliminary findings of this research are of considerable interest, arising as they did from a seminar involving operators from all the Ser.T in the region. It examined clinical procedures, dose levels, duration of treatment and the criteria used to determine the appropriate therapeutic choice for a patient.

18.8.4. From the preliminary research it emerged that there was fragmentation between the pharmacological and psycho-social interventions, which needed to be integrated, and between the evaluations of treatment made by those involved in these different interventions. It was also clear that

there was uncertainty about which criteria should be used, that some criteria were missing and that this made management of individual clients difficult.

18.8.5. It was concluded that better diagnostic tools were required for admission to treatment and a clearer understanding was needed of the managerial processes which would allow improved results to be obtained.

18.8.6. As a result of the seminar, the Region has undertaken two major research initiatives. The first is a retrospective study, involving all the Ser.T, examining treatment outcomes for patients receiving methadone treatment in different years. The second is a prospective study examining progress and outcomes for patients entering methadone treatment for the first time. Both studies have been developed to identify behavioural typologies, from the social, psychological, environmental and drug use aspects, amongst others, in order that appropriate treatments might be associated with particular typologies.

19. LAW ENFORCEMENT, DIVERSION TO TREATMENT, ALTERNATIVES TO PRISON

19.1. LEGAL FRAMEWORK

19.1.1. Within Italy there is no criminal offence of use or possession for personal use of a controlled drug. Criminal proceedings, therefore, are solely related to offences of drug production, supply, trafficking, facilitating drug use (including financing and money laundering) and instigating, proselytising or inducing minors to commit drug law offences. Unlawful use or possession of drugs is dealt with by administrative procedures rather than criminal procedures.

19.1.2. Drug users may be referred to the Judicial Authority for direct drug crimes, such as sale of drugs, trafficking in drugs, drug production or involvement in financing the sale, trafficking or production of drugs. They may also be referred for other offences against persons or property which may have been committed to support their drug use or under the influence of drugs. They may be referred to the police authorities for unlawful use or possession and be subject to the administrative sanctions available.

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

- Alternatives to custody at the sentencing phase (substitute sanctions)
- Alternatives to custody in the enforcement phase (community measures)

19.1.4. The main legislation relating to substitutive sanctions and community measures is Law 689 of 24 November 1981 "Modifications to the Penal System", the Penitentiary Act and Decree 309 of the President of the Republic of 1990. The first two are relevant to all persons charged with a criminal offence. The latter deals with measures specific to drug users.

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

19.1.6. Before illustrating each sanction and measure in detail, the substantial differences between substitute sanctions and community measures needs to be clarified. Substitute sanctions are decided by the judge as a replacement for imprisonment at the same time as s/he passes sentence. The intention is to avoid offenders receiving short sentences from going to prison. Community measures are granted by a specific judicial authority, the Supervisory Court, during the execution phase of a penalty, at the offender's request.

19.1.7. ***Substitute Sanctions***

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

- Semi-detention - where a penalty does not exceed one year

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

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

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

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

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

19.1.7.5. The duration of the substitutive sanction is calculated by considering each day of imprisonment as equivalent to one day of semi-detention or to two days of monitored liberty. Fines are calculated by considering each day of imprisonment as equivalent to 75,000 Italian Lire.

19.1.7.6. The conditions attached to semi-detention and of monitored liberty are set by the Supervisory Magistrate, who can also change them where this is considered absolutely necessary.

19.1.7.7. The police are responsible for checking that the conditions attached to an order are observed.

19.1.7.8. If an offender sentenced to semi-detention and monitored liberty breaks any of the conditions imposed, the remaining part of the substitute measure is converted into a prison sentence. The conversion order is issued by the Supervisory Court.

19.1.8. *Community Measures*

Italian legislation provides the following measures as alternatives to custody.

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

19.1.8.1. Offenders may be assigned to the Probation Service when their prison sentence, or the remainder of the sentence to be served, is less than three years.

19.1.8.2. Assignment to the Probation Service replaces the prison sentence and entails a rehabilitation programme carried out in the community under the supervision of social workers attached to the Penitentiary Department.

19.1.8.3. This measure is usually granted on the basis of the results of one month or more observation in prison of the offender's personality, carried out by a special team. In cases where the measure is deemed likely to contribute to the rehabilitation of the offender, thanks in part to the conditions that may be attached, while ensuring the prevention of relapse, an assignment may be approved. Thus assignment to the Probation Service must be based on a conviction that the danger represented by the offender can be dealt with through the instruments provided by the measure rather than on a conviction of the lack of danger presented by the offender.

19.1.8.4. It is now possible for assignment to be adopted before the offender is committed to prison, thus preventing it.

19.1.8.5. Assignment orders list all the conditions which offenders must observe as regards their relations with the Probation Service, their residence, employment, use of means of transport and any veto on the places they may frequent.

19.1.8.6. The order may also forbid the probationer from residing in one or more named towns, or provide for him/her to reside in a named town; in particular, it sets out conditions preventing him/her from carrying out activities or maintaining relations which might lead to further offences.

19.1.8.7. The order must also provide for any reparation that the probationer must make to the victim of his/her offence, as well as for compliance with his/her family duties.

19.1.8.8. The conditions set out in an order may be modified during the execution of the order by the Supervisory Judge.

19.1.8.9. The Probation Service supervises the conduct of probationers and helps them overcome the difficulties of social insertion. This includes establishing contacts with their families and other people in their every-day life.

19.1.8.10. The Service reports regularly to the Supervisory Magistrate on the behaviour of each probationer.

19.1.8.11. Assignment may be revoked where the offender's behaviour does not comply with the law or with the conditions imposed and is, therefore, deemed incompatible with the continuation of the measure.

19.1.8.12. For the measure to be revoked it is not sufficient for the probationer to have committed a single breach of the conditions, even if it be a serious one. The breach should rather be considered as the expression of a negative overall attitude, demonstrating lack of a positive response to treatment. Therefore, single episodes must be evaluated in light of the offender's conduct as a whole.

19.1.8.13. According to a decision by the Italian Constitutional Court (sentence Nº 343/87), where an assignment is revoked, the Supervisory Court sets the length of imprisonment remaining to be served, taking into account the length of time the probationer has been assigned to the Probation Service and his/her conduct during assignment.

19.1.8.14. Successful completion of the assignment period extinguishes the sentence and all other penal effects.

Assignment of Special Categories of Offenders to the Probation Service (Art. 94 of Presidential Decree Nº 309/1990)

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

19.1.8.16. To reach a decision on an assignment, the Supervisory Court may acquire a copy of the case records and order appropriate inquiries regarding the suitability of the proposed treatment programme. It must also be ascertained that the offender is not just using the addiction to drugs or alcohol and the execution of the rehabilitation programme to obtain assignment with no commitment to the treatment programme.

19.1.8.17. At the end of these proceedings, the Supervisory Court issues an assignment order and immediately informs the Prosecutor responsible for its execution of the order.

19.1.8.18. If the Court does not grant assignment, the Prosecutor issues an imprisonment order.

19.1.8.19. If the Supervisory Court grants assignment, the conditions imposed must also include those that determine the programme implementation modalities. The order must also specify the forms of

monitoring that will be adopted to ascertain that the drug-addicted or alcoholic offender is following with the programme.

19.1.8.20. This special type of assignment may be granted only twice to an offender.

19.1.8.15. Unless otherwise established, the regulations governing the ordinary assignment of offenders to the Probation Service are applicable to this measure.

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

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

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

19.1.8.18. The measure may also be applied generally, that is, to offenders other than those listed in the categories above, where the sentence or residual part of the sentence does not exceed two years. Where the conditions do not exist for assignment to the Probation Service, the measure must be considered suitable for preventing the commission of further offences. The measure cannot be granted for offences connected to organised crime.

19.1.8.19. This measure is aimed at the “humanisation” of sentences, rather than at offender re-insertion.

19.1.8.20. When ordering Home Detention, the Supervisory Court establishes the conditions attached to the measure. It also gives instructions to the Probation Service. These conditions or instructions may be amended by the Supervisory Magistrate with jurisdiction over the area where the measure is implemented.

19.1.8.21. An offender on Home Detention is not subject to the penitentiary regime as provided by the Penitentiary Act and its enforcement rules. No costs relevant to maintenance or health care of offenders undergoing Home Detention is borne by the Penitentiary Department.

19.1.8.22. Home Detention is revoked when the behaviour of the offender does not comply with the law or with the conditions imposed and therefore appears incompatible with the continuation of the measure.

19.1.8.23. It can also be revoked if the offender leaves his/her place of residence without permission. This is considered as a prison escape which in itself is a crime. Under the last paragraph of Art. 47c of the Penitentiary Act, the simple fact of being reported for this crime used to cause suspension of the measure, but this provision was declared illegal by the Constitutional Court (sentence Nº 173/97).

