European Monitoring Centre for Drugs and Drug Addiction

Punto focale nazionale Reitox

2005 NATIONAL REPORT TO THE EMCDDA
by the Reitox National Focal Point

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

REITOX

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SUMMARY

Increase in the use of psychotropic substances in the general population and a reduced perception of the risks involved

Surveys taken among the general and school and youth populations show an increase in the use of illegal substances and a reduction in awareness of the dangers associated with drugs, particularly amongst the younger generation. Approximately one third of the young people interviewed are exposed to cannabis at least once, if not more, in the course of their lives.

The trend towards the use of cocaine and amphetamine derivatives

The past years (latest confirmation comes from studies carried out in 2004) have consistently shown an increase in the consumption of psycho-stimulants (cocaine and amphetamine derivatives). A significant amount of the drug is being consumed by today's youth starting already from a very early age.

Health and safety risks and problems with civil cohabitation caused by the widespread circulation of drugs

Although the current data indicates a drop in the recourse of the youngest generation to opiates (heroin), the increase in the number of consumers who use cannabis, cocaine or other drugs simultaneously, and who, in an ever larger percentage, move from periodic use to regular use, allows us to forecast serious repercussions for the psycho-physical health of Italy's citizens regarding their safety and civil cohabitation.

Exposure of youth to drugs: risk and protective factors

An important part of the Report provides data regarding the use of illegal psychotropic substances by the age bracket comprising adolescents to early adults. The data shows that exposure to drugs happens very early, is correlated to previous experiences with legal substances like nicotine and alcohol and that a substantial investment must be made in prevention campaigns aimed at young people. In particular, the fact that a significant number of adolescents between the ages of fourteen and sixteen have already experimented with cocaine indicates to what degree young people's expectations with regard to drugs have changed, what risks may be looming on the horizon during the course of their youth and how these new elements must be considered in the outlining of prevention operations.

The correlations revealed in a sample study of a group of students demonstrate the importance of involvement in school work and academic success as protective factors and indications of adolescent well being. School attendance up until the age of eighteen seems to play a decisive role in reducing the exposure to illegal psychotropic substances.

The data would appear to emphasise the importance of appropriate strategies for early detection of conditions of psycho-social unease, trauma and negligence that lead to a higher percentage of school drop-outs, in turn associated with lower self-esteem, the inability to plan for the future and a weakening in the sense of belonging to a family or a pro-social institution.

Parent involvement in children's lives, with proper supervision, is an important prevention factor. To this end, an extensive tutoring program aimed at the family through the school, the media and strategies sustained by local organisations, could help to reduce young people's use of illegal drugs. Increasing parental capacities, offering instruments for effective emotional communication and conveying drug associated risks and the need for intense parent child relationships would most certainly lead to an increase in adolescent unwillingness to experiment with drugs.

Risk factors recognised on an international level, such as aggressive behaviour, impulsiveness and the tendency to be involved in situations of conflict also emerged from the 2004 sample study carried out in Italy. These vulnerable minors and their families should not be left to make their way alone on the path through adolescence that has been leading an ever higher percentage of them to the use of illegal substances.

Importance of the relationship between Prefectures and Social health Services

The Police Force's reports to the Prefecture regarding the seizing of narcotics have been consistently increasing over the last years. These offer opportunities that must not be lost through the inattention of the Institutions as they allow contact to be established with a large number of consumers, including those who would not otherwise spontaneously turn to such Services. The increase in psycho-stimulant consumers highlights a change in the characteristics of the phenomenon and underlines the need to continue the implementation of collaborative programs between the Prefecture and Health Services in order to transform such judicial-administrative events into occasions to help and eventually deal with the situation at hand.

New challenges for public and private Services

The data presented in the Report clearly demonstrates the changes in the requests for treatment at public and private Services. Compared with the uniformity of patients who availed themselves of Ser.t. and other rehabilitation communities several years ago, the profile of the treatment request in 2004 indicates a consistent variability. More in depth research is necessary to determine the specific problem for which the young cannabis and amphetamine derivate users turn to the treatment centres. At the moment it is still difficult to understand if the recourse to Services is spurred by a general sense of malaise, a real addiction, psychiatric or relational disturbances or by simple concern on the part of the accompanying adults. On the other hand, the ever increasing amount of cocaine being used by patients appears to indicate another change in the demand for treatment at the Services. If we add the patients addicted primarily to cocaine to those who use it in conjunction with other drugs we see how approximately forty percent of the patients treated by the Services are in contact with psycho-stimulants.

Reorganisation of the Services: training, certifications and collaboration between the public and private centres

On the basis of this evidence, a substantial initiative should be taken to reorganize and update the Services. New training and certifications, a change in clinical and rehabilitative treatment paths and the use of new therapeutic tools, both in the psycho-social and pharmacological fields, are all essential in order to respond effectively to the new problems.

The network that counts over five hundred Drug Addiction Services and numerous private-social therapeutic-rehabilitative centres that is unique in Europe, should be accompanied in a major effort to become certified to use the new scientifically validated methodologies in order to develop a varied and well focused therapeutic solution. The Services created for the treatment of heroin addicts should elaborate complex strategies typical of modern clinics removed from all prejudicial positions. Different settings for different patients, special, non standardized rooms and facilities, personalised therapeutical treatments are all future goals for the institutions serving in this field.

In order to deal with this complexity, the public and private Services have to work together and unite their specific and individual skills, experiential resources and training opportunities and, in a functional whole characterised by equality, outline detailed therapeutic-rehabilitative solutions as mentioned above.

Psychiatric problems associated with disorders caused by substance abuse: joint efforts with the Mental Health Services

An ever higher incidence of psychiatric disorders associated with disturbances caused by substance abuse is requiring greater qualified input on the part of the private and public Services. These clinical conditions, in some cases pre-existing the drug abuse and in others caused by the drugs themselves, require a complex diagnostic-therapeutic approach that makes use of all the existing resources in conjunction with those of the Mental Health Departments. If a large number of drug addicted patients are affected by serious psychiatric disturbances or personality disorders, only through the application of specific interventions, integrated with the treatment of the addictive pathology can one achieve significant improvement in therapeutic efficiency.

The urgency of interventions for drug addicts in prisons

Despite the significant reduction in drug abuse amongst inmates, the percentage of drug addicts in the prison population is still very high. These patients require a specific rehabilitative approach that comprises, as much as possible, the application of alternatives to imprisonment and that offers the population within the penitentiaries the same treatment resources available to patients being

treated in Services outside the prison walls. In particular, an improvement in the clinical-rehabilitative conditions should be implemented for the younger inmates, those with the highest percentage of dramatic conditions related to feelings of psycho-social unease. These adolescents must be guaranteed a highly qualified relational approach within the Penal Institute, as well as an in depth diagnostic investigation and intensive support for their reinsertion within society, which should in turn reduce the incidence of relapses regarding deviant behaviour and the use of drugs.

The need for uniformity and quality guarantees in the prevention, treatment and rehabilitation operations

Still today, the organisational facilities that each Region has dedicated to dealing with the problem of prevention and treatment of drug addiction differ greatly from region to region. While still respecting the independence of the Regional Administrations in this regard, an extensive, constructive comparison should be undertaken in order to homogenise the prevention strategies, the diagnostic opportunities, the quality of the therapy and the efficiency of the reinsertion operations. To this end, a group project established by the various Regional administrations, in conjunction with the central State administrations, could offer suitable strategies for the supervision of the undertaking and guarantee conformity with the guidelines inherent in the “good practices”.

The Police Forces’ commitment to reducing drug availability

The Report offers a clear outline of the Police Forces’ intense and constant commitment to combating the trafficking of illegal drugs. The effort aimed at the reduction of drug availability takes on an essential synergic role with that of the reduction of demand. If, on the one hand a well focused prevention campaign and qualified interventions can contribute to combating the phenomenon, on the other hand, the commitment to reducing young people’s contact with illegal substances and to make their availability more difficult becomes itself an essential element of prevention. Being aware of the presence of institutions that reduce access to drugs in Italy through a solid battle against drug traffickers, strengthens citizens’ faith in a social condition that is not a slave to the world of drugs nor to the laws of the criminal organisations that traffic within it.

PART A NEW DEVELOPMENTS AND TRENDS

1. NATIONAL POLICIES AND CONTEXT

Overview

During 2004, by means of the Decree of the President of the Council of Ministers of 15 March 2004, concerning “Modifications to the Decree of the President of the Council of Ministers of 23 July 2002, setting out the regulation of the general structures of the Presidency of the Council of Ministers”, the National Department for Drugs Policy was included among the general executive organisation of the Presidency of the Council of Ministers; subsequently, with the Decree of the Vice-President of the Council of Ministers of 26 July 2004, the organisation of the National Department for Drugs Policywas arranged.

This organisation is aimed at the difficult work of coordinating the Government’s activities in this sector both in terms of the strategies to reduce drug supply and demand and the strategies in the field of drug addiction prevention and care. Great importance is also attached to the coordination of the central and local administrations in order to monitor the trend of the drug phenomenon in Italy and promote research in cooperation with research institutes and universities.

As for the legislative framework, the due bodies are still examining some review proposals for the legislation on illegal drugs and related drug addictions.

1.1 Legal framework

The legislative framework regarding illegal drug substances still consists of a consolidation act regulating narcotics and psychoactive drugs, prevention, cure and rehabilitation of addictions to them, approved by Presidential decree n.309 on October 9, 1990 and its subsequent amendments and regulatory measures that have complemented and defined the structure of the National Department for Drugs Policy (DNPA) in its organizational and functional aspects.

1.1.1. Drug-related laws, regulations, directives or guidelines

In 2004 the following legislative measures were issued:

- Decree of the President of the Council of Ministers dated March 15 2004, concerning "Modifications to the Decree of the President of the Council of Ministers dated July 23, 2002, relating to the Presidency of the Council of Ministers general structure." Through this the National Department for Drugs Policy became part of the Presidency of the Council of Ministers' general executive organisation;
- Decree of the Vice-President of the Council of Ministers dated May 31, 2004, stating "Administrative guidelines applicable to promotion and coordination policies adopted to prevent and combat the growth of drug and alcohol addictions", which identified the annual duties and objectives of the Department;
- Interministerial Decree of the Ministry of Labour and Social Policies in conjunction with the Ministry of the Economy and Finance, dated July 1, 2004 on distribution of the National Fund for Social policies, by which 14,000,000 euros was allocated to the Presidency of the Council of Ministers' National Department for Drugs Policy;
- Decree of the Vice-President of the Council of Ministers dated July 26, 2004, concerning the organization of the Presidency of the Council of Ministers National Department for Drugs Policy;
- Decree of the Ministry of Health dated November 17, 2004 by which the substance Amineptine was included in Table IV attached to the Consolidation Act regarding narcotic drugs.

1.1.2 Law implementation

During 2004 the approval process for Bill A.S. 2953 evolved as follows:

- In the early months of 2004 the Bill was examined technically by the permanent Conference on State Relations and the autonomous Regions and Provinces of Trento and Bolzano. At the close of these meetings, the Regions presented no document and reported their decision, unanimously adopted by the designated regional directors, to transfer to a political executive level examination of the Bill, declaring it "not amendable";
- In March 2004 the event at political level went unattended by the Regions due to conflicts with the Government. At that point, the Presidency of the Council of Ministers made the decision to send the Bill to Parliament;
- Also in March 2004, the competent office of the Presidency of the Council of Ministers, through the legislative coordination Office of the Ministry of Economy and Finance, sent the Bill to the accounting section of the same office for the prescribed seal of approval. The process concluded in May with the granting of the seal and with the subsequent communication of the adopted measure to the Presidency of the Republic for the President's signature;

- subsequently, with the participation of DNPA staff and the assigned Senate Office, the text of the Bill was drafted based on the “quality” parliamentary rules on “quality” set for regulatory acts;
- on May 10, 2004 the bill was presented to the Senate President and assigned the number 2953;
- In September of 2004, The Bill was assigned to the joint Senate Commissions of Justice (II) and Health and Hygiene (XII) and Sen. Flavio Tredese and Sen. Francesco Tirelli were named as the bill’s proponents;
- Towards the end of 2004, based on instructions from certain state agencies and independently by the Office itself, in order to correct the effect of other legal measures or because of the need to amend the regulatory measure because of some material errors encountered, more than 60 amendments to the bill were sent to the proponents.
- The same Joint Commission also pursued, together with examination of Bill n. 2953, a comparison with other similar measures revising regulations in the area of narcotic substances and their relative addictions presented during the X!V legislature:
- Bill n. 44 dated May 31, 2001
- Bill n. 488 dated July 17, 2001
- Bill n. 987 dated December 20, 2001
- Bill n. 1113 dated February 7, 2002
- Bill 1322 dated April 10, 2002
- Bill 2599 dated November 24, 2003 and Bill 2922 as dated April 27, 2004
- Bill 2985 dated June 14, 2004

1.2 Institutional framework, strategies and policies

1.2.1 Coordination

Organization of the National Department for Drugs Policy, which occurred in 2004, was aimed at a major effort to coordinate the Government’s activities in this field. Bringing together the efforts of all central agencies in implementing strategies aimed at reducing drug supply and demand involves creating a dense inter-institutional network capable of producing synergies and avoiding overlap. Similarly, inspiring Regional governments to draft more homogeneous and professional guidelines for intervention in the field of addiction prevention and treatment is the National Department’s basic task. While respecting the Regions’ autonomy, the newly formed coordination structure will be able to contribute to liaison and reflection on the Regions’ part for the purpose of ensuring professional intervention for drug addicts and their families throughout the country. An intense effort in the area of monitoring the phenomenon and promoting research is also part of the Department’s functions, in collaboration with the CNR, the National Institute of Health and some Universities. In accordance with Italy’s choices, the International Narcotics Control Board, a UN body assigned to monitor application of international agreements on drugs, suggests that a coordinating structure not located in a single government agency but with a trans-disciplinary reach, may be the best way to combat the phenomenon.

1.2.2 National plan and strategies

In 2004, significant progress was made in procedures for closing out the National Plan of action in the field of prevention of narcotic and psychoactive drug abuse, combating illicit trafficking, medical treatment, and social reintegration of drug addicts (2004-2008).

The aforementioned document prepared by the National Department for Drugs Policy, with the support of the Scientific Committee of the Italian Drug and Addictions Observatory, and based on the information provided by all competent government agencies, was approved by the National Coordinating Committee for anti-drug action on March 12, 2003.

The national planning document's aim is, among other things, in compliance with current constitutional approaches and institutional jurisdiction, to direct the efforts of the various interested public and private subjects so that, in close collaboration with one another, they can implement a series of convergent measures aimed at developing a modern system for promoting and protecting health, keeping in mind and developing the various prevention, recovery and reintegration methods.

To comply with the principle of due collaboration with the Regions and the Autonomous Provinces of Trento and Bolzano, and in order to develop a coordinated and integrated system of measures nationwide, the plan, after approval by the government with regard to that part of it over which it has jurisdiction, was examined by the Region representatives charged with examining and probing the parts of greatest interest to them. These activities took most of the year and at the moment are pending ratification by the State-Region Conference of the updated draft prepared following meetings between Region representatives and the DNPA.

Although the Plan will be considered approved only after this last phase, it does however represent the Italian Government's tangible effort to implement an organic, effective and consistent strategy in combating the phenomenon of drug addiction.

1.3 Budget and public expenditure

It is very difficult to determine the overall expenditure for all activities relating to the drug addiction phenomenon.

It is only possible to indicate a few expenditures regarding specific areas.

1.3.1 Budget and public spending for health and social services, coordination, national strategies and international efforts

Spending for assistance by the National Health Fund is distributed between hospital assistance on one hand and regional assistance, semi-residential assistance and residential assistance on the other. While it is impossible to quantify hospital assistance, the General Programming Office of the Ministry of Health has data regarding the Essential Levels of Assistance (LEA), i.e., regional assistance (outpatient clinics and home care), semi-residential and residential assistance. The last figures available refer to 2003 and are broken down as follows:

Regional assistance (outpatient clinics and home care)	Euro 480,797,000.00
Semi-residential assistance	Euro 111,790,000.00
Residential assistance	Euro 191,191,000.00
Total	Euro 783,778,000.00

The numbers are provided by each Region and autonomous province through special forms sent to the National Health information System.

The Juvenile Justice Department of the Justice Ministry has surveyed the expenses incurred by the Juvenile Justice Centres in 2004, for the placement of juvenile narcotics users in rehabilitation centres.

Correction facilities	Sums committed and spent in Euro	Number of drug abusing minors in rehab centres
Turin	7,635.00	3
Milan	150,981.89	*17
Venice	172,837.74	32
Bologna	280,257.48	36
Florence	17,662.80	4
Rome	61,960.92	5
Naples	116,011.67	20
Bari	0	**2
Catanzaro	3,284.94	1
Cagliari	15,307.92	2
Palermo	0	**1
TOTAL	825,940.36	

* including 3 covered by the ASL (Local Health Agency)
** covered by ASL

In 2004 as in 2003, because of the Budget (Law n. 289/1992, art. 46, comma 1), the funds allocated to the Regions for social policies were released "without a binding destination." Therefore, the Regions received from those endowments resources intended to the fight drug addiction in the form of prevention and rehabilitation projects. Specifically, the resources paid out to the Regions for social policies totalled € 1,000,000,000.00

The Presidential Decree dated October 11, 2004, provided for an increase in the President's estimated 2004 budget in terms of jurisdiction and availability, C.R. 1 "General Secretary" – 1.1.1.6 "Human resources and organization" – Cap.183 "Expenditures for the National Department for Drugs Policy functions," of Euro 14,000,000.00.

Internationally, the Foreign Affairs Ministry (MAE)through its Directorate General for Cooperation in Development (DGCS), contributes to anti-drug programmes on several fronts:

› multilaterally, through voluntary contributions to the UNODC, which in 2004 received 9,000,000 Euro; 35% of this contribution is intended for general resources and is therefore freely utilised by the organisation. The remaining 65% is directed towards financing UNODC activities with MAE approval, based on geographic and topical criteria and priorities;

› multi-bilaterally, through funding for the DGCS regional offices and international organisations. In 2004 two projects were carried out in Peru, "Conservation of Native Cultures", through the UNDP (Euro 929,622) and "Management of the Tambopata-Inambari basin system and environmental conservation", with IUCN (Euro 2,426,049). Another project on a regional scale (Peru, Bolivia, Colombia and Ecuador) was launched called "Assistance in the fight against corruption and drug trafficking" assigned to the UNICRI (Euro 258.565).

The following projects are being carried out with Italian NGOs:

› BOLIVIA: "Social and health integration among the Young of La Paz" (Executive NGO: Italian Solidarity Centre, CIES, Euro 464,811)

› EAST JERUSALEM: "Combating drug addiction and social promotion of the Jerusalem youth population" (Executive NGO: PROSVIL, Euro 179,706)

1.3.2 Funding arrangements

The following Graph illustrates the Regional distribution of funds. The numbers refer to 2004. with regard to five Regions (Emilia Romagna, Lombardia, Puglia, Tuscany and Sicily), the sums shown are those "spent" in 2003, since the Health Agencies' budgets for 2004, as of April 30, 2005, were still being approved.