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

19.1.8.25. Under this measure the offender, whilst still considered a prisoner, may spend part of the day outside the prison for purposes of work, education or participation in other activities which contribute to his reintegration into society.

19.1.8.26. As a general rule, the prisoner may be granted semi-liberty only after having served at least half of his/her sentence.

19.1.8.27. For prisoners convicted of serious crimes, for instance, Mafia-type association, kidnapping, homicide, extortion and aggravated robbery, association in the trafficking of illegal or psychotropic drugs and the like, semi-liberty may be granted only after the serving of two thirds of the whole sentence. For those sentenced to life imprisonment, it is only available after 20 years in prison.

19.1.8.28. The measure may be granted before imprisonment where the sentence does not exceed six months. Immediate granting of semi-liberty is also possible where the sentence does not exceed three years and the prisoner, having applied for Probationary Assignment, has been found unsuitable by the Supervisory Court.

19.1.8.29. Internees, i.e. persons subject to detentive security measures, may be granted semi-liberty at any time. The granting of semi-liberty is decided in relation to the progress made by the prisoner in the course of treatment and where the conditions for a gradual social re-insertion exist.

19.1.8.30. A special treatment programme is laid down for each prisoner/internee granted semi-liberty. The programme contains the conditions which the prisoner/internee must observe during the time spent outside prison.

19.1.8.31. Semi-liberty may be revoked, at any time, where the recipient proves unsuitable for such form of treatment.

19.1.8.32. Moreover, a report of escape (i.e. when the recipient is unjustifiably absent from the prison establishment for more than twelve hours) causes suspension of the measure, and conviction for escape causes revocation.

19.1.8.33. Revocation of semi-liberty results in continuation of the original imprisonment sentence.

19.1.9. ***Other Concessions***

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

Suspended Sentences for drug and alcohol addicts (*Sospensione dell'esecuzione della pena detentiva*) (Art. 90 - 93 of Presidential Decree Nº 309/1990. The Consolidation Act for Drugs-Related Legislation)

19.1.9.2. The Supervisory Court may suspend for five years the execution of a prison sentence or the residual part of a longer sentence not exceeding four years in the case of offenders who have committed crimes related to their drug or alcohol addiction, provided that they are already undergoing therapy or a social rehabilitation programme.

19.1.9.3. If the convicted person follows the programme and does not commit any crime punishable only with imprisonment, within five years following the suspended sentence, the penalty and all penal effects are removed from the records.

19.1.9.4. Suspension is revoked if the offender abandons the programme without a justified reason, or commits a non-culpable crime punishable only with imprisonment.

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

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

19.1.9.6. Offenders on conditional release are subject, up until the expiry of the sentence, to supervised liberty. This measure involves a series of obligations intended to prevent opportunities for further offences. Monitoring of offenders on conditional release is carried out by the Police. The Probation Service provides support and aimed at reintegrating offenders into society.

19.1.9.7. Conditional release is revoked if the offender commits a crime or petty offence, or breaches the conditions attached to supervised liberty, from the time of release until the expiry of the sentence.

19.1.9.8. According to a Constitutional Court decision (Sentence Nº. 282/1989), in cases of revocation of conditional release, it is for the Supervisory Court to determine the length of imprisonment remaining to be served, taking into account the time the offender has served on conditional release, the limitations of liberty imposed while on release, and his/her conduct during that time.

19.1.9.9. Prior to this decision by the Constitutional Court, the time spent on conditional release was not taken into account on revocation. The offender used to serve the whole sentence with only the part of it already served in prison being deducted.

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

Work Release

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

"Reward" leave permits

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

Leave for offenders in semi-liberty and for internees

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

Early Release

19.1.9.14. This concession is granted to offenders who have demonstrated active participation in the rehabilitation process. It involves sentences being shortened by 45 days for each 6 month period in which the offender has been assessed favourably by the Supervisory Court. The consequence is that the custodial sentence is abridged

but fully served. There is, therefore, no action required by the Probation Service.

Release of Debt

19.1.9.15. Offenders who are serving a custodial sentence, a community measure or have been released at the end of their sentence may apply for release of debt related to legal costs and costs of maintenance in prison. The Supervisory Magistrate may ask the Probation Service to enquire into the social and family background of offenders to provide him/her with information which will assist a decision on whether or not to accept the application.

19.1.10. ***Specific Measures for drug and alcohol addicts***

19.1.10.2. *Assignment of Special Categories of Offenders to the Probation Service* (Art. 94 of Presidential Decree Nº 309/1990) and *Suspended Sentences for drug and alcohol addicts* (*Sospensione dell'esecuzione della pena detentiva*) (Art. 90 - 93 of Presidential Decree Nº 309/1990), both of which have been described in detail above, are specific measures which aim to promote and sustain treatment, rehabilitation and avoidance of further offending related to addiction.

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

19.1.11.2. Law N° 165 of 27 May 1998, containing "Amendments to Article 656 of the Code of Penal Procedure and of Law N°354 of 26 July 1975, and following modifications", modified and broadened the use of alternative to imprisonment measures It came into force on 14 June 1998.

19.1.11.3. This law establishes a mechanism to suspend a detention order, where the penalty is no longer than three years (or four years for drug-addicts), to allow the offender to be granted a Community Measure without entering prison.

19.1.11.4. In particular, the law provides for the imprisonment order to be suspended and for this to be communicated to the person concerned. Within thirty days, s/he may then submit a request for one of the Community Measures. The Supervisory Court decides, within forty-five days of receipt of such a request, whether it should be granted.

19.1.11.5. If the request is not made in good time, or the Supervisory Court determines that it is inadmissible or rejects it, the Public Prosecutor revokes the decree of suspension of detention.

19.1.11.6. Where the request for Probationary Assignment to the Social Service, or for the granting of Home Detention or Semi-liberty (in the case of prison sentences not exceeding six months) is proposed after

the beginning of the execution of the sentence, the Supervisory Judge may order, in the first case, the suspension of the execution of the sentence and the consequent release of the offender. In the other two cases, the provisional enforcement of the alternative measures may be ordered.

19.1.11.7. The suspension of the execution of the sentence, or the provisional enforcement of the alternative measures remains in force until the Supervisory Court delivers a judgement within forty-five days.

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

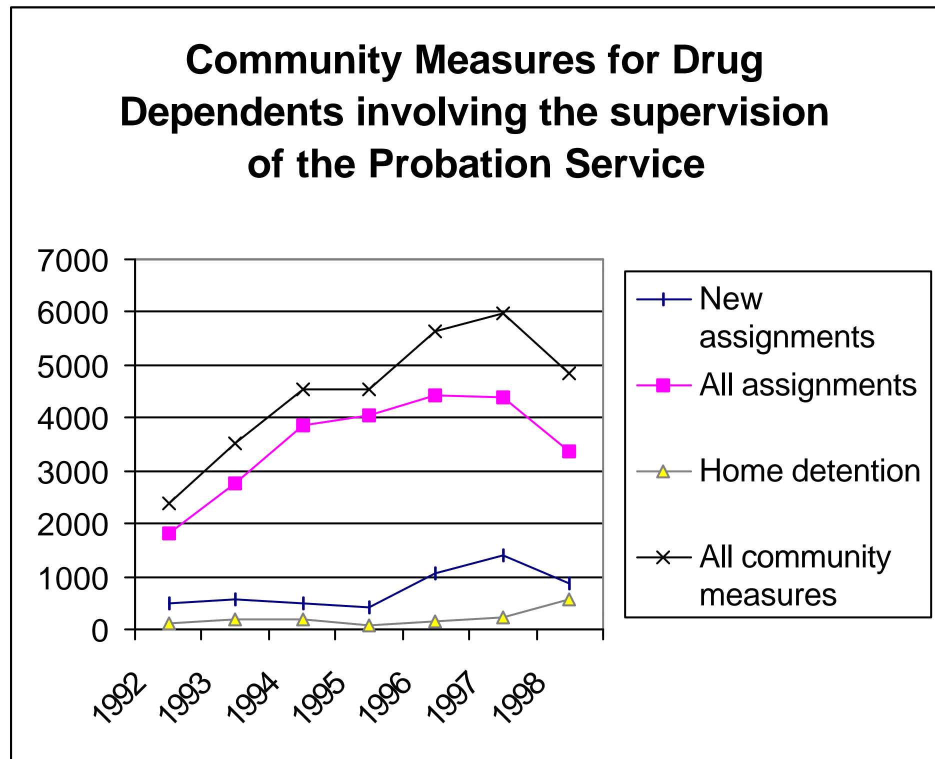
19.1.12. *Application of Community Measures*

19.1.12.8. There has been a substantial increase in the number of offenders benefiting from community measures over the last seven years In 1992, a total of 5,694 offenders were assigned to the Probation Service or granted home detention. By 1998, this had risen to 18,908 offenders. Moreover, in 1998 the Probation Service supervised 19,772 people under controlled liberty compared to 18,827 in 1997.

19.1.12.9. The number of drug dependents assigned to the Probation Service or granted home detention has also risen in the same period although in 1998 there was a significant decrease. It is not clear why this decrease has occurred when there has been no corresponding decrease in the number of drug or drug-related offences. There are a number of possible reasons.

19.1.12.10. First, it is possible that recidivism amongst drug using offenders has made them ineligible for community measures involving the Probation Service. Secondly, given that there has been a steady decline in the number of drug dependent Italians serving a prison sentence in recent years, it is possible that the use of substitute sanctions, which do not involve the Probation Service, have increased.

19.1.12.11. Graph 38 below shows the application of community measures involving the Probation Service as they apply to drug dependents. As can be seen, new assignments to the Probation Service peaked in 1997 whilst all assignments to the Probation Service peaked in 1996. At the same time as assignments have begun to decline. The use of home detention has risen steadily over recent years but this has not had any significant impact on the overall decline in the use of community measures for drug dependent offenders.



Graph 38

19.2. NATIONAL POLICY

19.2.1. National policy is that it is preferable for drug users to be treated for their drug misuse wherever possible and that where imprisonment is considered necessary, support and assistance in preparation for release and following release should be provided to reduce the likelihood of a return to drug use and re-offending.

19.2.2. To this end, Decree 309/90 of the President of the Republic made specific provisions related to drug misusers involved with the criminal justice system. Law Nº 165/98 made further changes which, whilst applicable to all categories of offenders, makes specific reference to drug dependent offenders and seeks to enhance the use of alternative to imprisonment measures.

19.3. SCENARIOS

19.3.1. *Unlawful drug use or possession*

19.3.1.1. DPR 309/90 defines the quantity of drugs for personal use as not more than the average amount which might be required for daily use. Where this condition is met, the person may be subject to administrative sanctions. These include suspension of driving and gun licences, of the passport and of other equivalent documents. The law makes a distinction between drugs in table I (opiates, cocaine, amphetamines, etc.) and table III (barbiturates and hypno-sedatives) and drugs in table II (marijuana, hashish, cannabis plants) and table IV (therapeutic drugs which can produce dependence but of less intensity or danger than those caused by drugs in tables I and III). For the former group, the administrative sanctions are for a

period of four months whilst for the latter group the sanctions are for a period of three months.

19.3.1.2. If a person is found in possession of drugs in tables II or IV and they are solely for personal use, they are summonsed for an interview with the Prefect of Police or his representative. If the user agrees to refrain from offending in the future, on the first occasion of the summonses, the user may be given a warning of the dangers of drugs and be formally invited not to use illegal substances again. If the person is a minor, this approach is used no matter in which table the drug is listed. Wherever possible in such cases the family of the user is involved to inform them of the circumstances and to advise them of the available intervention services, with an invitation to them to arrange a meeting with one of the services.

19.3.1.3. Should the person be found in unlawful possession of a controlled drug again, s/he may be re-summonsed to a meeting where the reasons for the violation are examined and new arrangements may be established to prevent further violations. In such instances the Prefect is assisted by advisers from local services.

19.3.1.4. Someone summoned for an interview having been found in unlawful possession of drugs may voluntarily request a treatment or rehabilitation service (as defined in the law). At this point proceedings are suspended whilst the user is referred to the Ser.T for an assessment, which must be completed within a specified time. If the user completes the programme then no further action is taken.

19.3.1.5. If the user asks for a voluntary treatment programme and then fails to attend the programme or leaves without a valid reason, he is called for a second interview with the Prefect or his representative and advised that he should follow the programme and of the consequences if he fails to do so. A second failure results in a referral to either the public prosecutor for the magistrates court (in the case of adults) or the public prosecutor for the juvenile courts (in the case of minors).

19.3.1.6. Anyone who has more than two failures in attending or completing a treatment programme with no valid reason, is subject to one or more of the following measures. These may be imposed for a period of 3 to 8 months in the case of table I and III drugs and for a period of 2 to 4 months in the case of drugs in tables II and IV.

- prohibition to leave the commune of residence without authorisation
- required to present themselves at least twice a week to the police
- be subject to a curfew
- be banned from going to certain locations indicated in the order

- have their driving and gun licences, their passport and equivalent documents suspended
- required to undertake unpaid work for the benefit of the community at least one working day a week
- sequestration of any vehicle owned by the user which was used to transport or hold drugs, as well as confiscation of the drugs
- probation assignment
- in the case of non-Italians, suspension of the permit to stay

19.3.1.7. Breaches of these conditions result in a referral to the relevant court. In the case of juveniles, the parents or the persons acting as parents, are informed of the situation.

19.3.1.8. The courts may still accept a request for treatment by the drug user and may apply conditions to the treatment order. The system for identifying if a user is truly willing to accept treatment and for determining the appropriate treatment programme is the same as for a referral from the Prefect. The difference is that a breach of the court order is itself an offence and where this occurs the suspension of court proceedings is revoked and the prosecution of the user is proceeded with. For each violation of the conditions the punishment may be imprisonment for up to three months or a fine of up to 1 million lire.

19.3.1.9. It is also an offence to leave a needle and syringe in a setting (public or private) where it might be a danger to others. A fine of between 100,000 and 1 million lire may be imposed for this offence. However, there is no readily available information on the extent to which this offence is prosecuted.

19.3.2. *Drug LawCriminal Offences*

19.3.2.1. The most common criminal offence affecting drug users is production and/or trafficking in drugs at the level of an individual. This is a less serious offence than drug production and/or trafficking as part of a group organised for this purpose.

19.3.2.2. The penalty for production and/or trafficking at an individual level is 8 to 20 years imprisonment and a fine of between 50 and 500 million lire (table I and III drugs) and 2 to 6 years imprisonment and a fine of between 10 and 150 million lire (table II and IV drugs) where significant quantities of drugs are involved. For smaller quantities, but larger than for personal use, the penalty is one to six years imprisonment and a fine of between 5 and 50 million lire (table I and III) and 6 months to four years imprisonment and a fine of between 2 and 20 million lire (table II and IV).

19.3.2.3. Drug users usually fall within the category of small scale suppliers or traffickers and are therefore subject to the reduced penalties. As described earlier (legal framework), in place of a prison sentence,

alternative measures may be applied. The measures may be applied at the sentencing phase or after a sentence of imprisonment has been made. In practice, wherever possible, an alternative measure is applied at the sentencing phase in order that the drug user might enter treatment. In some cases, the user is not yet ready to commit him or herself to treatment at this stage but should progress be made whilst in prison, often with the support of the Ser.T or other specialist drug service, the user may still apply for an alternative measure which would allow treatment to continue or to begin.

19.3.2.4. The clear difference between an administrative sanction and an alternative measure is that breach of the alternative measure may lead to the imposition of a prison sentence or a return to prison.

19.3.2.5. As described elsewhere in this report, there has been increasing involvement of the Ser.T and of socio-rehabilitative services within the prisons. For the drug using offender, this provides an opportunity to start or to re-start treatment and s/he may subsequently apply for an alternative measure in order that the treatment can be completed in a therapeutic environment. As stated earlier, the treatment service must provide the court with a statement of the treatment proposed, its suitability for the client and the court must be convinced of the commitment of the client to the treatment programme.

19.3.3. *Drug using offenders convicted for other criminal offences*

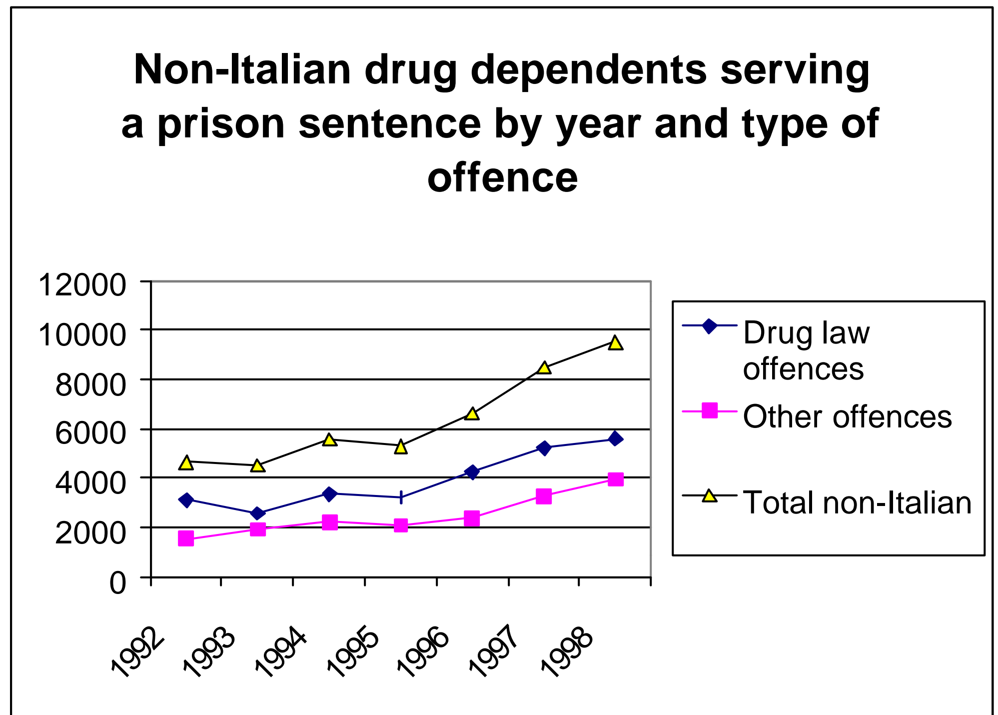
19.3.3.1. Alternative measures are available for all offenders where they meet the criteria defined in the law. For drug using offenders, the focus is specifically on treatment and rehabilitation measures which address both criminal behaviour and, as importantly, drug using behaviour which may have been an important factor in offending.