	Regional services			Rehabilitation centres			collateral destined to drugs from National Fund for Social Policies	
	2003	2004		2003	2004		2004	
	Sums spent €	Sums employed €	Sums spent €	Sums spent €	Sums employed €	Sums spent €	Sums employed €	Sums spent €
Abruzzo	-	*	*	**-**	*	*	1.000.000,00	**
Basilicata	-	3.576.568,12	3.830.201,78	-	1.016.848,84	1.139.225,18	327.106,06	327.106,06
Calabria	-	220.365,00	220.365,00	-	4.029.188,70	4.029.188,70	5.760.769,94	***
Campania (1)	-	47.629.000,00	47.629.000,00	-	10.137.837,00	10.137.837,00	38.721.725,00	11.460.459,00
Emilia Romagna (2)	**39.789.894,00**	-	-	**11.429.106,00**	-	-	4.594.144,00	***236.959,00
Friuli Venezia Giulia	-	**	**	**-**	**	**	5.095.413,23	3.057.247,92
Lazio	-	*	*	**-**	**	**	2.963.852,00	2.074.696,40
Liguria	-	**	22.192.801,00	-	**	8.715.668 ,00	1.200.000 ,00	1.200.000,00
Lombardy (3)	**58.772.527,00**	-	-	**22.146.063,00**	-	-	11.717.058,04	13.850.022,30
Marches (4)	-	9.910.101,00	9.910.101,00	**-**	2.083.087,40	2.083.087,40	1.690.000,00	1.690.000,00
Molise	-	**	**	**-**	**	**	**	**
Piedmont (5)	-	42.113.370,00	43.568.200,00	-	28.572.540,00	35.765.850,00	730.233,58	730.233,58
Bolzano Aut. Prov.	-	1.876.144,62	1.876.144,62	-	3.277.586,99	3.277.586,99	940.000,00	470.000,00
Trento Aut. Prov.	-	9.068.558,00	10.381.804,00	-	1.478.481,00	2.159.796,01	**	**
Apulia (6)	**31.871.000,00**	-	-	**16.382.000,00**	-	-	3.763.878,49	3.763.878,49
Sardinia	-	*	11.622.400,00	-	*	4.533.117,00	1.754.600,12	1.234.166,93
Sicily	**	-	-	**3.475.528,01**	-	-	**	**
Tuscany (7)	**44.876.000,00**	-	-	**10.783.000,00**	-	-	631.000,00	*
Umbria (8)	-	7.562.333,08	7.791.134,20	-	3.759.288,25	3.681.662,14	1.232.069,32	1.232.069,32
Valle D'Aosta	-	1.378.286,00	1.314.382,00	-	1.086.893,67	1.086.893,67	150.000,00	****
Veneto	-	45.198.553,00	45.198.553,00	-	17.000.000,00	16.628.525,70	8.056.348,04	8.056.348,04

* Not surveyed
** Not received
*** Being distributed
**** Under examination
(1) The "sums committed" in the "Funds" relate to the three-year period 1997/1999 – 2000 – 2001 of the National Anti-Drug Fund.
(2) "Funds assigned to drugs": includes the amount transferred to local bodies for this area and the financing of experimental projects by Region.
(3) "Funds assigned to drugs": "sums spent" refer to 2004, as activity, with 2003 funding, allotted under DGR n. 7/15452 dated 5.12.2003. "Sums committed" refers to the Social Policies Fund amount allocated under DGR n. 7/17997 dated 23.12.2004.
(4) "Regional services": these are estimated figures, pending approval in agency budget consultations (provided by the audit office of the Department for Services to the Individual and the Community). As for "Rehabilitation centres," costs refer to the 1st semester 2004.
(5) With regard to "sums committed" in "regional services" and "rehabilitation centres" the numbers refer to the estimated budget. As for "sums spent" in "regional services" and "rehabilitation centres," the figures are pre-final. The "sums committed" in funds allocated to drugs refer to fiscal years 2000 - 2001. D.G.R. n. 113/13294 dated 3.8.2004, regarding "distribution of the national intervention fund in the war against drugs transferred to the Piedmont Region, fiscal years 2002-2003. Approval of criteria for and methods of allocation,"

approved the tender for distribution of € 15,230,624.00 (fiscal years 2002-2003). The aforementioned funds have not yet been assigned, since the projects presented are still being evaluated.
(6) With regard to the item "Funds allocated to drugs by the National Fund for Social Policies", the figures shown refer to the sums committed and spent in fiscal 2004 but referring to previous fiscal years.

(7) The Tuscany Region approved experimental and/or innovative projects of regional interest, still being carried out, using funds from the Regional Health Fund and from the Regional Initiative Programme "Social-Health Integration and Goal Projects." when L. 328/2000 took effect, the Tuscany Region, by approving the 2002-2004 regional integrated social Plan identified those areas of priority for its use, including addictions, and issued directives to the social and health areas for approval of the anti-drug projects presented. To date, not all Social Area Plans – fiscal 2004 – have been approved by the mayors' area conferences; for this reason it is not possible to provide information regarding the resources used and the plans implemented.(8) With regard to the "sums" of "Regional Services" the data from three Local Health Agencies (ASL) have not been surveyed.

1.4 Social and cultural context

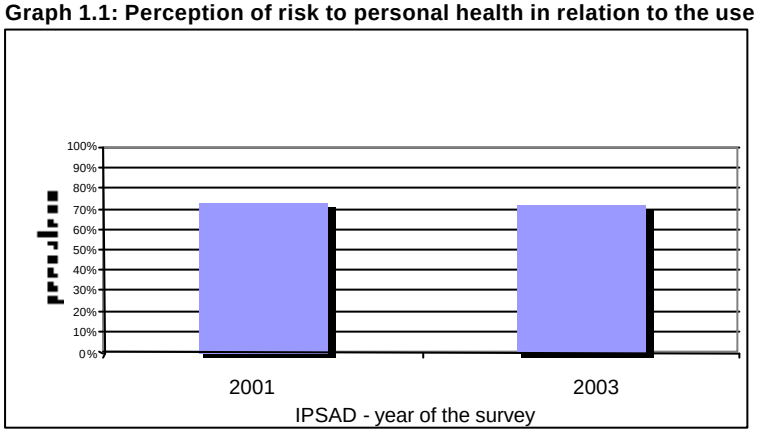
1.4.1 Public opinion on drug use

The figures presented here are the result of nationwide sample studies on the Italian population between the ages of 15 and 44 (IPSAD®Italia2001 and IPSAD®Italia2003). The answers given regarding perception of personal health risks associated with the use of illegal substances and disapproval of such behaviours were taken into account.

Risk perception in the general population

About 70% of those interviewed perceive any illegal drug use as a personal health risk. The sense of danger for their own health associated with the use of illegal substances appears therefore to be a widespread perception in the population studied in both the periods in question, even though, for about a third of citizens, drugs appear to present no risk.

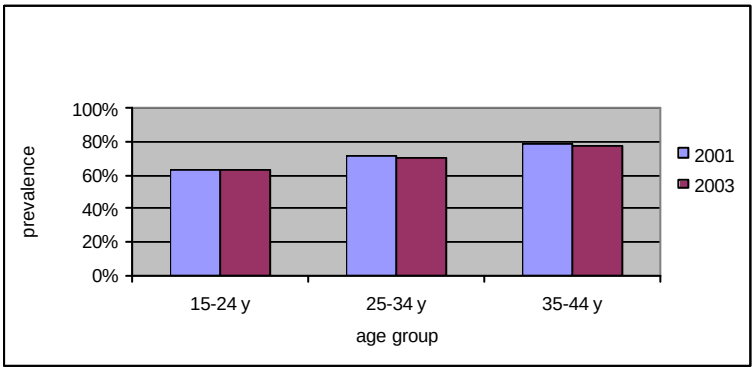
Graph 1.1: Perception of risk to personal health in relation to the use of illegal substances (2001-2003 compared).



Based on IPSAD®Italia2001 and IPSAD®Italia2003

In comparing research, a substantial[1] reduction in subjects perceiving risk can be noticed. Risk perception instead shows inconsistency within age groups between 2001 and 2003 (Graph 1.2).

Graph 1.2: Perception of risk to personal health in relation to the use of illegal substances by age group (2001 – 2003 compared)



Based on IPSAD®Italia2001 and IPSAD®Italia2003

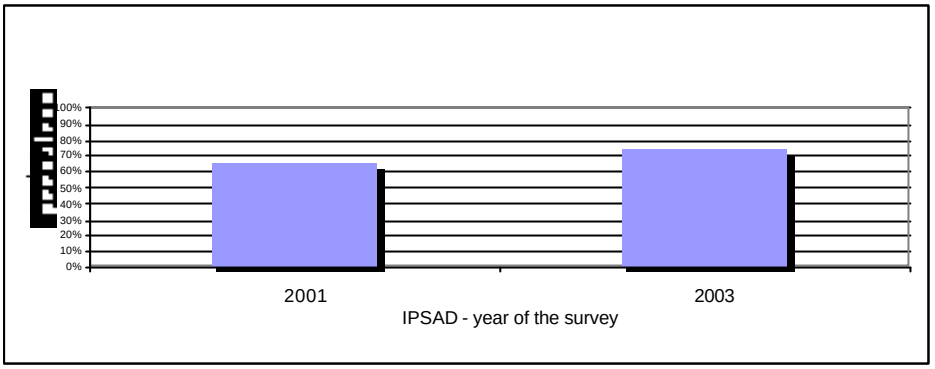
The sense of danger for personal health associated with the use of illegal drugs appears as a more widespread perception in adults than in youngsters.

[1] The term “substantial” in this text means that the highlighted difference may be considered not due to chance. Use of the term “substantial” suggests that relative statistical tests of difference evaluation have been applied.

Disapproval of use in the general population

Subjects who strongly disapprove of the use of illegal substances appear to be growing in number. In 2003 around 10% more of the sample's respondees, compared to those who answered in 2001, expressed their disapproval of drugs.

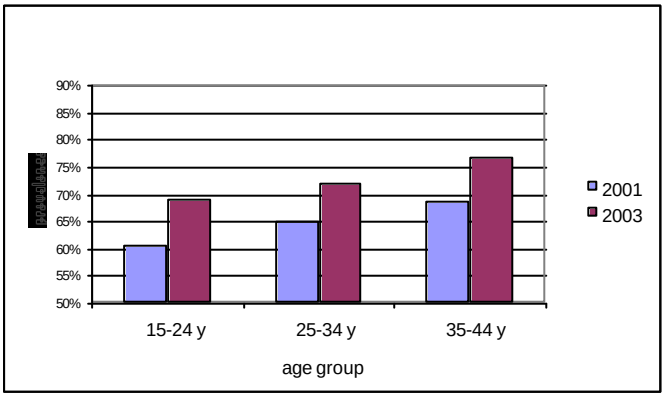
Graph 1.3: Disapproval of illegal substance use (2001-2003 compared).



Based on IPSAD®Italia2001 and IPSAD®Italia2003

In this case as well the expression of disapproval is slightly higher in the older age groups.

Graph 1.4: Disapproval of illegal substance use divided by age groups (cross-check years 2001-2003).



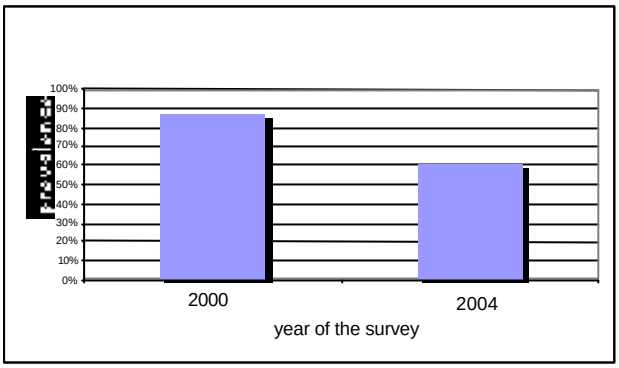
Based on IPSAD®Italia2001 and IPSAD®Italia2003

A substantially unchanged risk perception associated with growing disapproval of illegal narcotic substance use suggests that the increase in disapproval may be supported by multiple cultural and social factors and not only by convictions regarding problematic health consequences.

Perception of drug risk in young schoolchildren.

As can be seen from the data referring to sample surveys ESPAD®Italia2000 and ESPAD®Italia2004 (of youngsters between the ages of 15 and 19 attending secondary school), young people also perceive risks for their health associated with the use of illegal drugs. While still constituting a majority, students who express fears regarding substance use decline significantly in the period examined.

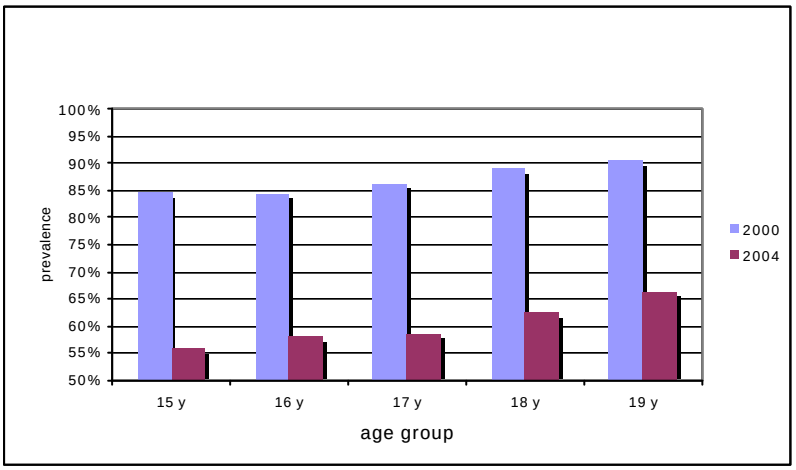
Graph 1.5: Perception of risk to personal health among students regarding the use of illegal substances (2000-2004 compared).



Based on ESPAD®Italia2000 and ESPAD®Italia2004

In 2000 almost 90% of those questioned had expressed a strong concern, whereas in 2004 only 60% perceive a risk in drugs: one-third less compared to the previous investigation.

Graph 1.6: Perception of risk to personal health among students regarding the use of illegal substances, by age group (2000-2004 compared).



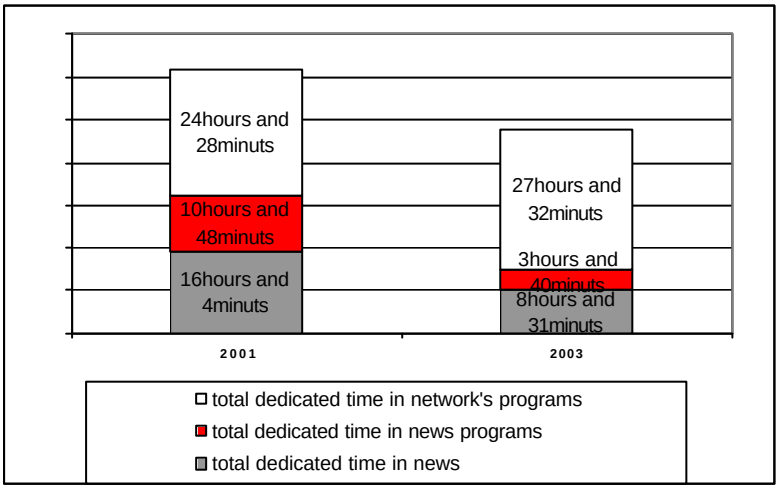
Based on ESPAD®Italia2000 and ESPAD®Italia2004

We may also note that it is precisely the youngest group who have "lowered their guard" towards risks for personal health associated with illegal substance abuse. This is particularly troublesome considering that it is exactly those age groups most exposed to initiation into drug use. In this regard, it becomes necessary for adults (parents, teachers, activity coordinators, law enforcement officials, the media) to take shared and accepted cultural positions so as to convey to adolescents in a unified fashion their full approval of laws relating to illegal substances, and a clear and grounded awareness of their danger. The climate of trivialisation associated with problems engendered by drugs, disillusionment with respect to the possibility of combating the phenomenon, and a sort of veiled willingness to live with illegal substances could be responsible for this reduced risk perception among younger age groups, with imaginable consequences for a growing exposure to substances whose use the international community has outlawed, considering them harmful and dangerous.

1.4.2 Media representations

In order to provide information and indications of what is described by the media, and in particular by Italian public media regarding the drug addiction phenomenon, the qualitative and quantitative findings of Teche Rai from 2001 and 2003 were taken into consideration: these surveys considered how much, in terms of time and context, the topic of "drug addictions" had been dealt with. While representing only a part of all radio and television stations, they can nonetheless be considered trend indicators.
In 2003, the subject of drug addiction was dealt with for 39 hours and 45 minutes compared to 51 hours and 20 minutes in 2001; in 2003, therefore, we saw a decrease in time dedicated to the subject compared to 2001, plus a significant increase in in-depth programmes i.e., programmes that are scheduled in network programmes.[2]
As can be seen in Graph 1.7, in both of the years examined, albeit at different intensities, the subject of drug abuse was touched upon in network programmes, often followed by news reports and headline programming. We need to point out that air time dedicated to the subject of "drug abuse" has, in the last year in question, dropped by one-half.

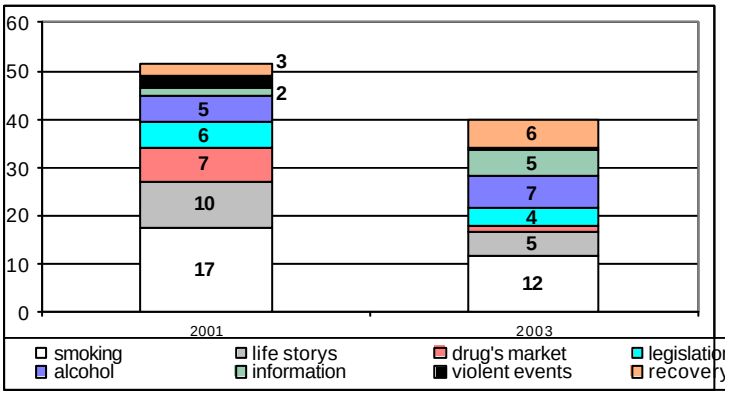
Graph 1.7 – Air time allotted to the subject of drug abuse by programme type – 2001 and 2003



Based on Teche Rai data

Graph 1.8 shows the overall duration in hours of air time of topics relating to drug addiction.

Graph 1.8 – Hours of air time and topics dealt with in all TV programming – 2001 and 2003

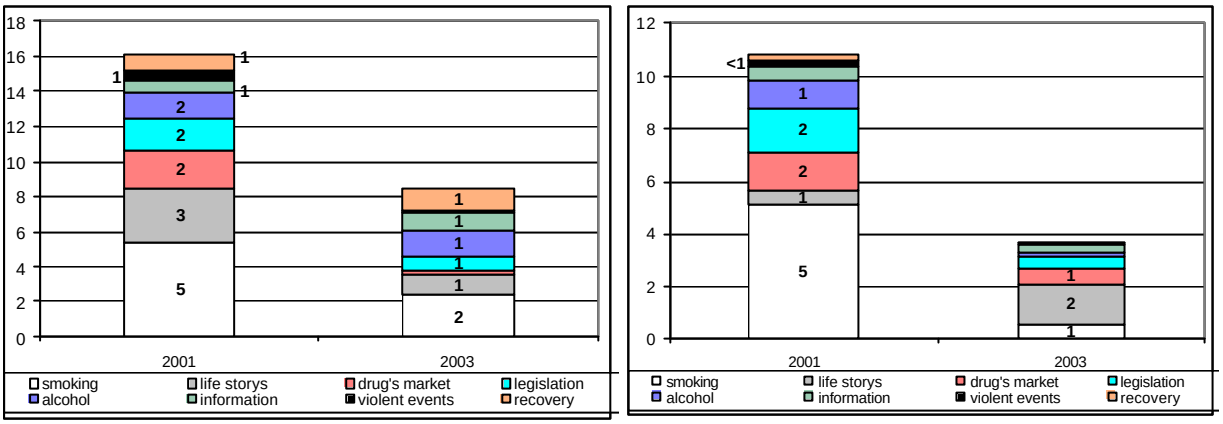


Based onTeche Rai data

[2] **Network programmes** are those attributable to the Rai network (Rai Uno, Rai Due, Rai Tre, Rai Educational). E.g., *Porta a Porta* on Rai Uno, *Gap* on Rai Educational. **Headline programming** refers to those for which news bureaus are responsible (Tg1, Tg2, Tg3, TgR, Rai Sport, TSP, RaiNews 24). E.g., *Tg Parlamento*

As can be seen, in all TV programming the topic to which the most time was devoted was smoking (17 hrs, or 34% of the 2001 total, and 12 hrs, or 29% of the 2003 total), followed by topics relating to everyday life (10 hrs, or 19% of the 2001 total, and 5 hrs, or 13%, of the 2003 total). Next is addiction to alcohol (5 hrs, or 10% of the 2001 total, and 7 hrs, or 17%, of the 2003 total). On the whole, looking at all programming, it would appear that the most discussed topics are those regarding legal substances (tobacco and alcohol), as told in personal stories of everyday life. In news bulletins the subjects most discussed concerned everyday life in both years, but with an overall difference in number of hours (from 8 hrs in 2001 to 3 hrs in 2003) (Graph 9). In 2003 there is also a decrease in topics relating to alcohol, legislation and drug markets, which go from 6 hrs of air time in 2001 to 3 hrs in 2003).