19.3.4. *Substitute Sanctions and Community Measures as they apply to Non-Italians*

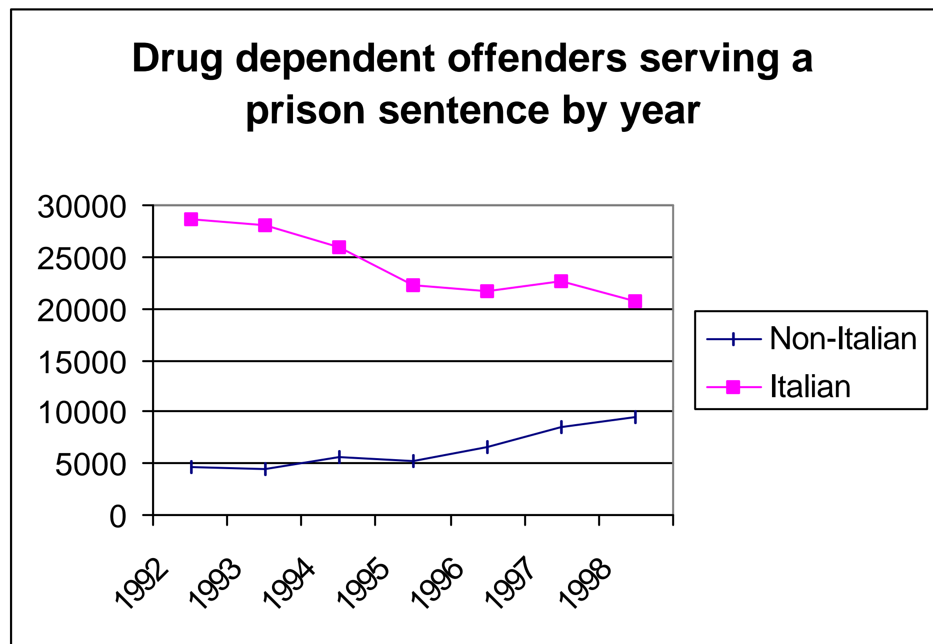
19.3.4.1. Whilst administrative sanctions related to the possession of small quantities of controlled drugs are generally applied, there is little data available on the use of substitute sanctions and community measures for criminal offences as they are applied to non-Italians.

19.3.4.2. As reported earlier, there is little information available about drug use or drug dependence amongst non-Italians. There is, however, data available on non-Italians prisoners who are assessed as drug dependent. Between 1992 and 1998 there have been annual increases in the number of drug dependent non-Italians serving a prison sentence for drug law criminal offences or for other criminal offences. This compares with a declining trend in the imprisonment of Italian drug dependent offenders.

19.3.4.3. Graph 39 shows the number of non-Italian drug dependent offenders serving a prison sentence by year and broad category of offence. Graph 40 compares the number of Italian and non-Italian drug dependent offenders serving a prison sentence.



Graph 39



Graph 40

19.3.4.4. As can be seen from these graphs, whilst there has been no significant change in the total number of drug dependent offenders serving a prison sentence in recent years, there has been a significant qualitative change. The decline in prison sentences for Italians has been largely replaced by the increase in prison sentences for non-Italians. The involvement of non-Italians in non-drug law offences as well as drug law offences has also increased. This suggests that an increasing number of non-Italian drug dependent offenders are resident in Italy either legally or illegally.

19.3.4.5. Data on juvenile offenders provides additional information. It shows that almost one in five of drug using offenders between the ages of 14 and 17 were non-Italians, the majority being from the Magreb countries (which also provide the highest number of adult drug law offenders). Moreover, over half of the non-Italians were habitual users or drug dependent, with 36% using opiates or cocaine.

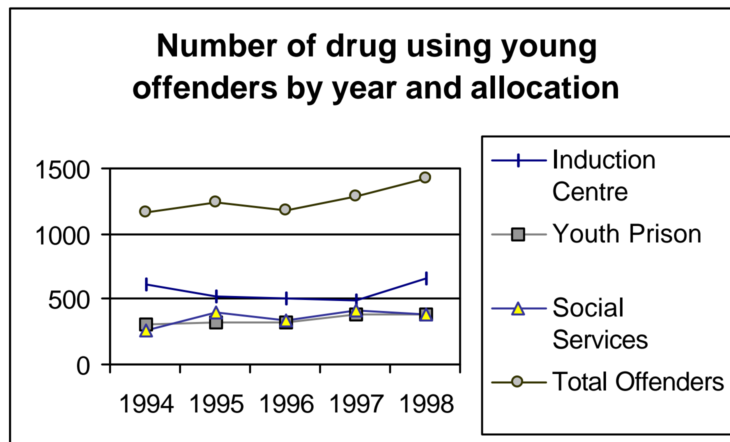
19.3.4.6. The data on adult non-Italian drug dependent offenders suggests that substitute sanctions and alternative measures are used less frequently for non-Italians than for Italians. This may be for several reasons.

19.3.4.7. First, it is possible that many are illegal immigrants into Italy for whom alternatives to imprisonment are inappropriate. Second, if they do not have command of Italian, it may be extremely difficult to offer them such alternatives. Assignment to the Probation Service and admission into a treatment or rehabilitation programme all demand substantial oral communication. Without verbal skills in Italian, foreign drug dependents may not be able participate in such programmes and therefore be deemed unsuitable for such measures.

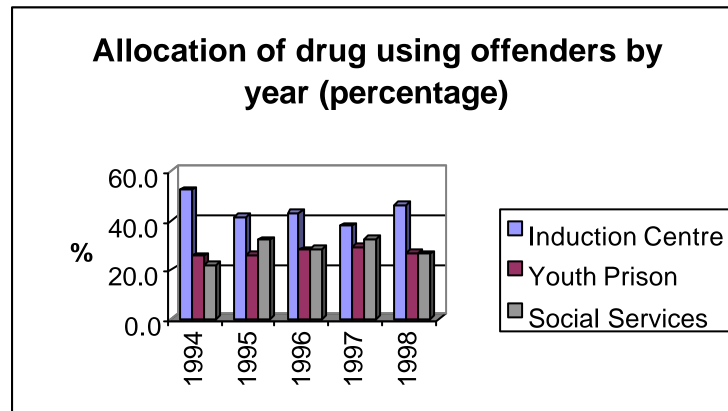
19.3.5. *Alternative Measures for Juvenile Offenders*

19.3.5.1. For juvenile offenders, alternative measures apply as for adult offenders. The difference is that the normal arrangements for dealing with juvenile offenders also apply.

19.3.5.2. Where possible an alternative measure is used for a juvenile convicted of a criminal offence. Graphs 41 and 42 show the allocation of drug using young offenders over the last four years.



Graph 41



Graph 42

19.3.5.3. Almost 3 out of every 4 drug using juvenile offenders receives a non-custodial sentence. The most common action is to send the young person to an induction centre (Centro Prima Accogliènza). Here the young person is assessed and an appropriate support and intervention programme is provided aimed at tackling the personal and/or social problems of the young person. This option is usually made available to young people who do not have major personal or social problems.

19.3.5.4. The second non-custodial option to send the young person to the Youth Social Services (Ufficio Servizi Sociale Minorile). This approach is used most often where the young person has significant problems and where a co-ordinated intervention programme is required involving the input of social workers and other specialist services such as psychology and drug treatment.

19.3.5.5. As for adults, alternative measures may still be applied even after a drug using offender has begun a sentence of youth imprisonment.

19.4. THE ROLE OF THE DIFFERENT ACTORS

19.4.1. The role of the different actors has largely been dealt with in the preceding sections. A wide range of services and professions may be involved depending upon the offence or offences involved, the needs of the individual and the age of the offender. The key actors, however, are:

- The Prefect of Police (or his representative), who determines the appropriate administrative sanction, in consultation with his advisers. The Police are also responsible for monitoring compliance with conditions attached to substitutive sanctions and some community measures.
- The Ser.T and/or other designated local socio-rehabilitative services which assess a drug user and provide reports and recommendations to the Prefect or the appropriate Judicial Authority to assist in determining whether to apply a particular administrative sanction or an alternative measure. They are also involved in providing therapeutic interventions to those who seek voluntary treatment, to those who receive an

alternative measure at the sentencing stage and to drug using prisoners who may subsequently seek an alternative measure.

- Social workers attached to the Ministry of Justice are responsible for supervising assignments to the Probation Service. In practice, with drug dependent offenders, they co-ordinate the provision of appropriate treatment services and receive reports on the progress of the drug dependent. They also liaise with the family and employers etc. The social workers also provide support and assistance to offenders granted conditional release from prison.

- Judges and Public Prosecutors have a role in determining whether or not a substitute measure is appropriate and should be applied in individual cases and the action which should be taken should the conditions attached to a particular measure have been breached. Their involvement, however, is essentially technical rather than operational.

- The Supervisory Court has a central role in approving any proposed community measure and in determining the conditions to be applied to a measure. It also receives regular reports (through the Supervisory Magistrate) on the behaviour of probationers, decides on the period of imprisonment to be served where the conditions attached to a community measure are breached, may suspend the execution of a sentence of imprisonment and replace it with a community measure and assesses whether a prisoner qualifies for early release or release from debt.

- For juvenile offenders, various centres which act as Induction Centres (Centro Prima Accoglìènza) have a role to play, again, often working with other services and professions in order that the offender might receive the most appropriate interventions.

- Also for juvenile offenders, the social service for young people is involved and for drug using young offenders its role is similar to that of the social work section of the Ministry of Justice. In this case, however, they also have a role to play in working with educational services where the young person is still of compulsory school age.

20. WOMEN, CHILDREN AND DRUG USE

20.1. THE HISTORICAL AND CULTURAL BACKGROUND

20.1.1. As has been noted earlier in this report, their are significant differences between northern and southern Italy. the northern Regions of Italy have moved towards a more 'European' culture based more on the nuclear family and with higher proportions of people living alone. They include the richest Regions of Italy and per capita income is significantly higher than that for the southern Regions. These Regions have also seen the development of a more specific 'youth culture', which is perhaps reflected in the higher levels of synthetic drug use. In these Regions gender equality is relatively well developed, although there are differences between social classes in the expression of this increased equality. Historically, women have always tended to represent a higher proportion of the drug using population in treatment in these Regions. It should, however, be noted that some Regions are much more rural, with relatively small populations and they have their own distinct characteristics.

20.1.2. The central Regions may be divided into two. The Regions of Tuscany and Lazio in the west have greater similarities to the northern Regions. They also attract large numbers of tourists throughout the year. To this extent they have developed a 'European' culture with strong international influences. This is reflected in the patterns of service provision with greater attention being paid to the specific needs of women drug users, especially those with child care responsibilities. At the same time, family involvement in both prevention and treatment services remains strong. The eastern Regions, on the other hand, have greater similarities with the southern Regions of Italy.

20.1.3. The southern Regions of Italy are the poorest with relatively low levels of per capita income. Broadly expressed, they reflect a popular image of Italy with extended families, a male centred culture in which male and female roles are clearly delineated and close knit communities which are capable of being highly supportive but also capable of intolerance of difference. Youth culture as such has not developed significantly and drug use has remained largely with traditional drugs such as heroin and cocaine. In some of the Regions there has also been established criminal organisations which have had an involvement in drug trafficking. For the south eastern Regions in recent years, there has been a high level of illegal immigration, mainly from the Balkan countries. There are some indications that they may also now be involved in criminal organisations. Together, these factors have focused demand reduction activities on more traditional prevention and treatment interventions with a high family involvement. They may also have led to a more cautious approach to innovations. In these Regions, women drug users are significantly less present in treatment services than in the northern Regions. This almost certainly represents an accurate picture of less female drug use in these Regions. The cultural traditions of the Regions may well offer a protective, or at least dissuasive factor for female drug use. On the other hand, these traditions might lead to a masking of true levels of female drug use and it is possible that female drug users often leave the Regions when drug problems start to develop.

20.2. TRENDS IN DRUG USE BY WOMEN

20.2.3. Throughout this report comparative trends between male and female drug users have been identified. This section will, therefore, bring together this material.

20.2.4. As has already been noted, information on patterns of drug use within the general population is limited within Italy. There are, however, a number of local surveys which give some broad indications.

20.2.5. The study conducted in Rome by the National Health Institute [6] found that 34% of female students between the ages of 14 and 19 had used drugs compared to 44% of male students, with the proportion of users rising with age. This study also found that around 31% of the young people smoked, with an equal percentage of males and females smoking although young women smoked fewer cigarettes than men (10 a day for women, 15 a day for men). With regard to alcohol consumption, 65% of young women and 77% of young men drank alcohol but whereas the quantity consumed rose with age amongst young men it remained constant with young women.

20.2.6. In terms of treatment demands, although the numbers are small, 31% of first treatment demands by people 15 or under are from women and 27.5% of all treatments for people 15 or under are from women. For both first treatment and all treatment demands, 1 in 5 treatment demands from people in the age range 15 - 19 came from women. For all other age ranges, women represent 1 in 8 of all first treatment demands and around 13% of all treatment demands.

20.2.7. There are very substantial differences in the male to female ratio of treatment demands between the regions of Italy and between different types of service. In the southern regions, based on data from the Ser.T, the ratio ranges from 10.1 males to each female up to 15.9 males to each female and the trend over the last five years has been for this gap to increase. In the northern and central regions, the ratio is between 3.7 males to each female and 8.7 males to each female with the average ratio being around 5:1. In the socio-rehabilative services, residential provision largely reflects the national ratio of 6.3:1, whilst for semi-residential services the ratio is 5.3:1 and for day services it is 3.7:1.

20.2.8. There may be several explanations for these substantial differences and it likely that the best one is that there are a combination of factors. The north/south difference may to some extent reflect cultural differences with the south reflecting a more traditional culture with expectations about the role and behaviour of men and women. In such settings, transgressions of the cultural norms by women are discouraged and this may act as a deterrent from seeking help with a drug-related problem until it is an established problem. By contrast, the northern regions tend to have adopted more general European culture and a more open attitude to gender equality. A second factor may be that, based on the available data, the drug use of women tends to have a different pattern to that of men. Where heroin is the main primary drug for men, women drug users have higher usage of a range of other drugs such as cocaine, cannabis and pharmaceutical drugs. Treatment services tend to be focused on

opiate users and to this extent may be male oriented in their provision to the exclusion of women drug users who might benefit from their services. The low male:female ratio in ambulatory services suggests that these may well provide interventions which are viewed as more appropriate by female drug users. There are regional differences in the provision of these services, with over 50% being based in just 6 northern regions, 20% in the four central regions and 30% in the 8 southern regions and the islands. It is the case, however, that where there are significant numbers of ambulatory services, no matter where in the country, that the ratio of male to female drug users is better (in many cases substantially better) than that for the Ser.T.

20.2.9. In terms of infectious diseases, the overall trend for HIV infection has been for a decreasing percentage of all those tested to be found HIV positive. However, the percentage of female drug users tested and found HIV positive is higher than for male drug users. From 1993 there has been a steady decline in positive results for both male and female users, with a sharp decline in female users in 1997 but an increase in 1998.

20.2.10. There is virtually no difference in the percentage of Hepatitis B infection between male and female users tested and the general tend has been a decline in infections. However, as for HIV infection, there was an increase in 1998 and it is too early to say whether this is continuing.

20.2.11. For Hepatitis C infection, figures are only available for 1997 and 1998. The overall trend is upwards and there was a sharp rise in the percentage of female drug users found to be Hepatitis C infected compared to male drug users.

20.2.12. In terms of direct drug-related deaths, the percentage of deaths of female drug users has ranged between 7 and 12% of all such recorded deaths over the last 8 years. This would suggest that, in general, there is a lower mortality rate amongst female drug users than amongst male drug users. However, it should be noted that in 1998 there was a 25% increase in the deaths of female drug users. Female drug user deaths represented 10.3% of all direct drug-related deaths, a rise from 7.6% in 1997. Moreover, figures are not available for indirect drug-related deaths at present. Given the higher levels of HIV infection amongst female drug users it would not, therefore, be surprising to find that they represent a higher percentage of these deaths.

20.2.13. From the available data, women drug users appear to be much less likely than male drug users to be referred for unlawful possession of a controlled drug, to be referred to the Judicial Authority for a criminal drug offence or to receive a custodial sentence for an offence committed whilst a drug user.