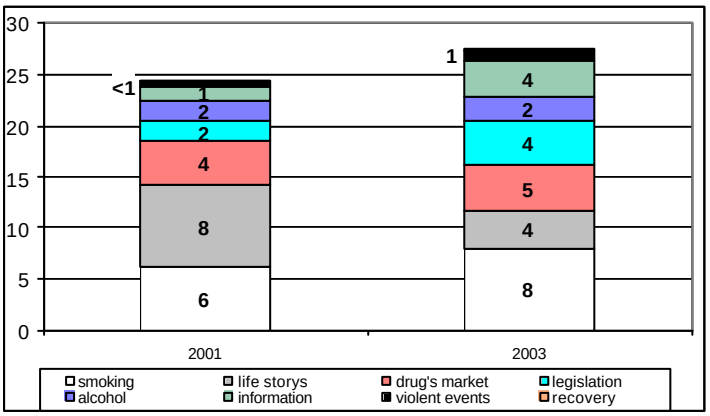
Graph 1.9 – Time allotted to topics dealt with on news broadcasts and headline programming - 2001 and 2003



Based on Teche Rai data

Among headline programmes, whose number of hours has drastically plummeted in screen time (Graph 1.9), in-depth information on drug addiction has gone from just above 7 hrs in 2001 to less than 2 hrs in 2003. Likewise, hours devoted to smoking and to personal stories of ordinary everyday life went from about 6 hrs in 2001 to about 3 hrs in 2003.
Finally, with regard to network programmes, those showing a small increase in air time devoted to substance-addiction topics (Graph 1.10), smoking and life stories represent the most-discussed topics (14 hrs of air time in 2001 vs. 12 in 2003). The time devoted to legislation and the market went from 6 to 9 hours, and the annual time devoted to information about drugs went from 1 to 4 hours.

Graph 1.10 - Percentage distribution of topics discussed in network programmes - 2001 and 2003



Based on Teche Rai data

Based on this evidence, we can conclude that the airtime given to public television programming devoted to information, awareness and consideration of illegal substances (about 20 hrs in a year) is very limited. On the one hand, drug-related news events are being discussed more and more hastily and superficially, or completely ignored and not considered sufficiently “news-making.” A sort of tolerance for and insensitivity to deaths from drugs and problems for health and safety, the

relationships between narco-trafficking and criminal organisations, risks making even the most dramatic events unworthy of note. On the other hand, in-depth and exhaustive scientific information, clear and not influenced by ideological prejudice, seems to reach Italian families less and less frequently, especially if we compare the drug addiction area with other areas of information in the context of health, behaviour, body image and nutrition.

2. DRUG USE IN THE POPULATION

Overview

The data reported on the general population refers to further processing of the sample surveys IPSAD®Italia2001 and IPSAD®Italia2003 conducted on the general population.
The data on the student population is taken from national prevalence studies carried out on a representative sample of Italian schools through questionnaires compiled directly by students (ESPAD®Italia2000 and ESPAD®Italia2004).
The prevalence of use during lifetime, which expresses the overall past experience, and the prevalence of use in the last 12 months, which expresses the most recent use of drugs, in line with the indications provided by the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA), both refer to a frequency of use of "once or more".
The surveys carried out in 2004 enabled the highlighting of an increase in the use of illegal drugs and a reduction in awareness of the danger of drugs, especially among young people. In addition, they confirmed the increase (already highlighted in previous years) of the use of psychostimulants (cocaine and amphetamine-derivates) which are used by a fairly large portion of young people from an early age.
In addition to this information, some data was recorded in relation to the use of illegal drugs in the military provided by the Ministry of Defence; this data shows that, while there was a significant fall in the case of heroin and other opiates, there was a rise in the use of cannabis.
This chapter also includes some preliminary data regarding the phenomenon of drug addiction among the immigrant population concerning only the city of Rome and which emerged from two studies undertaken by the National Department for Drugs Policy and the Institute of Clinical Physiology.

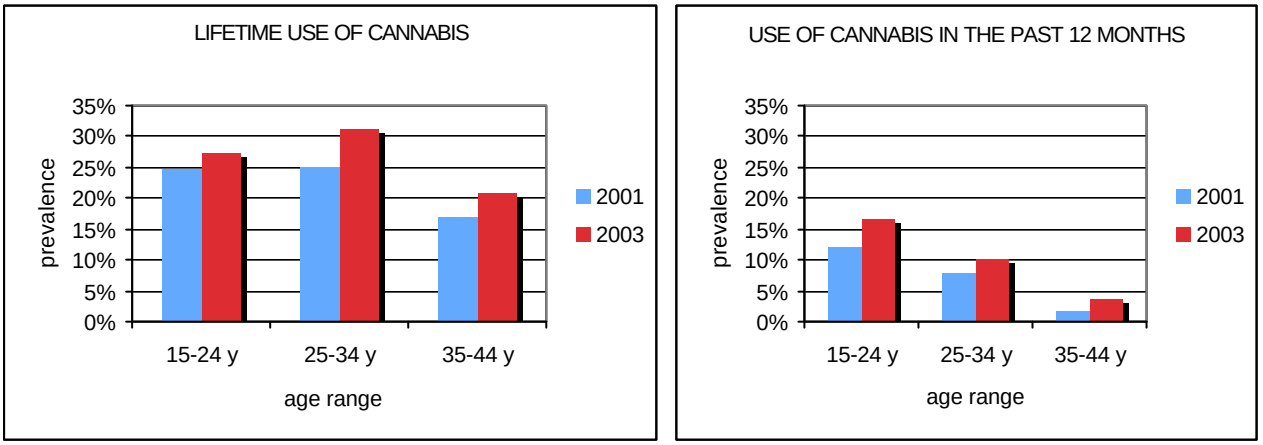
2.1 Drug use in the general population

The information provided here refers to further processing of sample surveys IPSAD®Italia2001 and IPSAD®Italia2003. Prevalence of lifetime use, referring to all past use, and the prevalence of use in the past 12 months, referring to the most recent use of substances, according to data provided by the European Monitoring Centre for Drugs and Addictions (EMCDDA) both refer to an incidence of "one or more times." In other words, the subjects examined are to be considered "experienced" if in the two periods observed they responded that they had used substances "one or more times." Prevalence found within samples allow us to estimate the same patterns of legal and illegal substance use in the Italian population between the ages of 15 and 44.

Cannabis use

In 2003, 26% of the population examined between the ages of 15 and 44, had used cannabis in their life, while 10.4% admitted to having used it in the past 12 months. As can be seen in Graph 2.1, the use of cannabis in the period between 2001 and 2003 involved young people far more, although in age groups the incidence increased significantly both in terms of trying it once (i.e., willingness to try the substance), and its use in the past 12 months.

Graph 2.1: Use of cannabis (one or more times in the past 12 months): by age groups (2001-2003 compared).



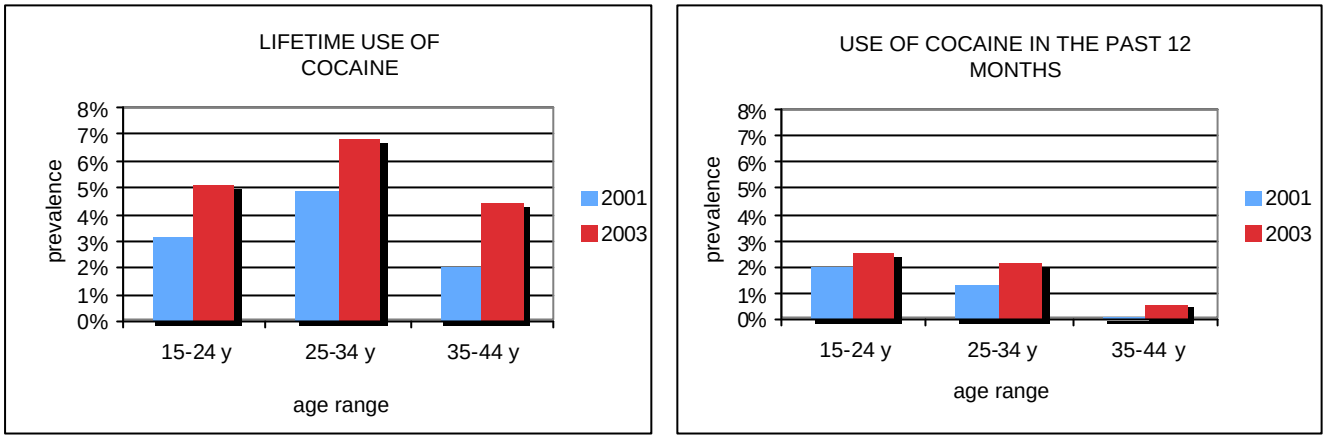
Based on IPSAD®Italia2001 and IPSAD®Italia2003

Young people between the ages of 15 and 24 in the past 12 months (16.5% admit to use) and young adults between the ages of 25 and 34 having used it at some time (31% admitted to use), show an increased exposure to cannabis, with a considerable increase of about 5% between 2001 and 2003.

Cocaine use

5.4% of subjects interviewed in 2003 stated they had used cocaine at least once in their life and 1.5% in the past 12 months. The use of cocaine (Graph 2.2) shows a significant increase from the year 2001 to 2003. Subjects between the ages of 35 and 44 admitting having used cocaine one or more times all has doubled. Use once or more times in the past 12 months increased in all age groups observed.

Graph 2.2: Use of cocaine (one or more times and in the past 12 months): by age group (2001-2003 compared).



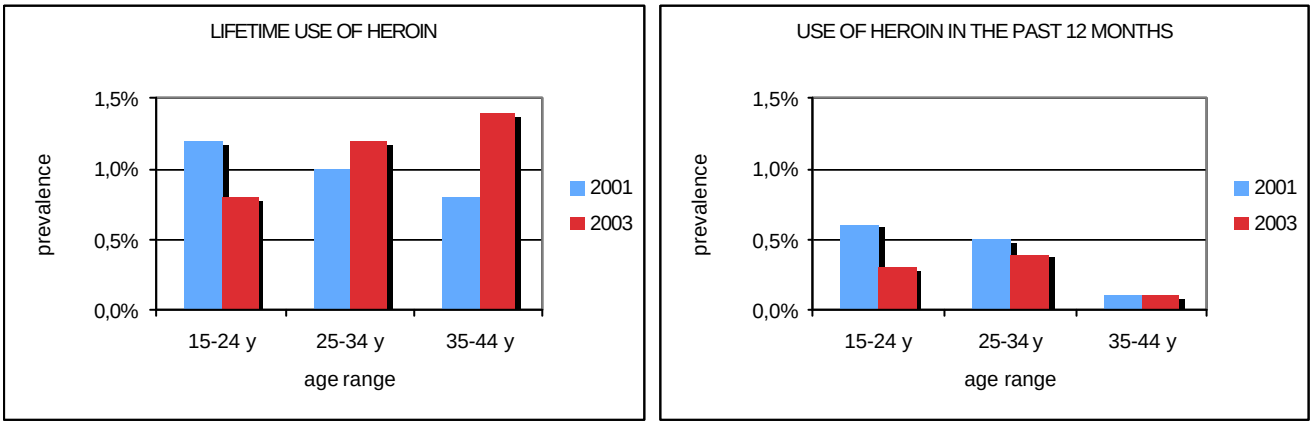
Based on IPSAD®Italia2001 and IPSAD®Italia2003

In the use reported for the past 12 months, the age group most exposed to cocaine use is the youngest one: the substance is used by teens and older (15-24 years) in a higher percentage than in the next age group (25-34 years). The greater increase in recent years is found in younger adults (25-34 years) and adults (35-44 years).

Use of heroin

Use of heroin once or more in total is reported by 1.2% of the population studied between the ages of 15 and 44 in 2003, while 0.25% admitted to using it in the past 12 months. Lifetime heroin use, comparing 2001 – 2003, showed an increase in the 25-34 age group, a more substantial increase in the 35-44 age group, perhaps caused by physiological aging in subjects who have used heroin in the past. We note a decrease in younger subjects who admitted having tried heroin once or more times . In the past 12 months heroin use dropped by one-half from 2001 showing a significant reduction among young people between the ages of 15 and 24 (Graph 2.3).

Graph 2.3: Heroin use (one or more times and in the past 12 months) by age group (2001-2003 compared).



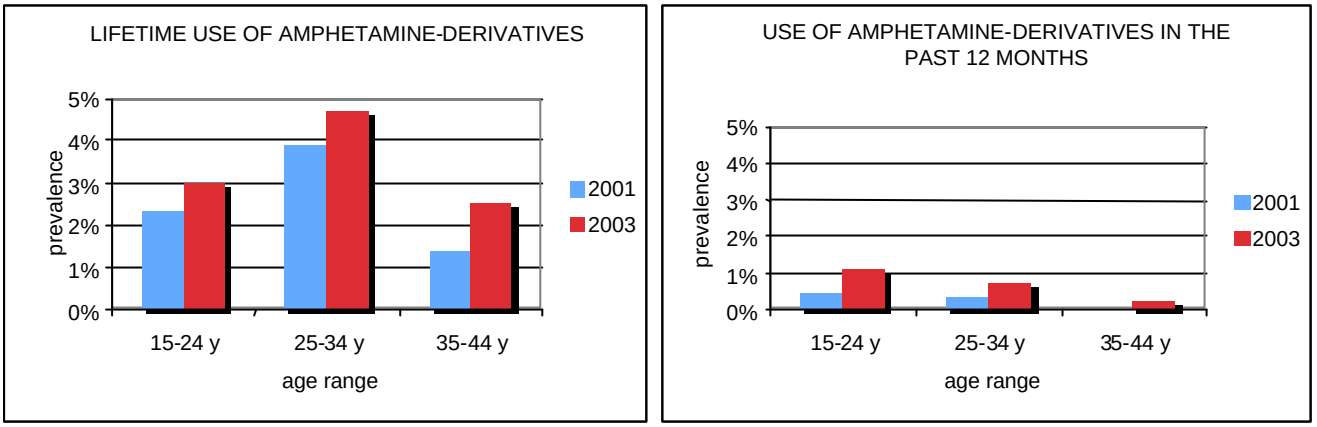
Based on IPSAD®Italia2001 and IPSAD®Italia2003

The remarkable decrease in heroin use registered in young people seems comforting and allows us to hypothesise that the use of opiate substances may have lost the appeal it had in recent decades.

Use of amphetamine derivatives

3.4% of subjects interviewed in 2003 admitted to having used amphetamine derivatives once or more and 0.6% in the past 12 months. we find a significant increase from 2001 to 2003 in the use of these substances (ecstasy, amphetamines) for lifetime experience and for use within the last year (Graph 2.4).

Graph 2.4: Use of Amphetamine derivatives (one or more times and in the past 12 months) by age group (2001-2003 compared).



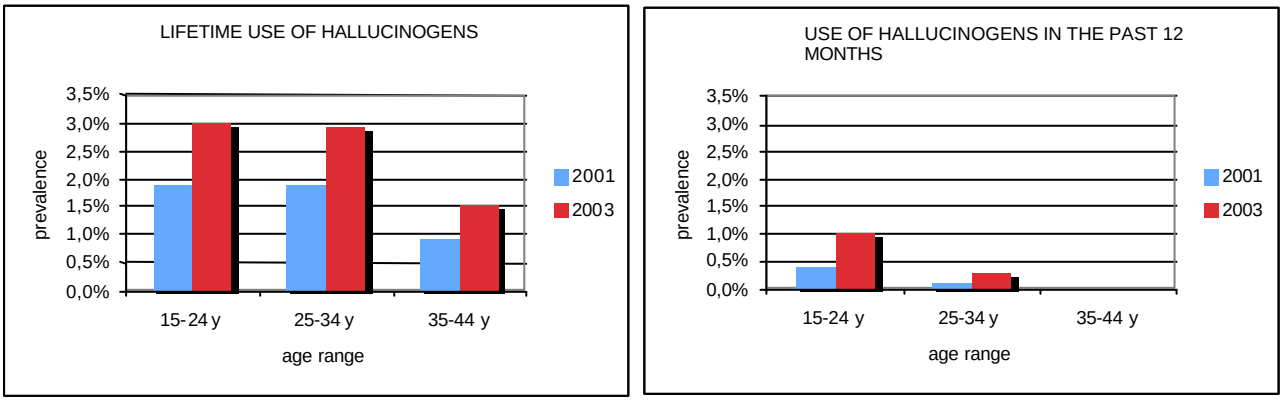
Based on IPSAD®Italia2001 and IPSAD®Italia2003

Use of amphetamine derivatives showed a significant increase with age groups. We should note the considerable increase among the very young (15-24) and in young adults (24–34). These are the groups that show the highest growth in numbers and are therefore the most exposed.

Use of hallucinogens

Similar growth to that of amphetamine derivatives is registered for the use of hallucinogens: 2.3% and 0.4% of subjects interviewed in 2003 admitted to using it at some time and in the past 12 months, respectively. Prevalence in those who admitted to use once or more is higher in the youngest groups, 15-24 and 25-34, with the same steady increase in the three-year period in question (Graph 2.5).

Graph 2.5: Use of hallucinogens (one or more times and in the past 12 months) by age group (2001-2003 compared).



Based on IPSAD®Italia2001 and IPSAD®Italia2003

A more substantial involvement in use in the past 12 months can be found in the 15-24 age group, which doubles from 2001 to 2003, in the number of subjects who report using them. We can however notice an increase in the 25-34 age group as well which, while remaining low, also doubles. The phenomenon seems to disappear over the age of 35, almost suggesting an exclusively juvenile use of this type of substances.

Age at first use.

The average age at which interviewed subjects report having first used illegal substances is between 18 and 22 years.

Table 1: Average age at first use.

	Average age at first use
CANNABIS	18 years
COCAINE	22 years
HEROIN	20 years
ALL THE OTHER SUBSTANCES	18 years

First use of cannabis is more precocious than that of "all other substances" (hallucinogen and speed compared to heroin, while the first use of cocaine is the latest.
The average report of first contact with cannabis is at the age of 18, but if we look within the age groups, in the youngest (15-24 years) we find a first contact age of around 16 years.

Pattern of use.

Patterns of illegal substance use vary by substance.
Most subjects reporting use in the past 12 months show sporadic use (once a month or less).

Table 2: Patterns of use in subjects having used in the past 12 months.

	Prevalence in the last 12 months	Once or less in a month	2-4 times in a month	2-3 times in a week	4 times in a week
CANNABIS	10,4%	54%	20%	12%	14%
COCAINE	1,5%	78%	13%	6%	4%
HEROIN	0,5%	39%	22%	4%	35%
ALL THE OTHER SUBSTANCES	1,0%	72%	12%	6%	10%

Use of cannabis does not appear to follow any particular pattern of use: over 50% of subjects reported using this substance less than once a month, 20% reported 2-4 times a month, and the remaining 30% smoked cannabis several times per week.
Cocaine was used once a month or less by 78% of subjects reporting use in the past 12 months (1.5% of total interviewed), 13% used cocaine 2 to 4 times a month and the remaining 10% reported using it 2 to 4 times per week.
Heroin users (0.5% of subjects interviewed) have different use patterns: 39% reported having used it once a month or less, 22% 2-4 times a month, whilst 39% used it 2 to 4 times per week.
All other substances were used sporadically by 72% of subjects examined.

Multiple use

In recent years the general population has shown a combined use of multiple psychoactive illegal substances. From the data provided by the IPSAD®Italia2003 study, around 5% of interviewed subjects (including those who reported never having used drugs) reporting having used illegal substances at some point (around one-fourth of the all subjects report having used illegal substances). In 99% of the cases, multiple use is associated with cannabis use.

Table 3: Percentage distribution of multiple users.

	Polydrug use	of which one is cannabis	other substances
Two substances	2,75%	2,72%	0,03%
Three or more substances	2,68%	2,66%	0,02%
Polydrug use	5,43%	5,38%	0,05%

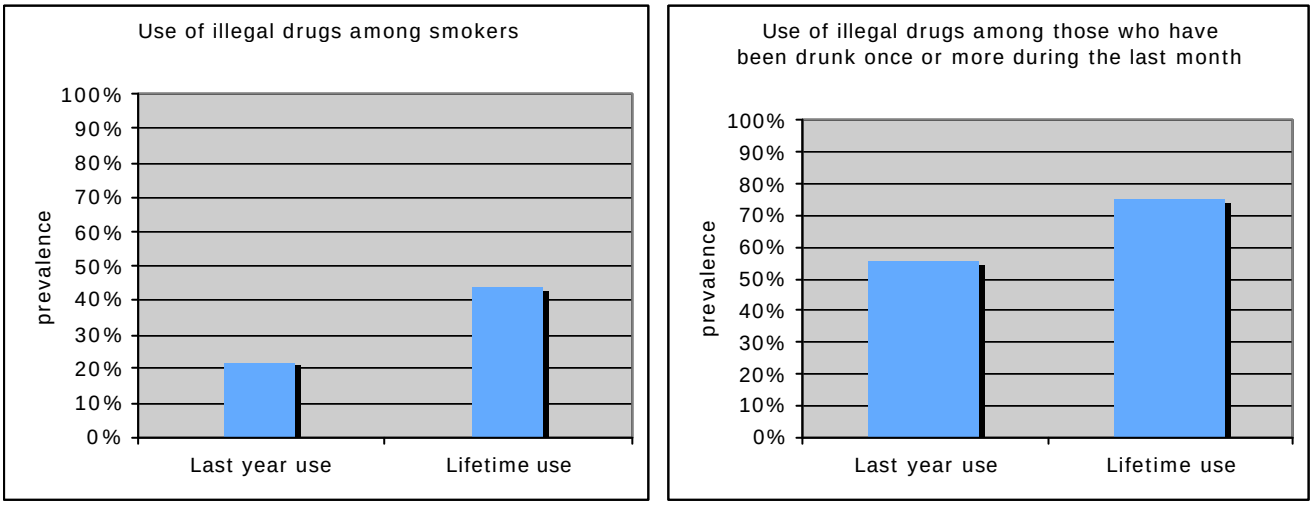
Based on IPSAD®Italia2001 and IPSAD®Italia2003

The most frequent association of two substances is that of cannabis and cocaine (68% of subjects), cannabis and amphetamines (16%), cannabis and hallucinogens (11%), cannabis and heroin (4%). If the association is of three or more substances, the combination cannabis, cocaine and amphetamines is the most frequent (24% of subjects), followed by cannabis, cocaine and hallucinogens (9%), cannabis, amphetamines and hallucinogens (5%), cannabis, heroin and amphetamines (2%).

Relationship between legal and illegal psychoactive substance use

In 2003, 22% of those who smoked cigarettes in the last month stated that at least once in the previous 12 months they used illegal substances. Among those who got drunk in the last month, 55% stated they had used illegal substances at least once in the past 12 months. If we consider the use of illegal substances one or more times in a lifetime, the percentage is 44% in smokers and 75% in subjects under the influence of alcohol (Graph 2.6.).

Graph 2.6: Illegal substance use in smokers or subjects drunk in the last 30 days (comparison between prevalence in the past 12 months and ever).



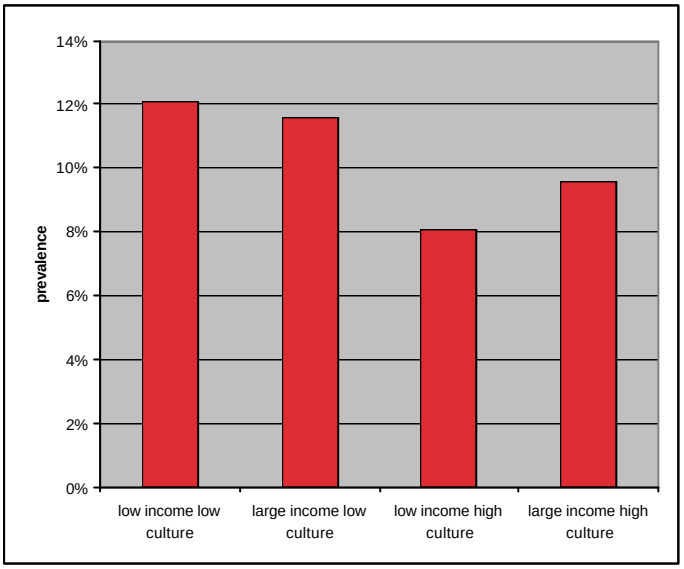
Based on IPSAD®Italia2001 and IPSAD®Italia2003

Highest contact with psychoactive substances (once or more in the past 12 months or in ever) appears to be more frequent in those subjects who said they got drunk one or more times in the previous month compared to smokers. This indicates that there is a strong link between being drunk and illegal substance use, while cigarette smoke associated with drug use is weaker, yet significant.

Illegal psychoactive drug use in relation to education and income

Considering the characteristics of the subjects interviewed in the IPSAD®Italia2003 survey in terms of educational level and profession, it was possible to examine a combination of the two economic groups (low and high, based on profession) and two cultural categories (low and high educational groups, based on schooling). The study outlines the protective factor of education with regard to illegal substances, particularly if associated with a low income (Graph 2.7).

Graph 2.7: Illegal substance use in subjects organized by income and cultural level.



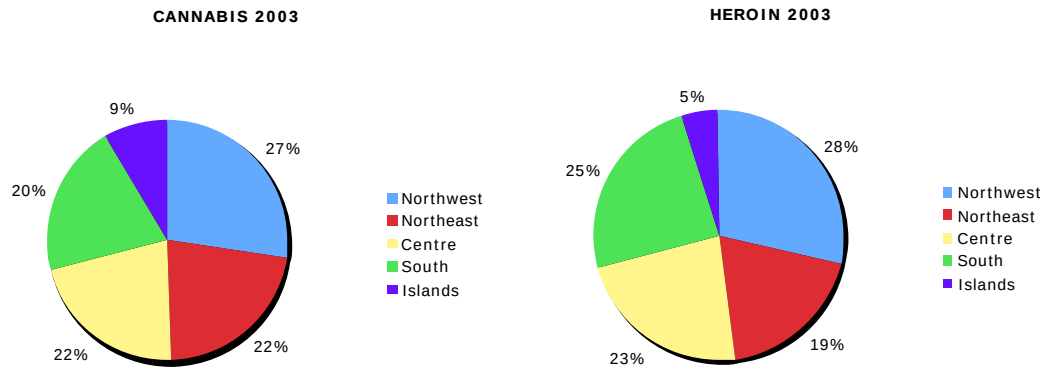
Based on IPSAD®Italia2001 and IPSAD®Italia2003

The “low-income/high-education” category is the least exposed to the use of illegal psychoactive substances.
The analysis correlating income bracket relative to profession and the educational categories based on schooling with exposure to illegal psychoactive substances underlines the protective role of education. Higher education in the general population seems to reduce the risk of experimenting with drugs. Protective factors linked to higher education levels is not influenced by social class and maintains its effectiveness even in lower-income brackets. The observation that education itself is protective towards health values has surfaced in several contexts in the social-sanitary disciplines, and has also been confirmed in relation to substance use.

Comparing geographic areas

In comparing different macro-areas, prevalence distribution of cannabis and heroin use was unchanged in the two years examined (2001–2003). So we report only the 2003 data which are quite the same of the 2001 ones.

Graph 2.8: Use of cannabis and heroin (once or more). Comparing geographic areas.

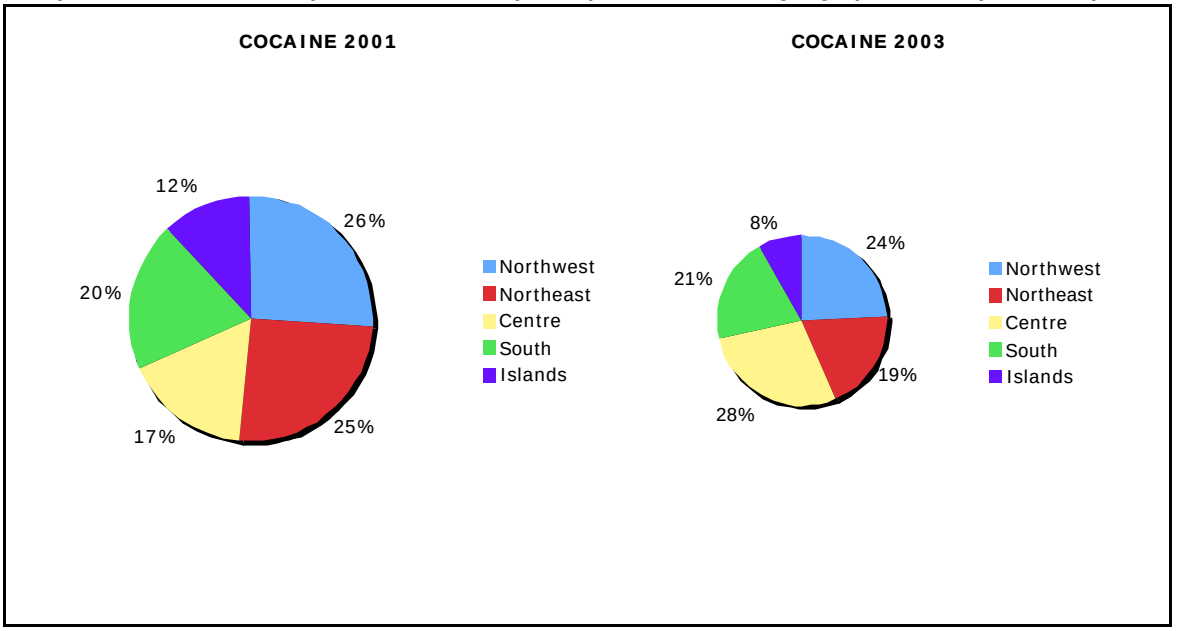


Based on IPSAD®Italia2001 and IPSAD®Italia2003

As we can see in Graph 2.8, all areas were affected by the phenomenon, except for the Siciliy and Sardinia, where only 9% of hashish and marijuana users and 5% of heroin users are found.

With regard to psycho-stimulants (cocaine), the North and Central regions appear to be most affected and less so in the South. Nonetheless, comparing 2001 and 2003, we find that exposure to use grew, especially in the Central part of the country, where the prevalence of those who had contact with the substance increased from 3.7% to 6.8% (Graph 2.9).

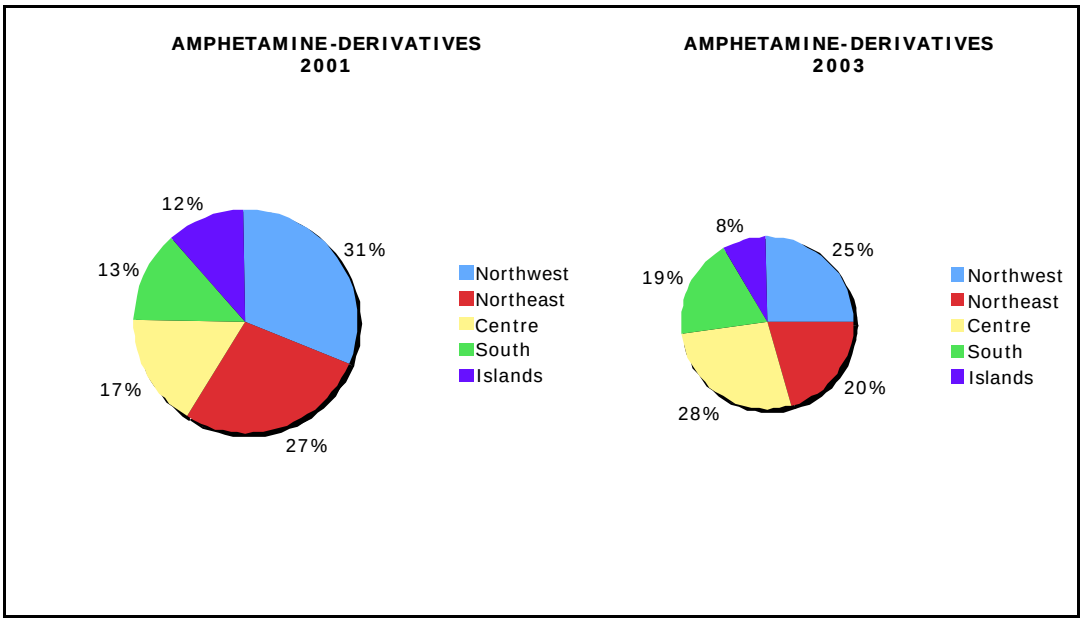
Graph 2.9: Use of cocaine (one or more times). Comparison between geographic areas (2001-2003).



Based on IPSAD®Italia2001 and IPSAD®Italia2003

In the same manner, use of synthetic amphetamine derivatives continues to be substantial in the northwest and northeast, albeit diminishing sharply in the three-year period, except for the central regions, where use seems to be concentrated, increasing from 3.5% to 4.5% in the general population (Graph 2.10).

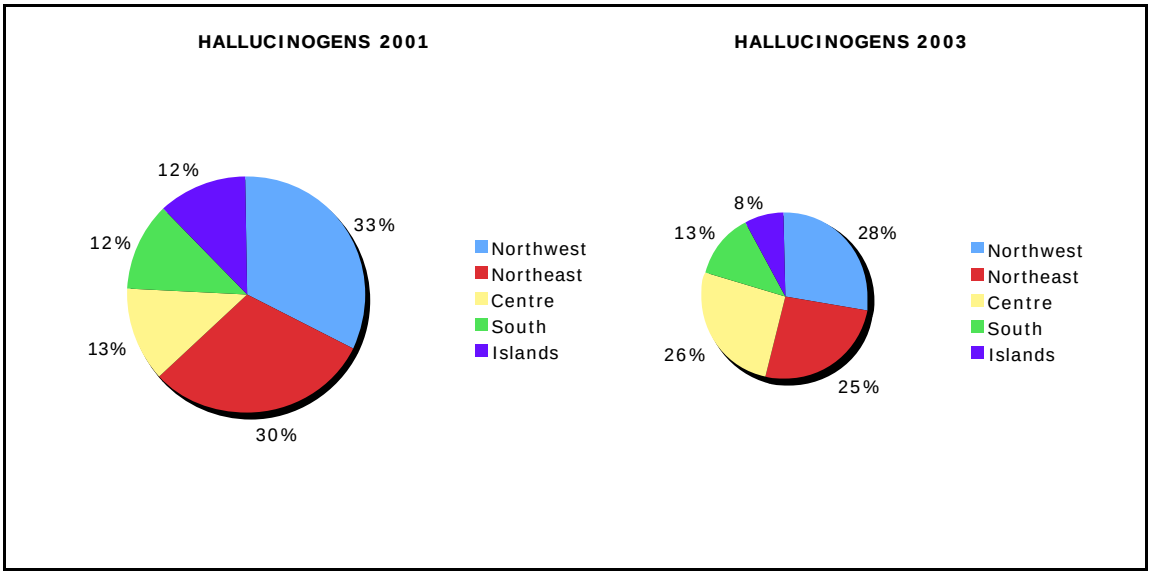
Graph 2.10: Use of amphetamine derivatives (one or more times). Comparison between geographic areas (2001-2003).



Based on IPSAD®Italia2001 and IPSAD®Italia2003

Use of hallucinogens, present mostly in the Central/Northern regions, shows a similar trend. Whilst in other areas the prevalence of subjects reporting use of hallucinogens was cut by half, in Central Italy use rates appear unchanged. (Graph 2.11).

Graph 2.11: Use of hallucinogens (one or more times). Comparison between geographic areas (2001-2003).



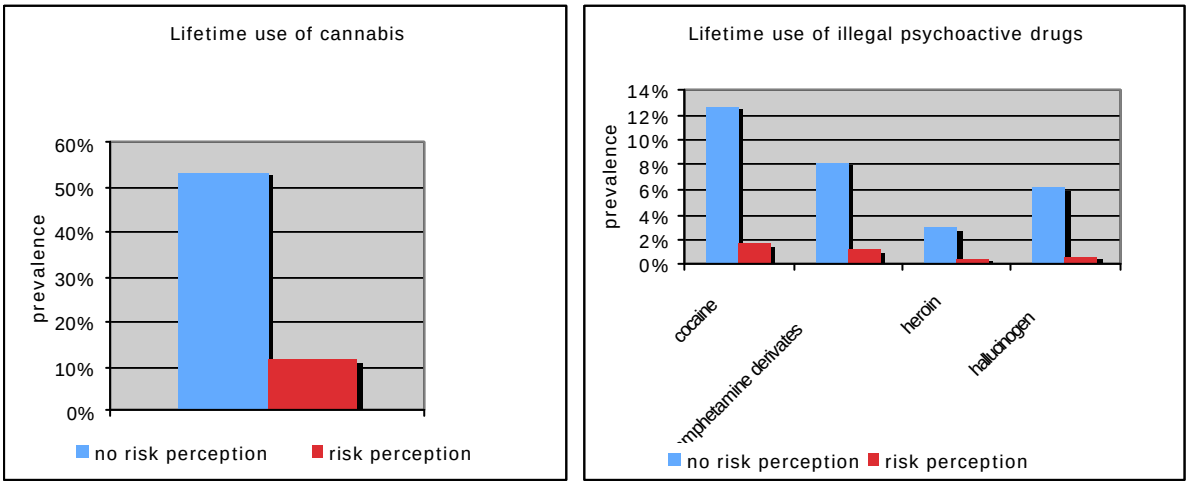
Based on IPSAD®Italia2001 and IPSAD®Italia2003

In order to interpret these different changes in use, we must consider socio-economic factors as well as the behavioural patterns and different lifestyles characterising the above mentioned geographic areas.

Risk perception and drug use

The general population study indicates that the perception of risk relating to the influence of illegal psychoactive substance use affects consumption. Obviously for that specific population segment that considers drugs harmless, the risk of being exposed is much greater.