20.3. IDENTIFIED CHARACTERSISTICS OF WOMEN DRUG USERS

20.3.3. The most substantial information on women drug users comes from research undertaken by IREFREA, by the ASL Centro Sud of Bolzano and from reports published by the Region of Emilia-Romagna. A qualification which must be attached to both these studies is that they were conducted

in northern Italy. They may, therefore, not be representative of the whole of Italy as northern Italy has the best male:female ratio in the country and has significant social and cultural differences from central and, in particular, southern Italy.

20.3.4. The IREFREA research [7] was conducted in five countries (France, Germany, Italy, Portugal and Spain) and the report published in Italy contains an analysis of the data collected within Italy.

20.3.5. In the study, three elements were identified as of considerable importance for the initiation into and continuation of drug misuse: the relationship with the family of origin and with the partner; prostitution and; HIV infection and other sexually transmitted diseases.

20.3.6. 80 drug using women were recruited to the study, 40 who had children and 40 without children. 68 of the women were resident in therapeutic communities and the remainder were in treatment in ambulatory or public services. All had been in treatment for at least 6 months and were between the ages of 19 and 40 with a median age of 27.9.

20.3.7. The research explored eight specific areas: education, employment; drug use; relationships; motherhood; offending; health and; the family. A minority failed to complete compulsory schooling whilst the majority completed compulsory schooling. The average age for ending school was 15.3 years and the most common reason was drug use. In interviews with the drug users it emerged that they were or felt marginalised or discriminated against by the other pupils.

20.3.8. In the 6 months prior to treatment most of the women were unemployed or had a part time job. Most commonly they were engaged in manual work and drifted between periods of employment and unemployment. This pattern was linked to their patterns of drug use.

20.3.9. In terms of drug use, the median age for drug use initiation was 16. In the vast majority of cases the drugs first used were legal drugs. This was followed by cannabis. Problem drug use was primarily with heroin followed by cocaine and the median age for problem drug use was 20. Alcohol misuse was commonly a link between drug experimentation and problem drug use. Initiation into drug use was associated with drug use by a partner or be a close friend. Around one third of the women, when they began problem drug use, injected drugs and some 59% inhaled. Over half of the women reported changing injection equipment occasionally and the number of women who never changed equipment exceeded the number of women who changed equipment frequently. This finding is of considerable importance and reflects the higher levels of HIV and Hepatitis C infection amongst women.

20.3.10. The research also found that almost half of the women had a history of suicide attempts, with a mean age of 19 for such attempts. In over half the cases recovery was made in a hospital. The level of suicide attempts was significantly higher for women than for men.

20.3.11. It was also found that the women in the study supported their drug use through employment but as problem drug use developed they became involved in criminal activity and prostitution. In a number of cases they were also dependent for financial support on their partner.

20.3.12. Nearly all the women were single, separated or divorced and lived either with their family of origin or with a partner. In only a few cases did they live alone.

20.3.13. When they were interviewed, most of the women had no current relationship. 39%, however, did have a partner and a stable relationship seemed to exist despite the problem drug use. In some cases the partner was also a drug user whilst in most of the other cases the partner has used drugs in the past. It was also noted that the problem drug use of the women followed a similar pattern to that of their partner.

20.3.14. In terms of sexual relations, there was a certain stability in the previous six months. However the use of contraception was irregular or was absent. 41% of the women stated that they has resorted to prostitution whilst they were misusing drugs.

20.3.15. Of the 40 women who were mothers, they had an average of 1.3 children with a mean age of 7.5 years. Only in 7 cases was the current partner the father of the child or children. The children for the most part lived with the mother or with grandparents and only in a few cases with foster parents.

20.3.16. One third of the women reported spontaneous or voluntary terminations. During pregnancy, almost half the women received methadone maintenance up to the seventh month of pregnancy. Most women also received some medical support during their pregnancy. A particular problem which was noted was proper and consistent use of medicines prescribed during pregnancy. 16% of births were by cesarean section and 16& were premature. No major complications were reported by the mothers but in 24% of cases the baby had initial withdrawal symptoms.

20.3.17. At the level of criminal behaviour, at the time of the interviews, only a few women reported that they had a criminal case pending. The most common crimes were drug law offences or theft. On average they had been sentenced to 3.6 years imprisonment but for the most part had benefited from alternative and substitutive measures. However, whilst in prison the vast majority did not have visits or meetings with their children and in no case did the children stay with the mother in prison. A quarter of the women reported that they had experienced discrimination in prison from both other prisoners and from the prison staff.

20.3.18. Over two-thirds of the women had physical health problems. 45% were infected with Hepatitis C, 18% were HIV infected and 9% were infected with Hepatitis B. Surprisingly, these levels of infection were below the national average for all drug users and below the percentage of infections amongst the general drug using population in their Regions.

20.3.19. In many cases frequent or sporadic episodes of maltreatment were reported. These were physical, mental and sexual and were most commonly committed by the father. Other perpetrators included the current partner, the mother, family members or friends and strangers. The maltreatment occurred when they were children and adolescents as well as when they were adults.

20.3.20. With regard to the family of origin, of the parents 90% of mothers and 69% of fathers were still alive and the majority were married. 16% of mothers and 30% of fathers had drug problems, most commonly alcohol abuse but also pharmaceuticals and for fathers 'hard' drugs. Mental disturbance was frequently reported in fathers and 13% had a criminal record.

20.3.21. On average the women had 2.5 brothers and sisters. 36% had drug problems and one third had problems of delinquency, mental disturbance or had attempted suicide.

20.3.22. The research conducted in Emilia-Romagna [8] was primarily concerned with the children of drug users and the relationship between the drug using parents and their children. This research is reported more fully in the next section. As far as information about women drug users is concerned, the data largely supports that obtained through the IREFREA research. This is not surprising as that research was in part conducted in the Region of Emilia-Romagna.

20.3.23. The research in Bolzano [9] largely confirmed the data gathered in the IREFREA study. It did, however, provide additional data on the children of drug misusers.

20.4. CHILDREN OF DRUG MISUSERS

20.4.3. The research conducted in Reggio Emilia was of a non-representative group of 33 children from 29 families whose parents were problem drug users and who were or had recently been in treatment with the Ser.T or had come to the notice of the Ser.T. It was a longitdudinal study over 2 years. The report contains detailed case reports for each of the children in the study. This section will, however, only reflect the overall findings of the study. The Bolzano research was a retrospective analysis of the case records of 653 clients which identified 180 children of drug users and 157 drug using parents.

20.4.4. For the Reggio Emilia study the children were considered in two groups, those who were 5 years old or under, representing 15% of the children and those who were over 5, representing 85% of the children. Of the under 5 year olds, 29% were under 1, 32% were between 1 and 3 years old and 39% were between 3 and 5 years old. 58% of the children were male and 42% female. Of the parents, almost half the mothers were between 25 and 29 years old and over a quarter were between 30 and 34. Over one third were manual workers, just under a quarter were unemployed and just under one fifth were housewives. Over 60% of the fathers were between the ages of 25 and 34 and 18% were between 35 and 39. 73% were either manual workers or tradesmen and 12% were

unemployed. It is noticeable that the mothers had attained a higher educational level than the fathers.

20.4.5. Almost half the children lived in a nuclear family structure, 9% in an extended family structure, 9% in a single parent family and 15% in a family structure consisting of the mother and another relative (most commonly grandparents). A more detailed analysis of the family setting was undertaken to assess the quality of the structure and this found important qualitative differences between families classified as living in a similar family structure. Conflicts within the family and with previous partners, limited or inconsistent parenting skills and a range of other problems created instability within the family with serious implications for the development of the child.

20.4.6. During the research period observations were made of the health of the children. It was noted that the children were well dressed and cared for and their physical health was good. One child was infected with Hepatitis C and was receiving treatment and one child was HIV positive, but was negative at a subsequent interview. Whilst all the children had normal childhood illnesses, their general health remained good at the second and third interviews. However, an examination of their medical histories found that 23 children had illnesses which could be related to the drug use of their parents. 2 were infected with Hepatitis, 1 had a duodenal ulcer, 3 had jaundice, 2 experienced abstinence syndrome at birth, 2 had dermatitis, 8 had respiratory problems, 3 were HIV positive (although one became negative later) and 2 had cardovascular problems.

20.4.7. Almost half the children experienced problems with sleeping, either being unable to sleep properly, talking in their sleep, having nightmares or disturbed sleep and the like.

20.4.8. 64% of the mothers breast fed their children whilst most of the remaining mothers relied on bottle feeding because of their own health circumstances (infected with Hepatitis or HIV). Information from paediatricians caring for the children indicated that there were no feeding problems and no problems arising from dietary changes as the children moved from liquid to solid feeding. Other aspects of early childhood development showed no significant differences from the development of children whose parents were not drug users. Moreover, the very young age of the majority of children in the study made detailed assessment more difficult.

20.4.9. When the various aspects of early childhood development were examined together and an overall assessment made, 8 children (24%) showed no particular problems, 10 (30%) had some problems and 13 (39%) had serious problems. This was an important finding because if single items were examined in isolation a substantially different picture of early childhood problems emerged.