Graph 2.12: Risk perception relating to illegal drug use



Based on IPSAD®Italia2001 and IPSAD®Italia2003

In particular, as far as cannabis is concerned (Graph 2.12) among those with a greater perception of the risk, the percentage of subjects having used the substance at least once dropped by 11% compared to 53% in less aware subjects. In other words, subjects not perceiving cannabis use as dangerous to their health are four times more likely to use it over those who do perceive the risk. For the other substances, those who do not regard the use of cocaine as dangerous as opposed to those who do have an exposure rate eight times greater; for heroin and amphetamine derivatives, 7 times greater, and 11 times greater for hallucinogens.

The spread of cannabis use is associated with a generalised underestimation of actual health risks and psycho-behavioural consequences. Users often ignore cognitive and memory-related issues, possible professional and scholastic impairments, personal relationship disorders and troubles concerning personal identity. Cannabis' ability to induce addiction as with all other drugs is often overlooked. The growing trend in the use of psycho-stimulants appears to coincide with new socio-cultural needs rather than a possible shift in trafficking strategies. Cocaine manages to present itself as a "drug to be used in recreational environments" in spite of its dramatic ability to trigger an addiction and its severe repercussions on health, even passing as the favourite substance of the well-off.

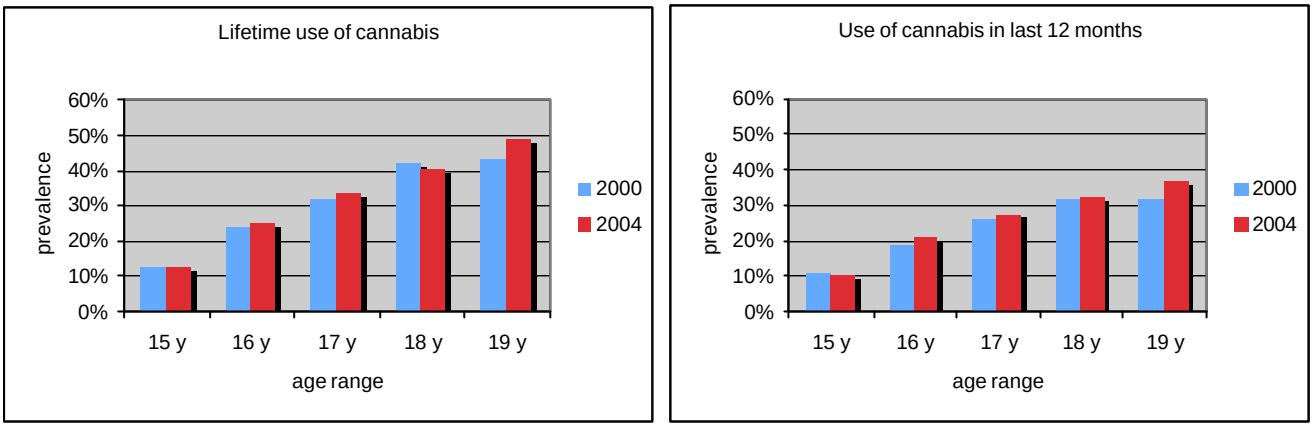
Use of cocaine in the general population presents various modes and environments: helping the level of use to grow are its use in public gathering places, at private parties, in night clubs, and private personal use and street use by multiple consumers. The methods of use change drastically in these environments, from snorting to inhaling to injection.
Among subjects with medium to long-term exposure who develop an addiction, cocaine triggers an actual neurological syndrome associated with psycho-motor disorders, paranoid ideation and loss of control, over impulses.
Among the young, use of opiates appears to have lost the attraction it had in recent decades in the Western countries. Use of these opiates, with their typical sedative-hypnotic effects and alienation, does not seem to meet the expectations of the young and is considered as a sign of social disadvantage and marginalisation. This stigma on heroin and the drop in use among the young should not cause us to lower our guard against opiates, which could in the future become drugs of choice for a growing percentage of psycho-stimulant users. In an advanced stage of addiction, these users could turn to heroin in a misguided attempt to medicate for problems associated with taking amphetamine derivatives and hallucinogens.
Use of amphetamine substances and hallucinogen drugs, in spite of the recent increase, seems to involve specific youth populations and does not seem to extend to the entire population. This particular sub-group of users shows specific cultural traits: going to special night clubs and raves, and following behavioural models present all over the Western world. The "altered state of consciousness" requires a combination of these drugs including ketamine and natural hallucinogen drugs. Contrasting with what came about in the '60s, these users seeking "psychedelic trips" maintain sufficient social integration and do not entirely interrupt their interaction with social life.

2.2 Drug use in the school and youth population

Data on the student population was taken from national survey conducted on a sample representing Italian schools by means of questionnaires filled out by students themselves (ESPAD®Italia2000 and ESPAD®Italia2004).

Use of cannabis
Use of cannabis at least once is applied to 32.1% and in the past 12 months to 25.5% of students: in the study conducted between 2000 and 2004, use of cannabis derivatives shows a generalised increase which becomes significant among 19-year-old students (Graph 2.13).

Graph 2.13: Use of cannabis (once or more and in the past 12 months) by age groups (2000-2004 compared).



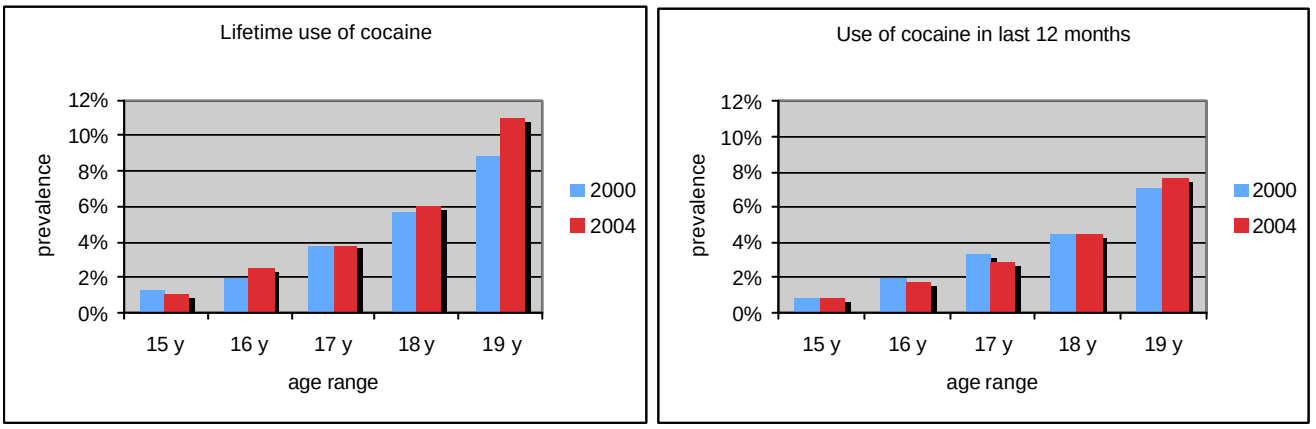
Based on ESPAD®Italia2000 and ESPAD®Italia2004

Contact with cannabis, which can be seen in the very young (ages 15-16), suggests that the first approach with the substance frequently happens before the age of 15. It is in this very delicate period that cannabinoid use may represent socio-emotional development issues in adolescents, produce cognitive and memory disorders and others linked to learning and may give way to psychiatric troubles in the more vulnerable subjects. Exposure to cannabis use is greater in the older age groups, and 19-year-olds are among those reporting the highest prevalence of use.

Cocaine use

The use of cocaine, too, is a danger signal in regard to the use of illegal psychoactive substances. Cocaine use among students at least once was observed in 4.8% of cases and use in the past 12 months in 3.5% (Graph 2.14).

Graph 2.14: Use of cocaine (once or more and in the past 12 months) divided by age groups (2000-2004 compared).



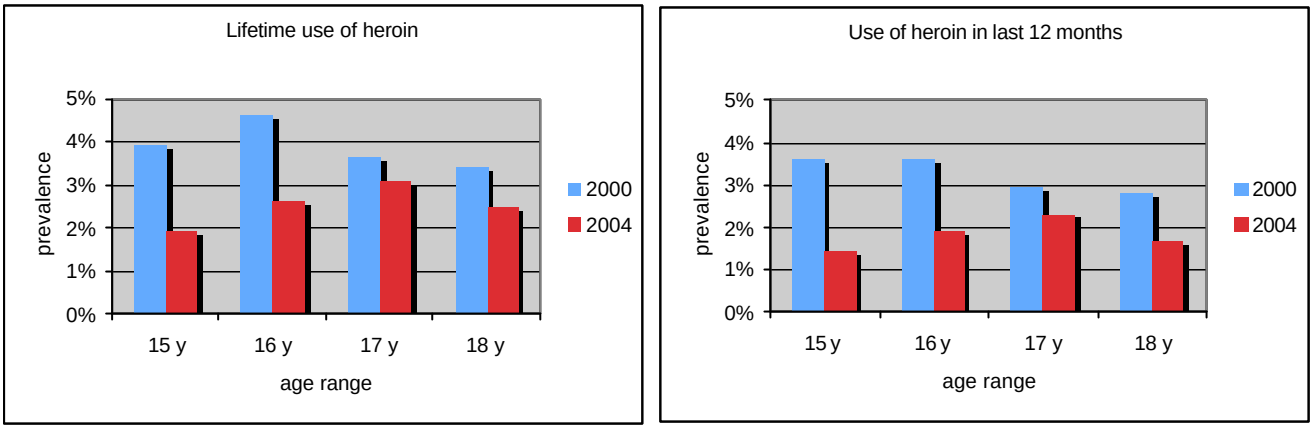
Based on ESPAD®Italia2000 and ESPAD®Italia2004

The increase between 2000 and 2004 is attributable to 19-year old students. Among subjects reporting having tried cocaine at least once, we find that, as early as age 16, more than 2% have had at least one contact with the substance while the figure at age 19 years exceeds 10%. The trend seen in the past few years throughout Western Europe, with the use of illegal substances tending towards psycho-stimulants, is confirmed. Compared with the typical need to numb emotional difficulties and ease the impact of relationships typical of expectations of depressants on the central nervous system, youngsters appear to demand from psycho-stimulants support for a more vivid introspection, a more sensitive communication of their feelings and help in overcoming that sense of emptiness, lack of motivation and finding answers to questions.

Heroin use

Heroin use appears to have lost its appeal among young students and dropped by one-half in the 2000 – 2004 study. Students reporting its use (once or more) went from 4% to 2% of the total and the age trend shows an accumulation of past use in older subjects. This decrease is confirmed by the data relating to use in the past 12 months (Graph 2.15).

Graph 2.15: Use of heroin (once or more and in past 12 months) by age group (2000-2004 compared).



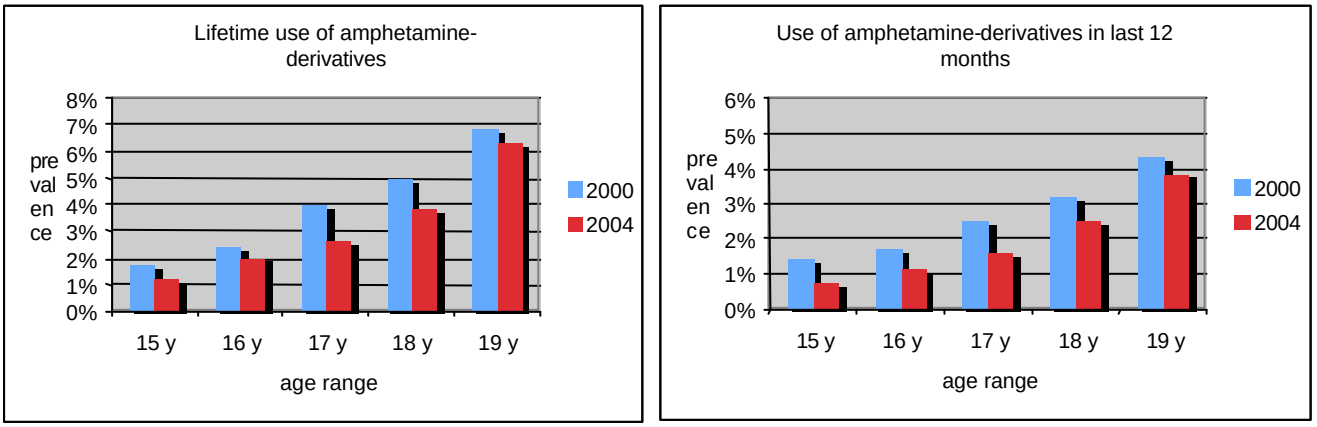
Based on ESPAD®Italia2000 and ESPAD®Italia2004

It is 17-year olds who show greater connection with the substance, with a rate of more than 2%. There are no significant differences regarding the periods examined.

Use of amphetamine derivatives

Contrary to what was observed in the general population, where use of amphetamine derivatives is rising, we notice a considerable decrease among students between 2000 and 2004 (Graph 2.16). This reduction is evident in all age groups and in both periods of use studied (once and in the past 12 months).

Graph 2.16: Use of amphetamine derivatives (once or more and in the past 12 months) by age groups (2000-2004 compared).



Based on ESPAD®Italia2000 and ESPAD®Italia2004

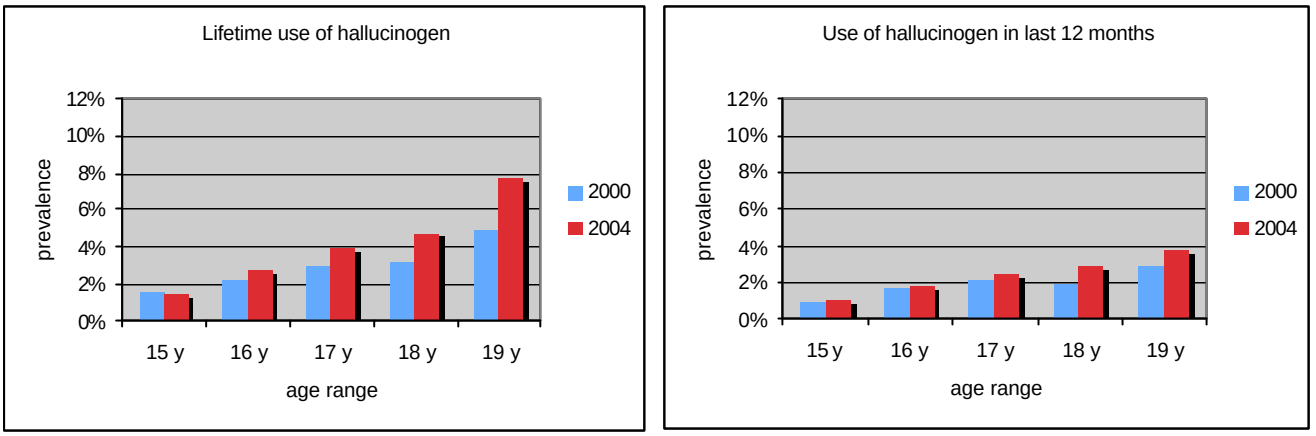
The reduction, less evident in 19-year olds, is consistent with the information gathered by the IPSAD study conducted on the general population where the increase observed in the 15-24 age group is applicable mainly to subjects over age 20.

Hallucinogen use

Use of hallucinogens increased in the two years examined. Students reporting contact with these substances in 2004 outnumbered those in 2000 by 150%. Students aged 18-19 report the highest frequency of having experienced using hallucinogens on the whole (Graph 2.17). we should note

the considerable stability in interest in such substances in younger students, who contribute little to the increase in the period studied.

Graph 2.17: Hallucinogen use (once or more and in the past 12 months) by age groups (2000-2004 compared).



Based on ESPAD®Italia2000 and ESPAD®Italia2004

Age at first use.

First contact with illegal substances, excluding cannabis, happens in 50% of students aged 16 or older.

Table 4: Average age at first use.

	11 years or less	12 years	13 years	14 years	15 years	16 years or +
CANNABIS	1%	2%	9%	26%	28%	34%
COCAINE	1%	1%	4%	11%	19%	64%
HEROIN	5%	3%	6%	16%	21%	49%
ALL THE OTHER SUBSTANCES	4%	3%	6%	16%	24%	48%

First use of cannabis is reported by 38% of students at age 14 or earlier, by 28% at 15 and by 34% over age 16.

Patterns of use

An analysis of frequency of use shows occasional use (once-twice in the past 12 months) of heroin, cocaine and “all other substances” in well over 50% of students.

Table 5: Patterns of use in subjects reporting use in the past 12 months.

	Prevalence in the last 12 months	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 or + times
CANNABIS	25,50%	32%	16%	13%	13%	10%	17%
COCAINE	3,50%	51%	18%	12%	7%	6%	6%
HEROIN	1,80%	63%	15%	5%	6%	4%	7%
ALL THE OTHER SUBSTANCES	3,60%	60%	17%	9%	5%	3%	5%

Around 50% of students reported sporadic use of cannabis (5 times or less in the past 12 months), while 26% of students report a monthly use (between 6 to 19 times in the past 12 months), and 27% report a higher frequency (20 or more times in a year).

Multiple use in students

The data from the study on the young student population also show that the use of illegal psychoactive substances is characterised in by multiple use. About 10% of students (representing one-third of users) reported having used more than one illegal substances.

Table 6: Percentage of multiple use

	Polydrug use	of which one is cannabis	other substances
Two substances	4,69%	4,59%	0,10%
Three or more substances	5,03%	4,75%	0,28%
Polydrug use	9,72%	9,34%	0,38%

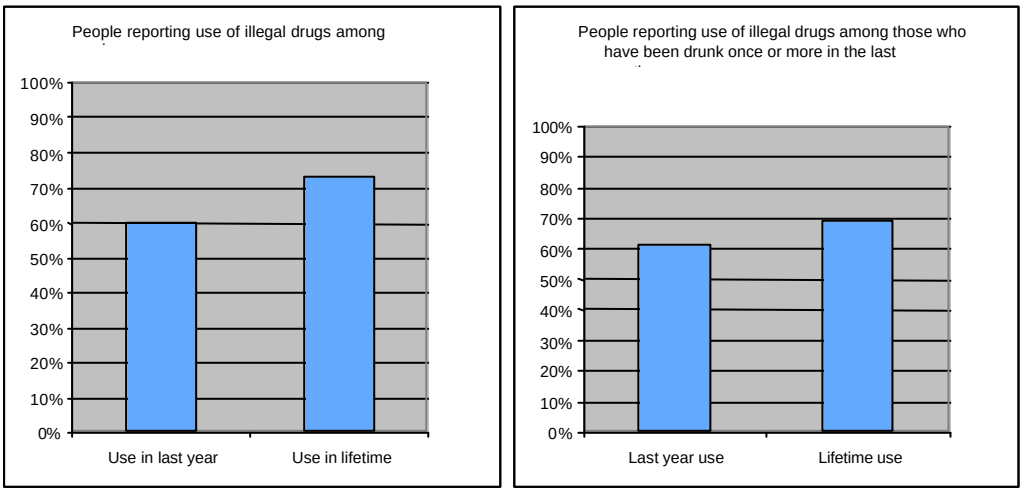
Based on ESPAD®Italia2000 e ESPAD®Italia2004

Of these subjects, 97% use cannabis. The association of two substances involves the use of cannabis and cocaine in 65% of cases, cannabis and amphetamines in 14%, cannabis and hallucinogens in 9%, cannabis and heroin in 3%. In the case of three or more substances, the combination cannabis-cocaine-amphetamine involves 22% of subjects, cannabis-heroin-cocaine-hallucinogens 7%, and cannabis-heroin-amphetamines 1%.

Relationship between use of legal and illegal psychoactive substances among students

In 2004, among those having smoked cigarettes in the past month, 60% of subjects report having used illegal substances at least once in the past 12 months (Graph 2.18). Among those having been under the heavy influence of alcohol at least once in the last month, 61% of subjects report having used illegal substances at least once in the past 12 months. If we consider the use of illegal substances once or more, percentages would be 73% in smokers and 69% in alcohol abusers.

Graph 2.18: Use of illegal substances in subjects having smoked and drunk in the past 60 days (comparing prevalence in the past 12 months and over).



Based on ESPAD®Italia2000 and ESPAD®Italia2004

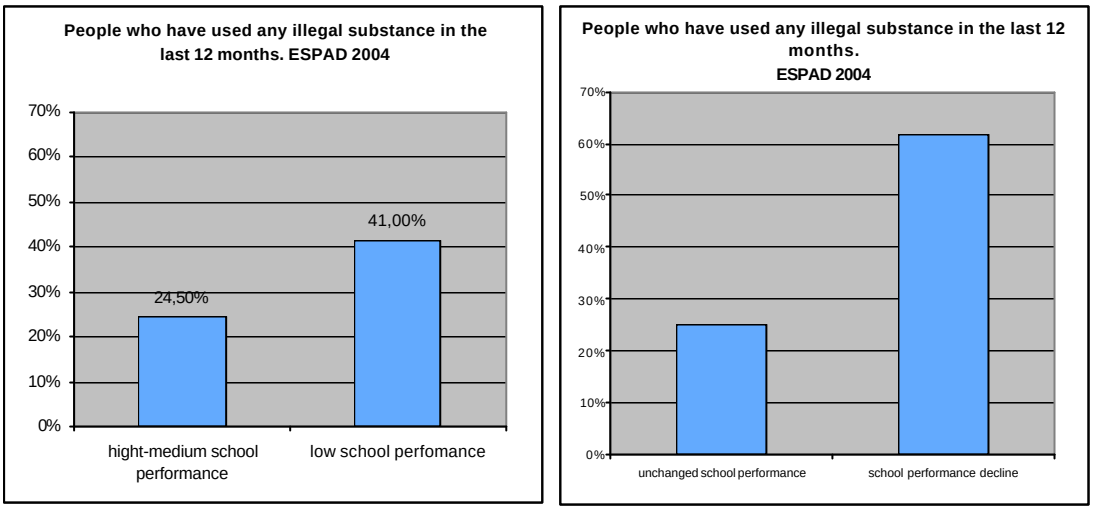
Among young students, similarly to what was observed in the general population, a correlation can be seen between alcohol abuse and illegal substance use (mainly cannabis). Around 70% of students who report having been drunk in the last 30 days, say they have used an illegal drug at least once. In this youth population we can also notice the association between cigarette use and he use of illegal substances. The study indicates that over 73% of subjects attracted to tobacco used illegal substances (once or more in the course of their life).

Use of drugs and academic performance

The tendency to experiment with drugs is significantly related to academic performance by students' own self-evaluation. As performance improves, the risk of exposure to illegal

psychoactive substances diminishes. In fact we find double the prevalence of illegal substance use among students with learning difficulties compared to those with higher scholastic standards. (Graph 2.19).

Graph 2.19: Use of illegal drugs (once or more in the past 12 months) and academic performance



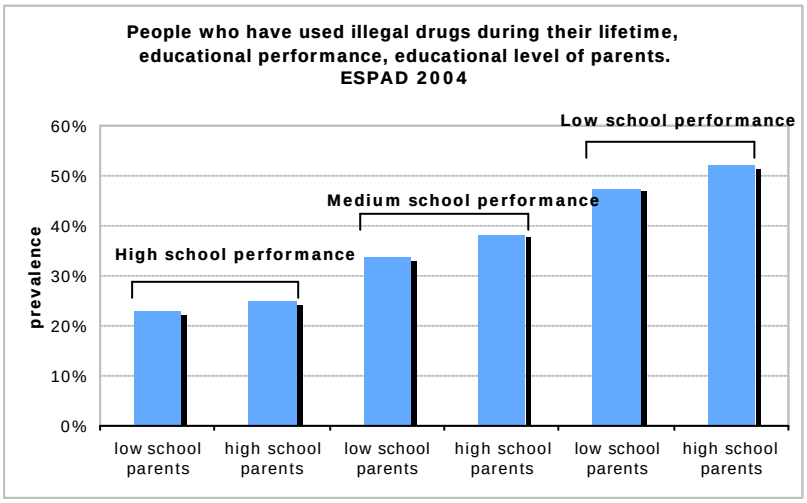
Based on ESPAD®Italia2000 and ESPAD®Italia2004

We can further observe a strong correlation between weakened scholastic results and illegal drug use, with a 250% greater likelihood of using illegal substances among those students having reported a recent decline in academic performance.

Use of illegal psychoactive substances in relation to parents' schooling level

If we consider the parents' schooling in relation to their children's academic performance, which is inversely proportional to substance exposure), we find that the prevalence of parents with a high level of schooling is associated with the best scholastic results. In any case, higher schooling in parents within groups in relation to good school performance does not seem to be a protective factor in itself (Graph 2.20). For example, subjects with poor academic results having parents with a higher schooling level show a larger exposure to substance use compared to youngsters in the same age group reporting unsuccessful scholastic performance with less schooled parents.

Graph 2.20: Use of illegal drugs (once or more), academic performance and parents' schooling level.

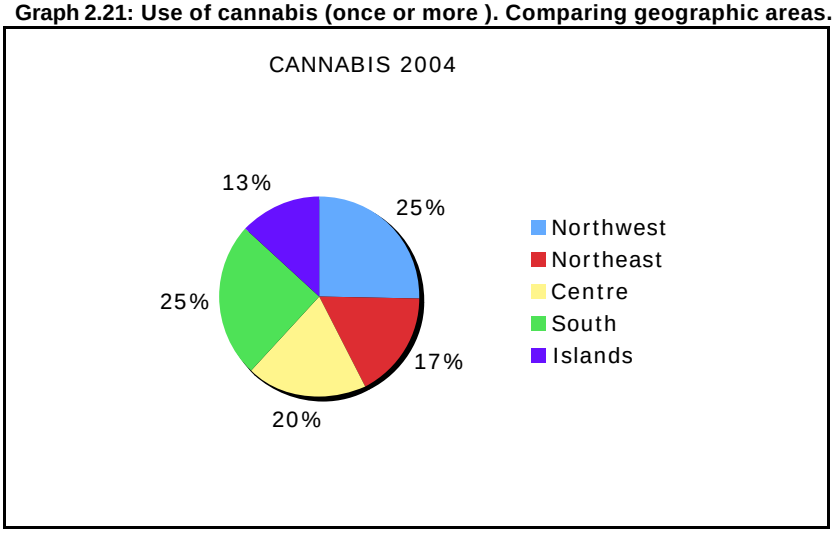


Based on ESPAD®Italia2000 and ESPAD®Italia2004

Comparison between geographic areas in drug use among students

The macro-area distribution analysis does not report differences as far as cannabis use is concerned (once or more) from 2000 to 2004. The phenomenon involves the entire country, with a small exception with regard to in the Islands (Sicily and Sardinia) where cannabis use is slightly lower (Graph 2.21).

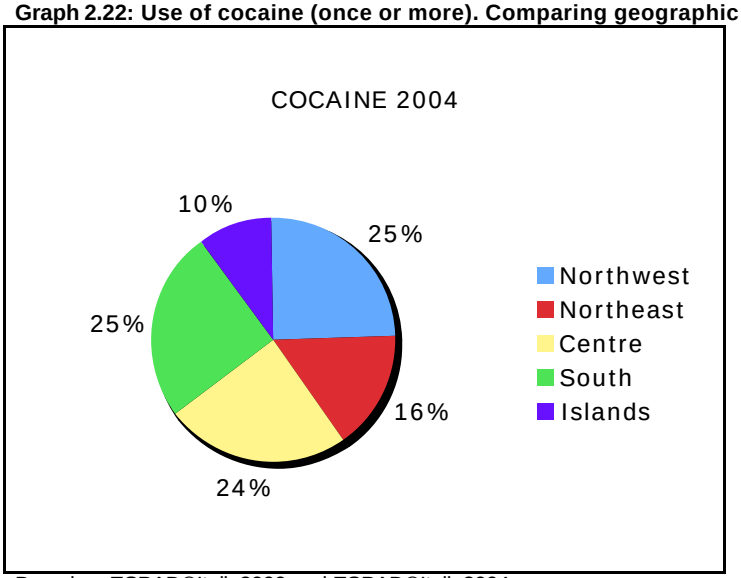
Graph 2.21: Use of cannabis (once or more). Comparing geographic areas.



Based on ESPAD®Italia2000 and ESPAD®Italia2004

Use of cocaine appears to be concentrated in the Italian South-Central regions (Graph 2.22). It is in fact the Central regions which, in the four-year study period, saw the greater increase in students reporting lifetime use, going from 3.7% to 6.9%. Use decreases in North-East and Island areas.

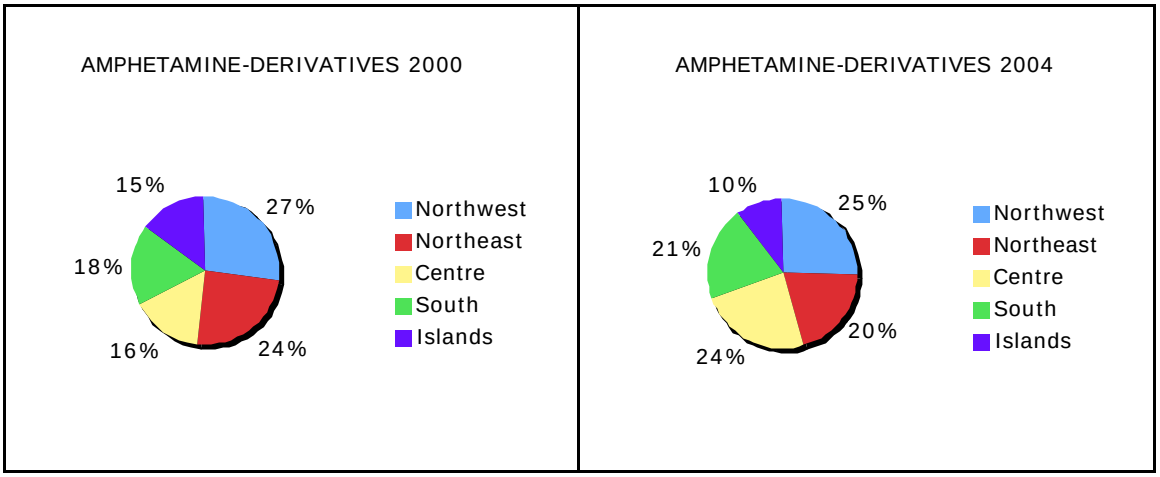
Graph 2.22: Use of cocaine (once or more). Comparing geographic areas.



Based on ESPAD®Italia2000 and ESPAD®Italia2004

As opposed to the national trend, with decreasing use of amphetamine derivatives, the Central regions report an increase in students reporting use (from 3.4% in 2000 to 4.3% in 2004). we find the phenomenon widespread throughout the Peninsula, with the exception of the Islands (Graph 2.23).

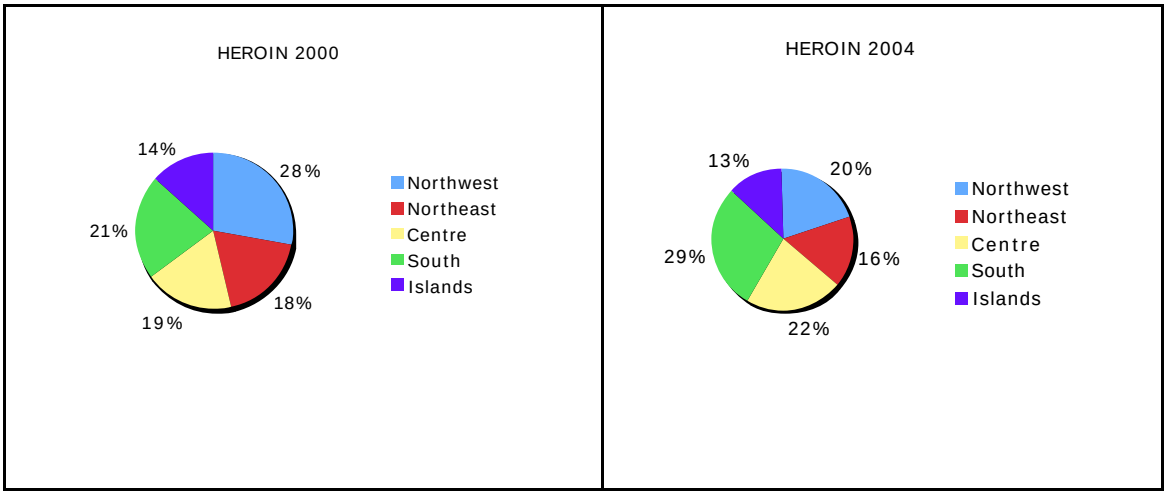
Graph 2.23: Use of amphetamine derivatives (once or more). Comparing geographic areas.



Based on ESPAD®Italia2000 and ESPAD®Italia2004

Again it is the Centre (albeit dropping in this case) that has the highest number of students reporting heroin use, as well as the South (Graph 2.24).

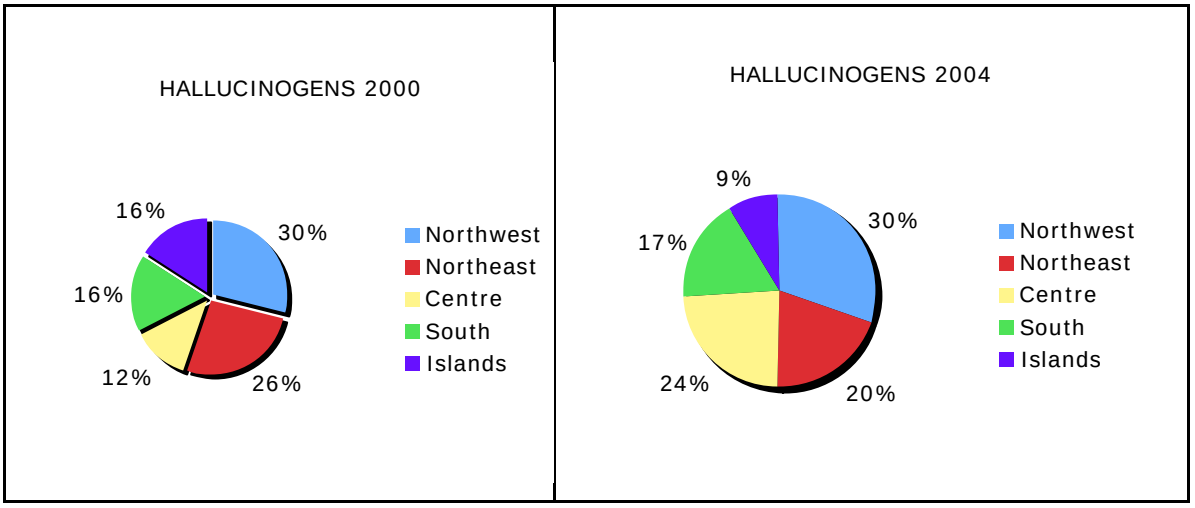
Graph 2.24: Use of heroin (one or more times). Comparing geographic areas.



Based on ESPAD®Italia2000 and ESPAD®Italia2004

Given this general increase in students with experience using hallucinogens, we find, in this case too, an increase in the phenomenon in the Central regions, where students reporting its use went from 2% to 5.5% (Graph 2.25).

Graph 2.25: Use of hallucinogens (one or more times). Comparing geographic areas.

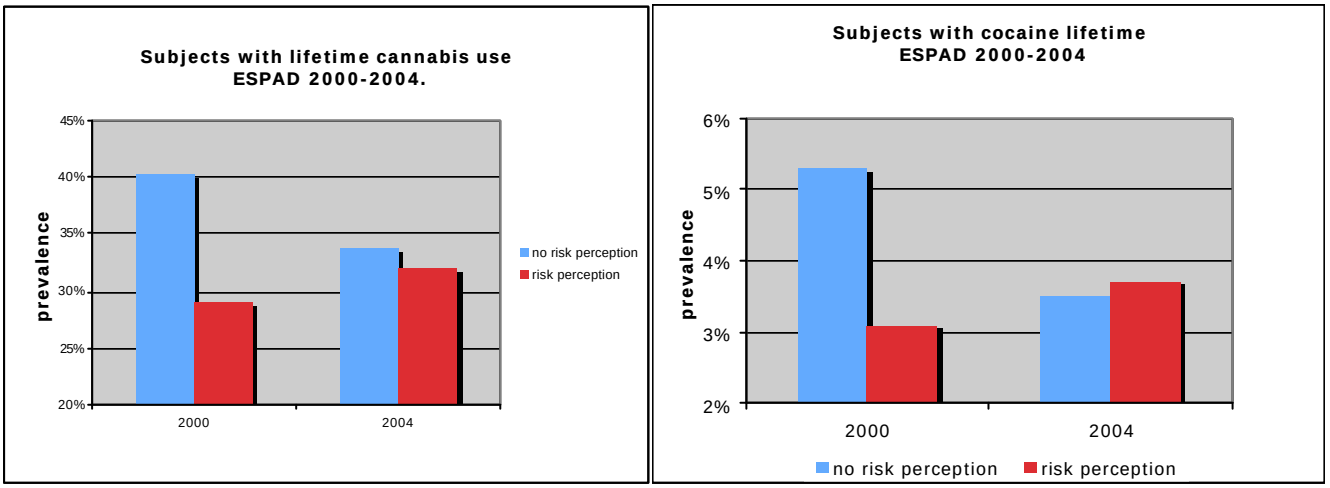


Based on ESPAD®Italia2000 and ESPAD®Italia2004

Risk perception and use among students

Recent studies show that risk perception in illegal psychoactive substance use, until recently closely associated with unwillingness to try substances, has been losing its protective character.

Graph 2.26: Perception of risk in using illegal drugs and use of illegal drugs. 2000-2004 compared



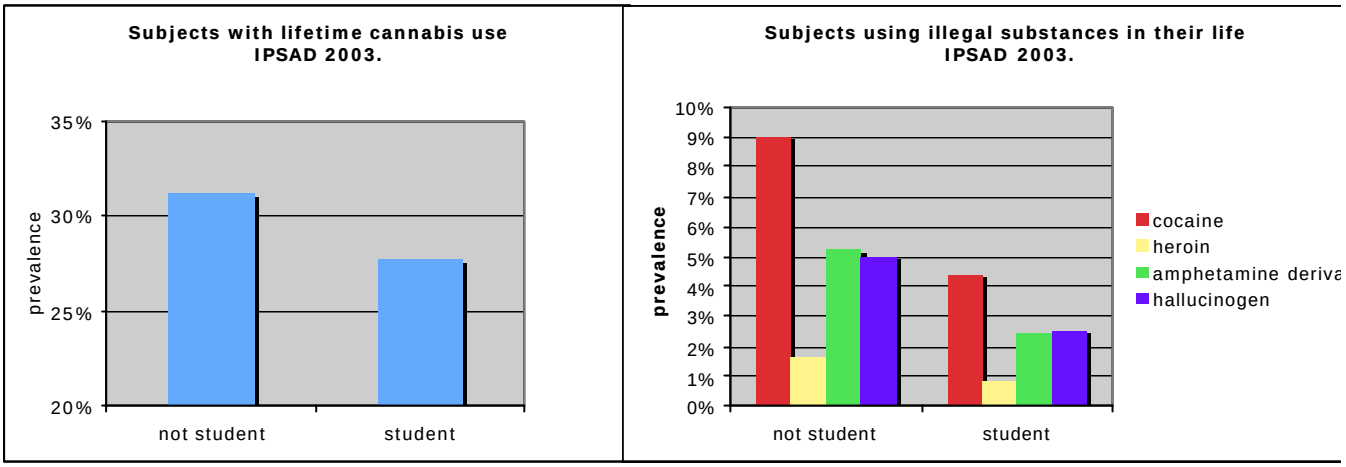
Based on ESPAD®Italia2000 and ESPAD®Italia2004

In 2000 students perceiving the danger in the use of cannabis were exposed significantly less frequently than those in the same age group who did not perceive the risk. In the 2004 study we find other adolescents who, even though they perceive the risk of drug use, nonetheless expose themselves to the use of substances (Graph 2.26).
Particularly significant are the data relating to students with experience using cocaine. From the study conducted in 2004, we find that students using cocaine and perceiving a risk for their health are more numerous than those using it and not perceiving the risk.