20.4.10. Pregnancy was an unplanned event in almost 60% of the cases. The birth of the baby, however, affected the relations of the parents, more often in a positive way, in almost two thirds of cases. Between the start and the end of the study the parents reported an improvement in their

relations with their children and had an increased concern for their future life.

20.4.11. Cross correlation between family relations and the condition of the child found that there was a clear link between these two elements. In 24% of cases where there were adequate family relations and 27% of children had no problems; in 33% of cases family relations were only partially adequate and 27% of children had some problems; in 36% of cases family relations were inadequate and 39% of children had serious problems.

20.4.12. In bringing up the children, there was a very positive development. On the birth of the child the family of origin, which had been considerably distanced, came back into contact and in particular the grandparents provided help and support in child rearing.

20.4.13. The drug using parents in the study were already in treatment, mostly with the Ser.T. This was not, however, the only service involved. 58% were also involved with at least one other service. With regard to the children, there was involvement from other services in only 27% of cases. The type of help offered to the family was in over 50% of cases psychological, followed by help with relationships (18%) and economic help (16%). In general, the help offered was considered adequate (73%) but almost one fifth considered it to be of no help.

20.4.14. The Bolzano study provided valuable additional data. Of the drug using parents, 63% were male and 37% were female. There was a considerable age spread in the children with 23% between 0 - 3 years, 17% between 4 and 6, 19% between 7 and 10, 11% between 11 and 13, 12% each for the ages 14 - 18 and over 19 and the age of 7% of the children was not known.

20.4.15. For 39% of the children both the parents were drug users, in 10% of cases only the mother was a drug user and in 15% of cases the mother was a drug user but the drug use status of the father was not known.

20.4.16. 31% of the children lived with the mother alone and 23% lived in a nuclear family group. The mother was a drug user for just over a quarter of the children living with their mother alone. For over two thirds of the children they were either unknown to social services or the information about such contact was not recorded.

20.4.17. The research provides interesting information on the role and decisions of the Tribunale dei Minori with regard to the children of drug using parents. In 31% of cases, no action was taken and in 36% of cases the information was not recorded. Of the remainder, in 7% of cases the child was placed with foster parents or placed for adoption and in a further 11% of cases the Tribunale placed specific controls on the parents for the safety of the child. 11% of children were fostered with another family member and 6% were placed in a children's home. Interestingly, over 50% of the children experienced time in treatment or in a therapeutic community either with both parents or with the father alone whilst only just

over a quarter experienced such treatment with both parents or with the mother alone.

20.4.18. The final piece of information from this research which is of interest concerns the mortality of the drug using parents. One father and 6 mothers had died as a result of overdose, suicide or homicide. This is clearly a higher death rate than amongst the general population. Moreover, 13 of the mothers, 14 of the fathers were HIV positive and in a further 6 cases both parents were HIV positive. These figures have considerable implications both for the future of the child and for the care of the parents.

20.5. TARGETED INITIATIVES

20.5.1. As has already been indicated in the report, targeted initiatives aimed at women, women drug users or children of drug users are relatively uncommon. The research which has been undertaken by IREFREA and in Reggio Emilia has helped to highlight a number of areas which might be addressed by future actions. The information available from completed local studies have already highlighted some additional issues relevant to prevention and the major school survey which is due to be reported shortly should provide further information which can guide prevention policy and practice.

20.5.2. PREVENTION

20.5.2.1. Prevention programmes have generally targeted broad populations and there is little material specifically designed for women. This situation is beginning to change with a number of local programmes being initiated. These are, however, still in their early stages and no substantial information on their activities is currently available.

20.5.2.2. For the children of drug using parents, the research detailed above indicated that these children were at particular risk to drug use or other problem behaviours. Evidence on the family background of the women drug users and of drug using parents suggested that they themselves came from families with a range of problems.

20.5.2.3. The school based prevention programmes referred to earlier in this report have sought to provide specific support to these children through the general prevention programmes but also through the Centres of Information and Consultation. There is otherwise no detailed information available about specific, targeted prevention programmes. A careful balance has to be found between identifying such children and given them specific support and raisin their profile within the school setting which might increase their marginalisation from their fellow pupils.

20.5.2.4. In the Veneto Region, a collaboration between several services has led to the development of SOFAR, a service designed to work with families at high risk because of drug use. Its primary objectives are to: assess the resources available for effectively carrying out the maternal functions; support maternal attitudes and competencies for

bringing up children; enhance the emancipation and autonomy of women through the collaborative working, including facilitating the re-entry into the work and social environment of young woman with children. Its preventive functions, therefore, are to offer early intervention and support for pregnant drug users and drug using mothers in order that they might avoid more acute drug problems developing, support and protection of the children whilst avoiding separation from the mother and improvement of the women's self-perception and her capacity to assume responsibility for her own life.

20.5.3. TREATMENT

20.5.3.1. Programmes specifically designed to work with women drug users who have children and with drug using parents are predominantly in the northern Regions of Italy. The main Regions where such services can be found are Emilia-Romagna, Lazio, Piemonte, Toscana and Veneto [10].

20.5.3.2. A number of Ser.T, ambulatory services and therapeutic communities have had a particular focus on the needs of women drug users, especially those who were mothers. In some cases they have had an even more specific focus, for instance, immigrant sex workers, AIDS and drug use.

20.5.3.3. All the services work in close collaboration with the social services for adults and for minors and with other public services as required, for instance, paediatricians, schools, and the like. Within the non-residential services, and where one or both of the parents is a drug user, this may take the form of shared care to monitor both the parents and the child. In the residential services, where the mother is in treatment accompanied by her child, this collaboration is based on case review whilst the care is largely entrusted to the residential service.

20.5.3.4. Several services have sought to provide complete family care where the drug using parents, and any children which they have are all involved in the treatment programme. The aim of these services has been to provide treatment for the drug problem, to assist the parents to improve their parenting skills and to provide support for the child.

20.5.3.5. A problem which has been noted is that where both parents are drug users, if the male partner abandons treatment the female partner is likely to leave treatment prematurely as well. To deal with this problem, particular attention has been paid to encouraging the women to develop self-confidence and to assert their individuality. They are then more in a position to make an independent decision about whether to continue treatment regardless of the decision of their partner.

20.5.3.6. A significant number of the women are single parents who have sole responsibility for the care of their child(ren). The involvement of the extended family has, therefore, been important to provide continued

support to the mother and child and in particular to provide some continuity of care to the child.

20.5.3.7. The staffing of the services normally includes, either full time, part time or on a contract for service, social workers, health workers, psychologists, adult and child psychiatrists, gynaecologists, paediatricians and educators.

20.5.3.8. The length of the programme is dependent upon the type of service which is being provided. In general, there is no difference in programme length from that provided in programmes for the general drug using population.

20.5.3.9. It has been difficult to identify programmes designed specifically for women who do not have child care responsibilities. Those residential services which have made provision for women with children also tend to have a higher proportion of women generally within their services. However, no clear documentation is available to provide information on how these services have modified from the generality of residential services to be more women centred.

20.5.3.10. As noted earlier, the ambulatory services tend to have a much better male to female ratio than any other type of service. It is not possible to make definitive statements about why this should be so, but a number of factors may be relevant.

20.5.3.11. The research indicates that the drug use of women tends to be slightly different than that of men, with a greater use of pharmaceutical preparations in addition to the more traditional illicit drugs. Ambulatory services, which are less involved with substitute prescribing, may therefore offer services which are more centred on the perceived emotional, social and psychological needs of women clients. These services also tend to focus upon particular target populations, for instance, female sex workers. To this extent they will inevitably have a higher number of women clients.

20.5.4. AFTER-CARE

20.5.4.1. All the treatment services referred to above have programmes for preparing their clients to re-enter the community. In general these are the same as those available to all clients of treatment and rehabilitation services. The main difference is the continued involvement of child protection and care services after treatment has been completed to monitor the situation, especially for the child. This has a benefit in that it can allow rapid intervention and support should there be a relapse. On the other hand, the research referred to above shows that these services are only engaged in less than half of the known cases of children with drug using parent(s).

20.5.4.2. A number of services have been specifically developed to support the re-insertion of women, including those with children, into the work and social environment. One example is Progetto Arianna in the Veneto Region. This again is a collaborative project involving a

number of services. It is provided to mothers who have completed a treatment programme and to women who want help and support but who do not want to enter a residential programme. The services offered include:

- A stable reference point for women when they are re-entering the community
- A network of services working together to assist and support the re-integration of women who have or have had drug problems
- Provision of a data bank about the available social, employment and training resources
- Provision of consultation and orientation facility to provide information and assistance for re-insertion
- A monitoring programme and assessment service to re-enforce and strengthen competence and personal resources
- Practical assistance for specific problems such as sero-positivity, health problems and legal problems

20.5.4.3. Some or all of these services may be offered by other treatment and rehabilitation organisations. Detailed information on their work with regard to this specific area is not at present available, only more general information about the provision of after care and support on completion of treatment.