IPSAD comparative study between schooled and unschooled (ages 15-24)

If we compare subjects in the youth population (ages 15-24) who attend school or university with those of the same age who have dropped out of school and are already working, significant differences emerge. Youngsters who drop out of school early risk greater exposure to the use of substances than do subjects staying in school (Graph 2.27).

Graph 2.27: Subjects using illegal substances (one or more times). Comparison between subjects in school (attending school or university) and those not attending.



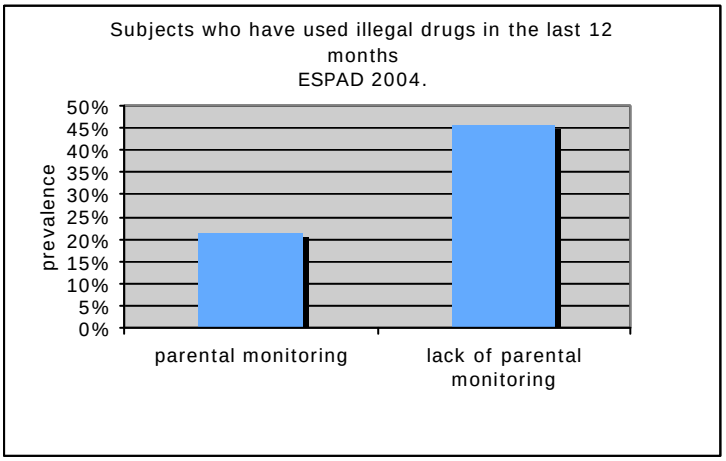
Based on IPSAD®Italia2001 and IPSAD®Italia2003

Preventing dropouts and offering adolescents an educational path to follow through to young adulthood represents an obvious protective factor. Subjects who continue to attend classes are less prone to risk compared to their peers who drop out, in terms of heroin, hallucinogens, cocaine and amphetamine derivatives are concerned. As far as cannabis goes, the difference is less but still lower for students.

Parental monitoring and drug use

Parental monitoring of adolescents (considered as being aware of their children's whereabouts and leisure activities) appears to be a strongly protective factor. Students reporting a constant lack of parental control run a 200% higher risk of coming into contact with illegal psychoactive substances compared with their "monitored" peers (Graph 2.28).

Graph 2.28: Use of illegal drugs (one or more times in the past 12 months) and parental monitoring



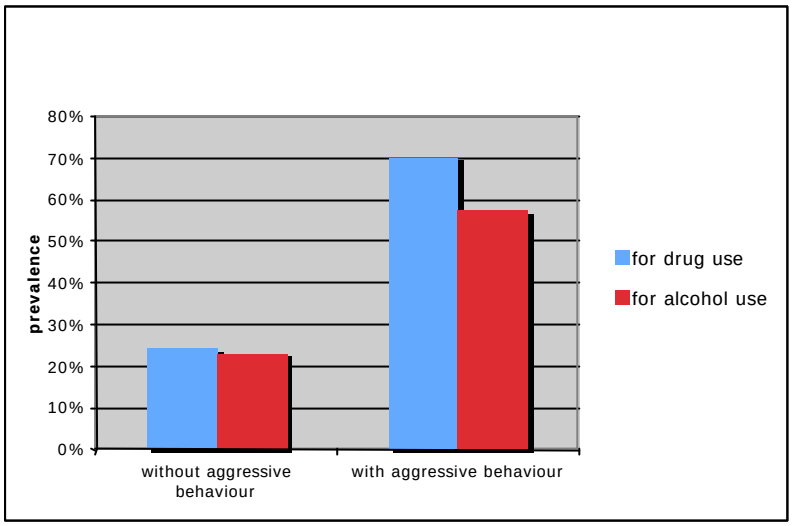
Based on ESPAD®Italia2000 and ESPAD®Italia2004

Parental involvement in their children's life along with sound emotional communication, a warm family environment of empathy and dialogue, and allowing psychological independence, are strongly protective according to the scientific literature, especially when associated with appropriate supervision and constant monitoring.

Aggressive behaviour and drug use

According to the ESPAD study, a correlation emerges between a readiness for conflict and aggressive attitudes and substance use. Students with a history of use run three times the risk of aggressive behaviour that their peers do. The risk factor increases considerably if we narrow the analysis to the type of substance used (Graph 2.29).

Graph 2.29: Use of illegal drugs (one or more times in the past 12 months) and aggressive behaviour.



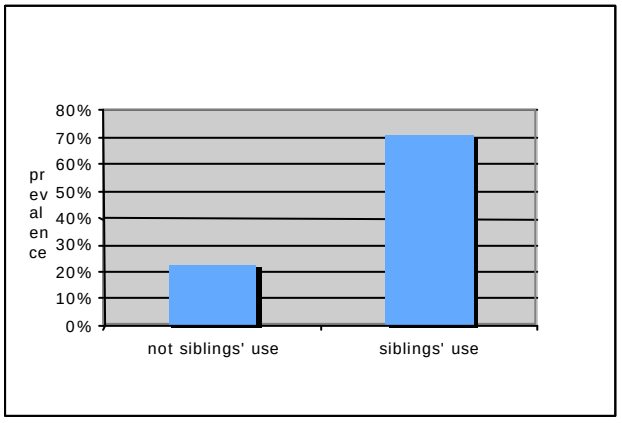
Based on ESPAD®Italia2000 and ESPAD®Italia2004

Whilst students with history of cannabis use run twice the risk, those with a history of cocaine use have eight 8 times the risk, and those subjects reporting use of amphetamine derivatives run ten times the risk over their peers who abstain from use. On one hand, illegal psychoactive substances may have led to aggressive behaviour; on the other it may very well be the more aggressive adolescents who experiment with drugs due to their personality traits.

Correlation between siblings using illegal substances and drug use history

A family member using illegal substances or alcohol has been reported in scientific spheres as an important risk factor. Particularly, drug use in siblings plays a role in exposing adolescents to substances.

Graph 2.30: Use of illegal drugs (one or more times in the past 12 months) and siblings using illegal drugs.



Based on by ESPAD®Italia2000 and ESPAD®Italia2004

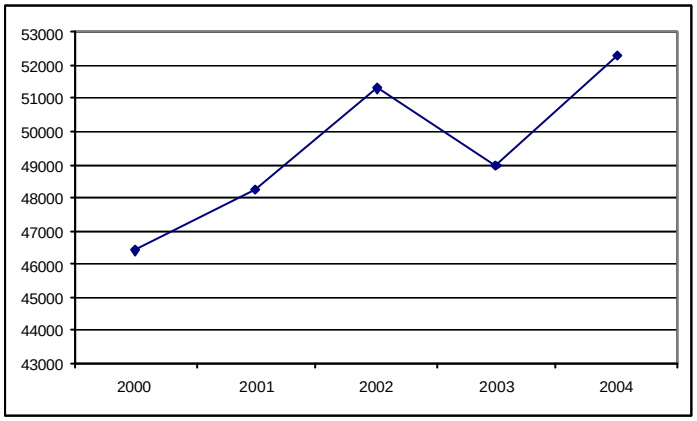
The 2004 ESPAD study confirms the following: as shown in Graph 2.30, students with a sibling who uses illegal psychoactive substances have three times the risk of experimenting with illegal drugs compared to their peers.

2.3. Drug use among specific groups

2.3.1 Prefecture reports of possession of illegal drugs (art. 75 Presidential Decree n. 309/90)

In 2004 the Central Office for Documentation and Statistics of the Interior Ministry, through the "terminal recording" system located at local government offices, or Prefectures, received 87,894 reports involving 67,551 subjects: 75% of subjects had only one report during the year, while the remaining 25% had two or more reports. in this last figure we see the presence of repeated reports in this brief period as a sign of repeated behaviour leading to reporting.
By comparing the information in the database of the Ministry of the Interior and the report forms in a sampling of Prefectures, it was possible to estimate the trend over time of the number of subjects reported for possession (Art.75 Pres.Decree 309/90), which increased 13% (Graph 2.31) in the 2000-2004 period.

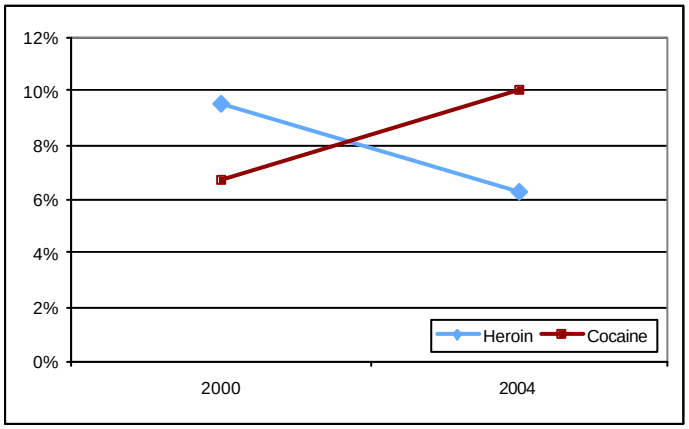
Graph 2.31: Number of subjects reported under Art.75 Pres.Decree 309/90. Comparing 2000-2004.



Data prepared by Central Office for documentation and statistics (D.C.D.S.)

The substance associated with the report is cannabis (hashish and marijuana) in 78% of the cases, cocaine in 10%, heroin in 6%, and amphetamine derivatives in 1%.
In the 5-year period examined, we find substantial stability in terms of reports concerning cannabis (81% of reports in 2000 vs 78% in 2004) and amphetamines (1% of reports both in 2000 and 2004). As far as cocaine and heroin are concerned, similarly to what was observed in the general population, Prefectural reporting shows a considerable increase in psycho-stimulants and a like decrease in opiates (Graph 2.32).

Graph 2.32: Subjects reported under Art.75 Pres.Decree 309/90. Comparing 2000-2004 in percentage distribution by substance type associated with the report.

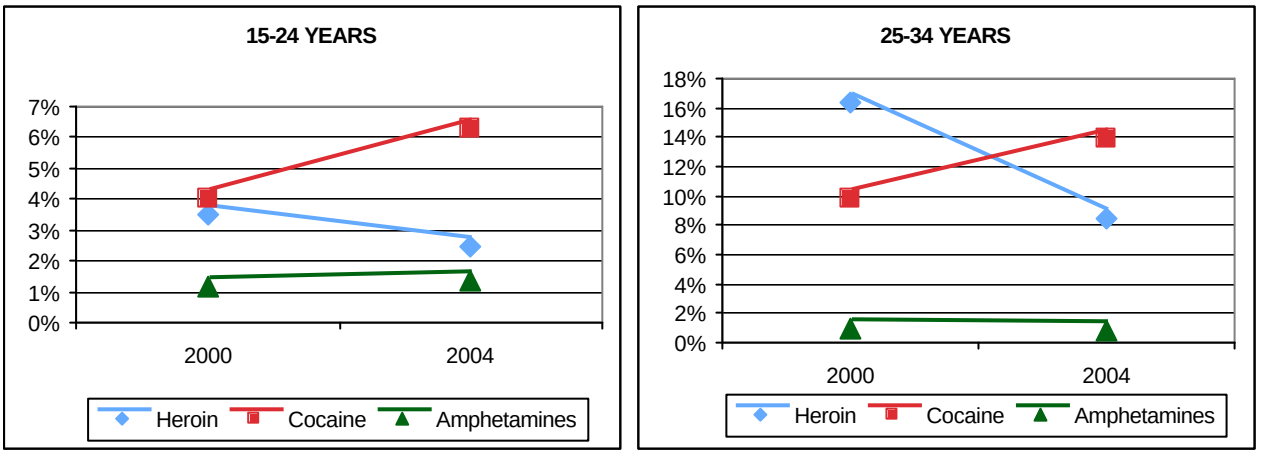


Data prepared by Central Office for documentation and statistics (D.C.D.S.)

Out of a total of 195,136 subjects reported in the 2000-2004 period, 56% were reported one time only while the remaining 54% had two or more reports. Reading the number of subjects reporting a

single notification as an indicator of the phenomenon's incidence, we find the trend remains constant.
The specific variations in substance type previously described above are confirmed within the various age groups and show a diversified phenomenon in terms of involvement of the youth population and young adults in relation to the substances in question.
The 114,511 subjects aged between 15 and 24 picked up by law enforcement officers between 2000 and 2004 were found in 88% of cases to be in possession of cannabis (hashish or marijuana), 5% cocaine, 3% heroin and around 1% amphetamines: a decrease for cannabis and heroin, as opposed to an increase for cocaine. Subjects reported for hallucinogens are below 1%.
The situation is different for the 60,593 young adults between ages 24 and 34, 72% of whom were reported for possessing cannabis, 12% for heroin, 11% for cocaine, 1% for amphetamines, and in less than 0.5% for hallucinogens. The trend over time in this case also shows an increase in subjects reported for possession of cocaine, stability for cannabis and amphetamines and a decrease for heroin (Graph 2.33).

Graph 2.33: Reports under Art.75 Pres.Decree 309/90, 2000-2004 comparison of number of subjects by age and type of substance associated with the report.



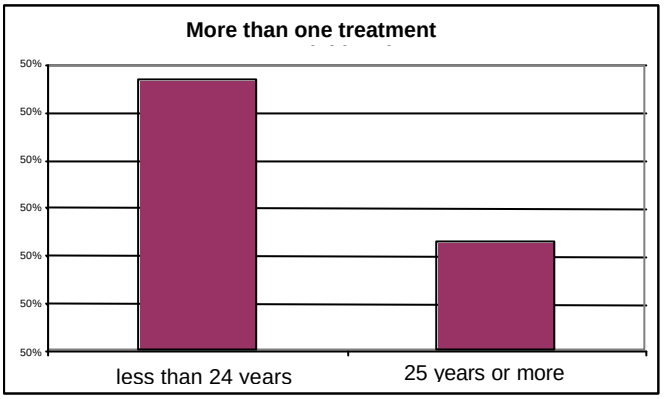
Data prepared by Central Office for documentation and statistics (D.C.D.S.)

Reported subjects aged 35 or older (18,684) represent only 10% of the total reports for the period and are broken down according to the reported substance, with 56% in possession of cannabis, 16% in possession of cocaine, 22% in possession of heroin and less than 1% in possession of hallucinogens and amphetamines.

Reported subjects referred to rehabilitation programmes

Among the 195,136 subjects reported by the Prefectures in the 5-year span 2000-2004, a sample of 7,476 subjects was examined (around 4% of the total), for whom a rehabilitation programme was initiated in collaboration with special assistance facilities at the local level. For 4% of these, more than one programme was set up in the 2000-2004 period (an average of 2 for each subject).
Graph 2.34 shows a link between age at first report and the number of programmes started (the earlier the start the more repetition): Pearson chi2(1)=9.0335 p=0.003).

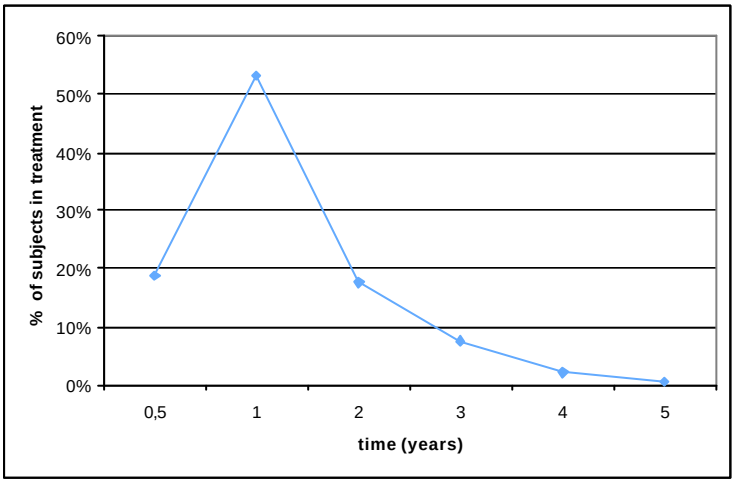
Graph 2.34: Percentage distribution of treatments started for each subject. Comparison by age at first report.



Data prepared by Central Office for documentation and statistics (D.C.D.S.)

More than 95% of subjects studied are still in treatment today. Using survival analysis methods, it was estimated that on average treatment lasts 2 years (Kaplan-Meier estimate). There is a significant difference between average treatment duration and age group at first report.
Graph 2.35 shows treatment duration referring only to those subjects having already ended treatment.

Graph 2.35: Duration of treatment in subjects who in 2000-2004 started and ended a treatment in local facilities.

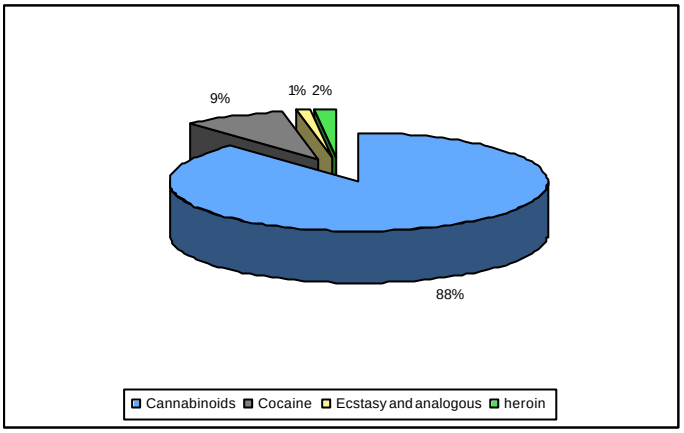


Data prepared by Central Office for documentation and statistics (D.C.D.S.)

2.3.2 Conscripts

If we consider tests conducted in the military in 2004, 1% of all subjects tested positive for drugs (note that the “drug test” is given in certain instances for mandatory toxicological check-ups and in other cases as a random sampling. Toxicological examinations conducted on military personnel expected to perform more specialised duties (e.g., Air Force officers) screened positive in 1% of cases, indicating an even lower exposure to illegal substances in the military population.
Subjects testing positive were distributed for slightly more than 96% among draftees and auxiliary/volunteers, and the remaining 4% hired permanent service personnel and civilians. Within this same group, cannabis is used in slightly more than 88% of cases (Graph 2.36) with a frequency determined as part of subsequent verifications of “once a week or less” in 45% of cases, “occasionally” for 34% and “several times a week” for the remaining 21%.