20.6. CONCLUSIONS

20.6.2. From local surveys conducted in recent years there are indications of a higher level of drug use by women than is represented by the number of women in treatment with the Ser.T. The patterns of drug use, of both legal and illegal substances, suggests that there may be a further increase in the number of women seeking treatment for drug problems in the future.

20.6.3. There are significant differences between the Regions of Italy in terms of the number of women seeking treatment and the male to female ration of drug users in treatment. This reflects to a large extent cultural patterns and the differential changes in culture between the Regions. However, female drug use may be more hidden in the southern Regions and may therefore be much slower to emerge as an explicit problem.

20.6.4. Ambulatory services appear to be more appropriate and responsive to the needs of women drug users. There are several possible reasons including that these services also often provide outreach services and work with specific populations such as prostitutes, that they have a greater focus on psycho-social services and they have more focus on practical assistance at the social, health, economic and employment levels.

20.6.5. The main targeted initiatives have been towards women drug users with children and children with one or both parents who are drug users. There is less evidence of targeted initiatives towards women drug users without

children. However, most of the women and children services have also attracted women drug users because they are seen as more sensitive to the needs of women. It may be assumed, therefore, that dedicated services have a greater likelihood of attracting the relatively hidden population of female drug users into treatment.

20.6.6. Interventions for female drug users with children are continuing to develop and have, at least in northern Italy, become part of the established pattern of services. Interventions for female drug users generally are less developed and there may be a need to explore ways in which existing services might be adapted to meet the needs more effectively of this particular population.

PART VI

CONCLUSIONS

21. MAIN ISSUES AND FUTURE INFORMATION NEEDS

21.5. SUMMARY OF MAIN POINTS, KEY TRENDS AND NEW DEVELOPMENTS

21.5.2. Drug use and misuse continues to be an area of serious concern within Italy. A small number of local surveys, preliminary information from a major schools survey and observations from a range of community based services suggests that drug use is widespread and shows no immediate signs of diminishing.

21.5.3. Changing patterns of youth behaviour in the use of tobacco and alcohol are a matter of some concern. The evidence suggests that early use of these substances, especially outside the traditional cultural patterns for the use of alcohol, are an indicator of likely experimentation with other drugs.

21.5.4. The number of people referred for administrative sanctions having been found in possession of 'personal' quantities of controlled drugs has continued to increase, with a peak age in the 18-20 year old group for both males and females. This would also suggest high prevalence of drug consumption.

21.5.5. Cannabis remains the most prevalent drug. Although in the referral for drug possession heroin is the second most prevalent drug followed by cocaine, from the observations of 'dance' projects, this seems more to reflect police processes rather than the actual prevalence of particular types of drug use.

21.5.6. There appear to be significant geographical differences in prevalence and in the relative popularity of particular drugs. Northern Italy and the metropolitan central Regions tend to have a 'European' culture and a much higher prevalence of synthetic drug use. Southern Italy tends to have a more traditional culture in which cannabis, cocaine and heroin are more likely to be used and where the overall prevalence of drug use appears to be lower than for the northern and central Regions.

21.5.7. For the first time for many years there has been a slight decline in the number of people registered for treatment with the Ser.T. There was, however, a small increase in the number of first treatment demands. In general, the treatment population appears to be ageing whilst new treatment demands may be made at an earlier age. It is also possible that, as the number of people receiving long term treatment increases, fewer vacancies will arise in existing treatment services to accept new treatment demands. Overall, pharmacological treatment interventions have increased whilst psycho-social treatments have declined.

21.5.8. Injection remains the most prevalent form of problematic drug use. However, the levels of HIV and Hepatitis B infection amongst the drug dependent population has continued to fall. Hepatitis C infection has risen but the available data only covers a 2 year period and cannot be taken to

Indicate a particular trend. Clients already in treatment with the Ser.T have a much higher level of infection than new clients to the Ser.T. Women drug users have significantly higher levels of both HIV and Hepatitis C infection than men.

21.5.9. The substantial difference between the northern and southern Regions in the male to female ratio of drug users attending for treatment has widened even further. The high male to female ratio in the southern Regions may well be influenced by social and cultural factors and may not, therefore, fully reflect the true level of problematic drug use by women in these Regions.

21.5.10. The number of drug dependents referred to the Judicial Authority for criminal offences has risen although the number of drug dependents receiving a prison sentence has fallen slightly. There has continued to be a sharp increase in the number of non-Italian drug dependents received into prison. The prevalence of HIV infection amongst drug dependent non-Italian prisoners is considerably higher than that for drug dependent Italian prisoners and higher than that for drug dependents attending the Ser.T.

21.5.11. There has also been an increase in the number of drug using juvenile offenders, with over one third being habitual or daily users. This appears to reflect the findings of the limited data available from local surveys.

21.5.12. There is no clear pattern or trend for drug markets. Drug seizures continue to be substantial but there are continually changing patterns in supply routes and methods. Nationals of the Magreb countries remain the single largest group arrested for drug law offences after Italians.

21.5.13. The increasing prevalence of cocaine use, shown in local surveys, first and second preference drugs and from anecdotal evidence, is a cause for some concern. Equally worrying is the multiple use of drugs be drug experimenters and occasional users, most commonly the combination of alcohol and synthetic drugs.

21.5.14. The most significant development during the year has been the implementation of Law 45/99. This has released funds for demand reduction activities at both the national and local levels. It has also established a new National Drugs Observatory which includes the Reitox Focal Point.

21.5.15. There have been few major developments in the area of demand reduction during the reporting period. Many initiatives which have been proposed were held back pending implementation of 45/99.

21.5.16. There has continued to be an increase in the use of measures designed to divert drug dependent offenders away from custody and into treatment. However, there are difficulties in using these measures for non-Italians with the result that they are becoming an increasingly large group in the prison population.

21.6. NEW INFORMATION NEEDS AND PRIORITIES FOR THE FUTURE

21.6.1. The new National Drugs Observatory, advised by the Scientific Committee, is in the process of defining information needs and priorities. These will be included in the next report.

21.6.2. A number of important information gaps are now being addressed. The lack of any general population survey on drug use has meant that there has been no adequate base data from which to assess changes. Action is now being taken to rectify this situation. The epidemiology section of the National Observatory will also now be in a position to establish data collection on a standardised and annually comparable basis. The Ministry of Health is also undertaking work to improve treatment demand information from both public and private services using European standards. Finally, work is progressing to provide improved data on direct drug-related deaths and, for the first time, to develop data on indirect drug-related deaths.

21.6.3. As noted above, the National Observatory will establish its own priorities. This report has noted a number of areas where there is a lack of data and where further exploration is needed to understand certain trends. These include: closer examination of the factors influencing the very high male to female ratio of drug users in treatment, especially in the southern as compared to the northern regions; improved recording of ethnicity amongst drug users, both Italian and non-Italian; qualitative data from private/NGO treatment services in addition to quantitative data.

21.6.4. It is hoped that qualitative and quantitative data from services and projects financed through the National Drugs Fund will start to become available in late 2000. The plans for the development of the EDDRA system within Italy will greatly assist in focusing attention on monitoring and evaluation. This could, in the future have an important beneficial impact on the provision of data.

21.6.5. In conclusion, the arrangements in Italy are at present in the midst of substantial changes designed to improve co-ordination, data and the delivery of services. For 1999 this has meant inevitable delays and some degree of confusion whilst the exact arrangements have been finalised. For 2000 it is anticipated that the new system will be fully operational and in a position to provide information and data valuable for the development of national and local policy and practice and meeting the information needs of the EMCDDA and other international bodies.

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[10] The services which have been identified and for which documentation is available are:

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- Comunità terapeutica "Luna Stellata", Centro di Solidarietà Sociale di Piacenza (Emilia-Romagna)
- Comunità terapeutica "Virginia Woolf", Cooperativa "Il Sorriso" di Imola (Emilia-Romagna)
- Ser.T di Reggio Emilia (Emilia-Romagna)
- Il Centro Madre e Bambino di Roma (Lazio)
- Fondazione Villa Maraini (Lazio)
- Gruppo Abele di Torino (Piemonte)
- CeIS di Pistoia (Toscana)
- Communità Incontro di Pistoia (Toscana)
- Villa Regina Mundi di Treviso (Veneto)
- Ser.T di Monselice (Veneto)
- Ser.T di Venezia (Veneto)
- Ser.T di Mestre (Veneto)
- Communità Terapeutica "Villa Renata" (Veneto)
- Communità Terapeutica "Progetto Aurora" (Veneto)
- Progetto Arianna" (Veneto)
- SOFAR (Servizio di Orientamento per Familglie ad Alto Rischio) (Veneto)