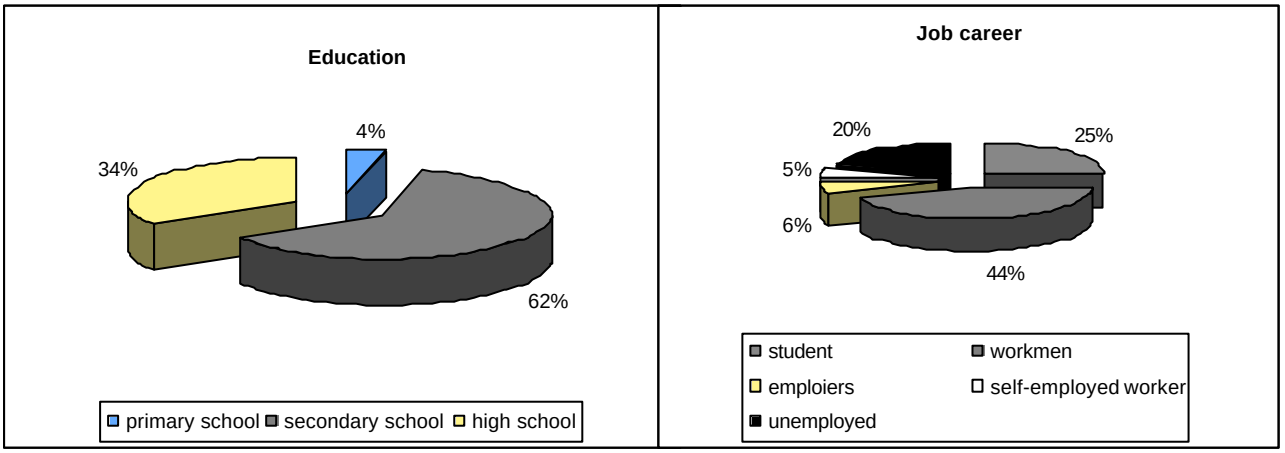
Graph 2.36 Drug use in the military



Data prepared by Ministry of Defence

Taking a closer look, we can see that around 62% of those testing positive had an educational level limited to middle school, 44% were workmen in civilian life and 20% reported being unemployed (Graph 2.37).

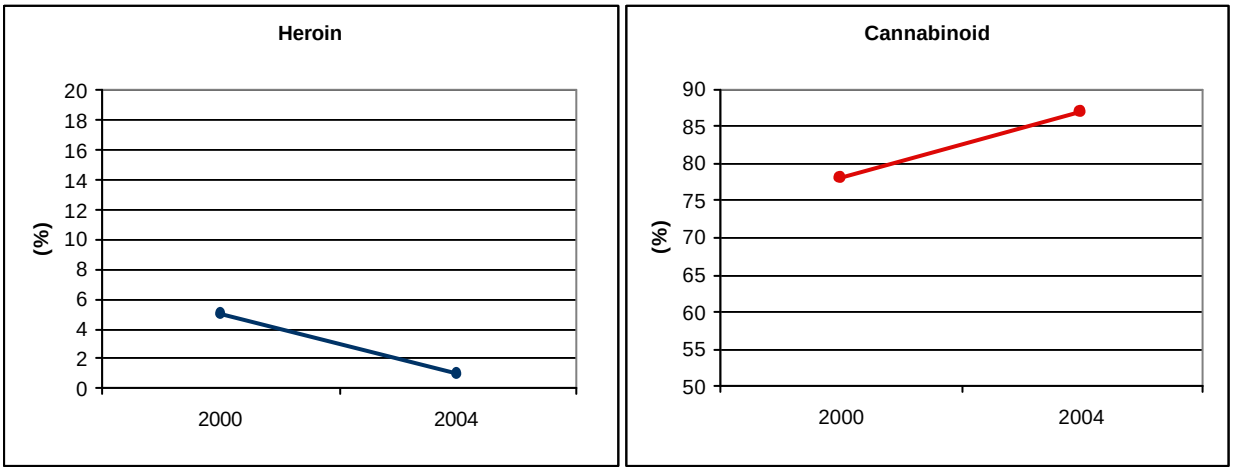
Graph 2.37: schooling and work history in drug users



Data prepared by Ministry of Defence

A comparison conducted in previous years (2000-2004) shows that (Graph 2.38) in contrast to a significantly downward trend (p=0.009) reported in the case of “heroin and other opiates” there is increase in cannabinoids (p=0.03).

Graph 2.38: percentage of heroin and cannabinoid users among subjects testing positive: years 2000-20



Data prepared by Ministry of Defence

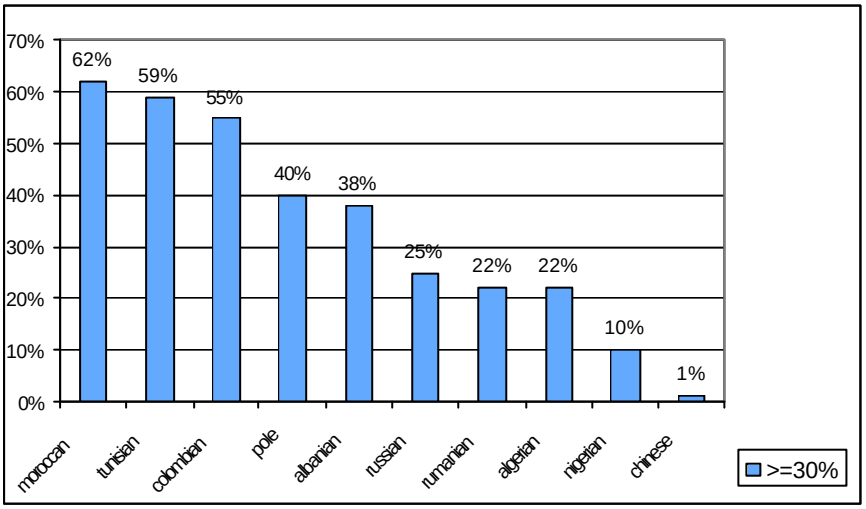
2.3.3 Minorities

Two different studies conducted in 2004 obtained preliminary data involving the phenomenon of drug addiction among the immigrant population in Rome. One was conducted by the National Department for Anti-Drug Policies and the other by the Institute of Clinical Physiology of the National Research Centre (C.N.R).
The first study adopted a quantitative methodology, with the help of a structured questionnaire given to 1000 immigrants living in the capital and aiming at collecting data and information regarding the spread of substance use, and possible risk factors. The other study adopted a qualitative methodology, gathering life histories and using the participant observation technique.

Quantitative data

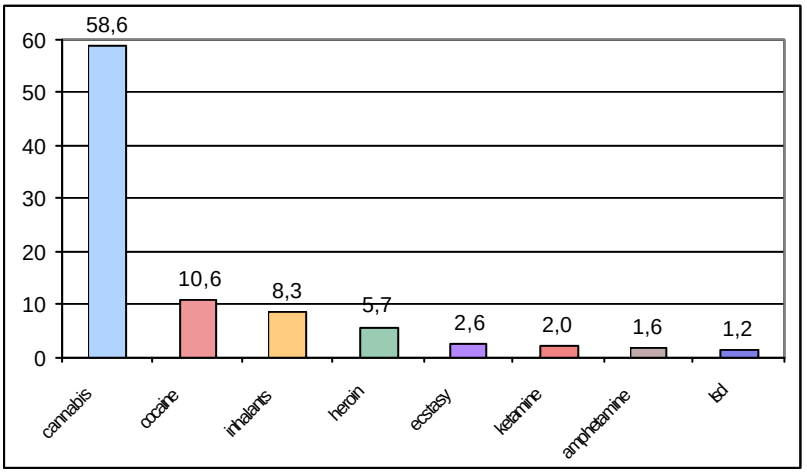
Generally speaking, the ethnic groups which most perceive the seriousness of drug use among fellow-countrymen are those from Morocco, Tunisia and Colombia (Graph 2.39). Among the Chinese, Nigerians, Romanians, Russians and Algerians, there is a prevailing belief that the level of drug users among compatriots is limited, equal to or less than 10%.

Graph 2.39 Percentage distribution (=>30%) of substance users according to nationality of subjects screened



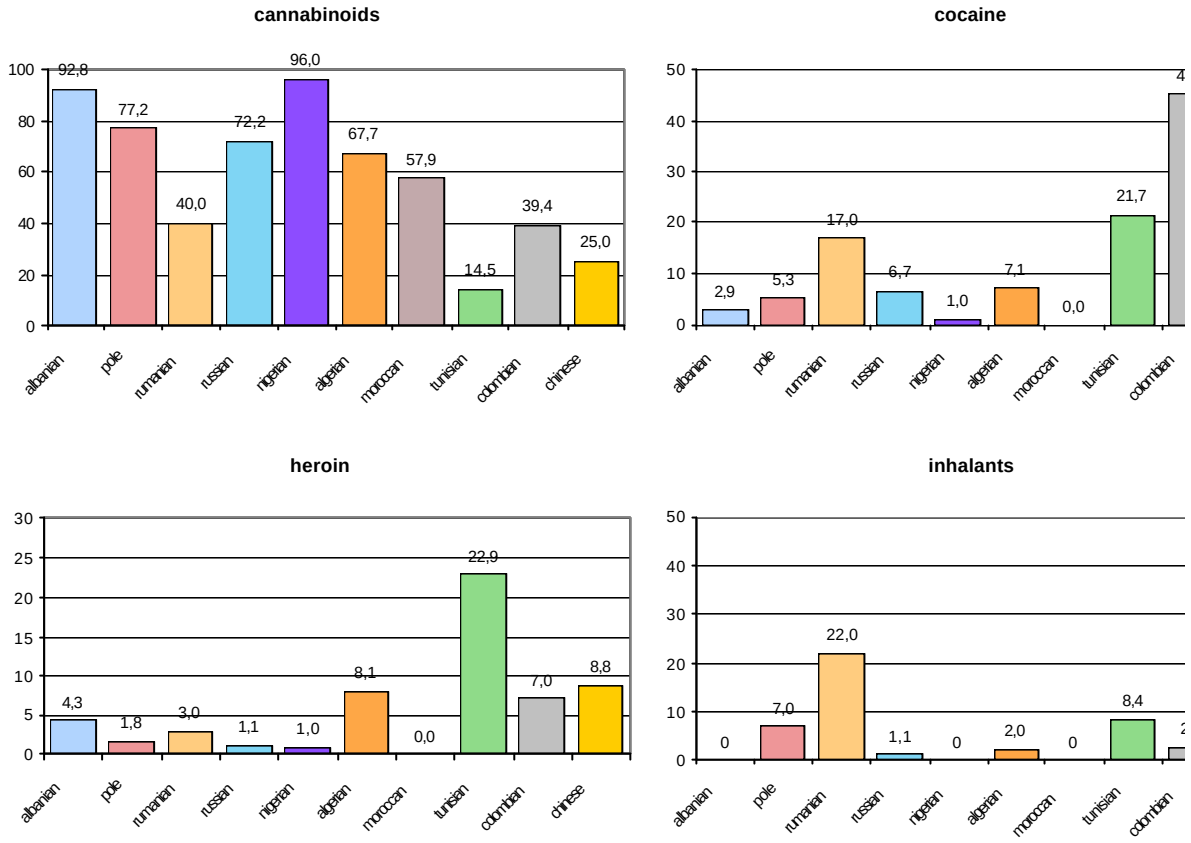
According to 59% of those interviewed, the substance most used by their countrymen (Graph 2.40) is cannabis, followed by cocaine (around 11%) and inhalant drugs (around 8%).

Graph 2.40 Percentage distribution of main substance used



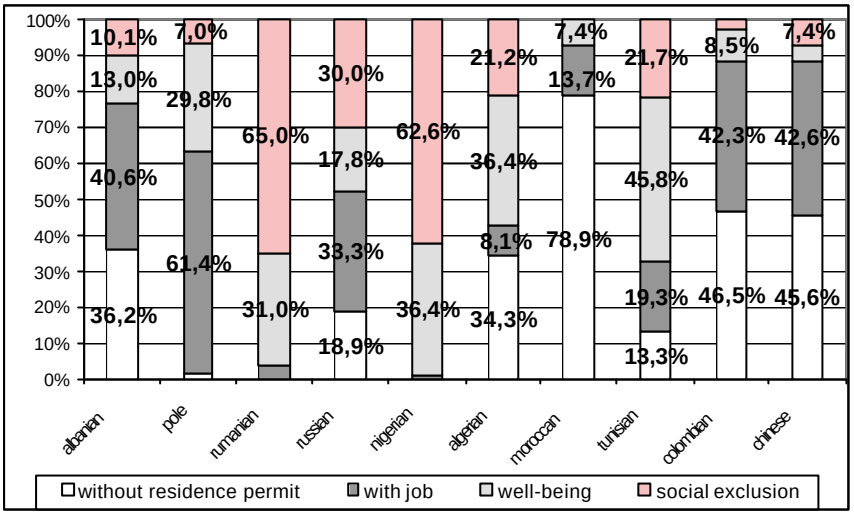
Analysis of the substances used according to nationality (Graph 2.41) shows that cannabis use is reported mainly by Nigerians and Albanians, cocaine by Colombian subjects, heroin and inhalants by Tunisians and Chinese.

Graph 2.41 Percentage distribution of main substance used according to nationality



Four risk factors were identified in relation to substance use: possession of a residence permit, a secure home, a steady job and a good income.
These factors appear to affect in different ways the increase in the risk of taking drugs in relation to the various ethnic groups: whilst in some cases greater social exclusion promotes use, in others it is greater integration, with the resolution of the more dramatic problems relating to survival, that leads to drug use.
Hence, risk factors in relation to substance use vary according to the nationality of the subjects interviewed (in some cases with strong variations within the group): in fact, whilst among Nigerians and Romanians there is a prevailing belief that total exclusion and deprivation lead to substance use, according to almost all the Moroccans interviewed, drug use depends on the lack of a residence permit.

Graph 2.42: Percentage distribution of risk factor changes among different nationalities



Among immigrants coming from Poland the prevailing belief is that substance use is associated with a "steady job," while in the case of Tunisians, we find the greatest variation among the various notions as to what leads to at-risk conditions (Graph 2.42).

Another aspect surveyed regarded expectations (with regard to the effects produced by substances) that would lead the interviewees' fellow-countrymen to use substances; drug taking in this case is assumed to be aimed at forgetting personal problems and the need to feel happy, according to 43% and 32% respectively of those participating in the study. Use may help to "face fatigue better" and "remain in a group" according to 17% of cases and to "stay calm" for the remaining 6%. As the subjects interviewed were not directly involved with substance use, their knowledge of its effects is limited; within the ethnic groups observed there are in fact no significant associations between the various kinds of substances and expectations of them.

On the other hand, the reasons that supposedly push people to drug use are the need to "defeat depression and boredom" or "having fun, and curiosity" in around 32% of cases, "ease of getting the substance" for almost 17% of surveyed subjects, and "being like others" in the remaining 15% of situations.

The analysis by substance (Table 7) shows that whilst in the case of heroin the predominant reason is easy access (around 33%), as far as amphetamines and inhalants are concerned, use is primarily due to "defeating depression and boredom" (40% and 33% respectively); in the case of cannabis, cocaine, ecstasy and ketamine, curiosity and enjoyment are the reasons responsible for their use.

Table 7: Percentage distribution for reasons of substance use, among different nationalities

Substances	Reasons for substance use				
	Easy access	Defeating depression	Being like others	Enjoyment and curiosity	Other reasons
cannabis	15,3%	32,6%	13,4%	34,8%	3,9%
cocaine	23,2%	18,9%	21,1%	31,6%	5,3%
heroin	32,7%	23,1%	19,2%	19,2%	5,8%
amphetamine	13,3%	40,0%	26,7%	20,0%	0,0%
ecstasy	20,0%	30,0%	5,0%	40,0%	5,0%
lsd	20,0%	10,0%	30,0%	30,0%	10,0%
ketamine	22,2%	33,3%	5,6%	38,9%	0,0%
inhalants	13,0%	33,3%	17,4%	29,0%	7,2%
other substances	15,0%	40,0%	16,3%	23,8%	5,0%

Qualitative survey

The objective of the second survey was to study the phenomenon of drug addiction among migrant populations in Rome, and taking as context public services and private social services with drug-addicted users. The semi-structured interviews were directed at addicted foreigners: the countries of origin were those of the Magreb (Algeria, Morocco, Tunisia), of sub-Saharan Africa (Democratic Republic of Congo, Kenya), of Eastern Europe (Ukraine, Serbia, Russia) and Sri Lanka, Egypt and Greece. Interviewees were for the most part males (of the entire sample only 2 were women), between 19 and 57 years of age.

Life stories were gathered through the use of semi-structured interviews on the basis of a complex grid which revealed the following areas as most relevant:

Relationships and material life: living and working conditions, social relations, leisure time, religion.

A large number of drug-addicted immigrants have not succeeded in creating a solid social and professional integration process. As for professional integration, a majority of interviewees suffered precarious working conditions, even for extended periods of time.

Living situations, often seen as transitory solutions, were highly varied and located in urban areas of extreme degradation: train stations, underpasses, welcome centres, abandoned homes, shared private residences, temporary rented rooms, and quarters provided by employers.

As for other indicators like social network, leisure time and emotions, the interviewees (with rare exceptions) were found to be rarely integrated within a social network of either family, friends or community; the only personal relationships are fragmentary and involve drug-addiction environments (fellow-addicts, petty crime groups, professional figures, social workers, etc.). Substance use weakens emotional and friendship links and sours long-distance relations with the family of origin.

As for religion, which normally plays a protective role in terms of drugs, it appears to have lost its role as deterrent among the interviewees.

The addict's experience: types of drugs used, age and use patterns, contexts of use, motivations, therapy and relationship with services, legal issues and jail.

Among those interviewed, some report having first approached drugs in their country of origin, while others report having started in our country. It was found that those making first contact with drugs in their country of origin are characterized by having started with cannabis (marijuana and hashish), usually in a peer group (in places like the street, bars, friends' homes) and at an early age. Use of drugs, for some occasional and for others habitual, was not looked upon as something dangerous or representing a risk in compromising social relations, integration at work or health.

Those whose first approach to substance use occurred in Italy began with heroin, cocaine and psychoactive drugs (except in some cases where the firstly tried drug was cannabis).

The stories told reveal a prevalence of multiple use among all immigrant users; in contrast, preference for some substances and methods of use (smoke, nasal, oral or intravenous) are varied and defined by culture. For example, among African drug addicts, whether from the Magreb or sub-Saharan Africa, the methods chosen for substance intake are also closely associated with body image. This group in fact shows strong opposition to the idea of "poking holes", considered damaging for the body itself and its wholeness, thereby impairing the individuals' dignity.

Addiction behaviour in the foreign population is therefore highly diversified according to cultural origin of the specific addicted subjects. Nonetheless, as confirmation of other studies conducted on this phenomenon, this difference seems to disappear with the development and prolongation of the addiction: intravenous drug-taking is rapidly spreading among those groups who did not initially adopt this method. In this way, the pathology tends to prevail over all other variables, whether ethnic or cultural, thus giving way to a considerable uniformity among the subjects involved.

Another factor common to the majority of subjects interviewed is involvement with specialized petty crime groups employed in daily scams, dealing and theft.

Among those interviewed, some turned to therapeutic facilities, often through the counselling and psychological support of social workers and doctors; others turned to Ser.T (Public Addiction Services) for pharmaceutical requests and others to low-threshold facilities (street units, day and/or

night emergency reception centres). In any case, the primary need leading addicted immigrants to turn to these facilities appears to be overcoming material issues (lodging, meals etc.).
Several political-health intervention projects in this area offer foreign addicts a chance to return to their country of origin with economic and professional support provided by the Italian services. For these subjects, however, a return programme is often associated with feelings of shame and dishonour (as they feel they are both a "failed immigrant" and a "drug addict"). For this reason, however strong the desire to return to the country of origin, the opportunity is usually postponed until the therapeutic process is completed.

Use and abuse of drugs among prostitutes

The ratio between use/abuse of substances and prostitution has been the object of close analysis in the research project "Prostitution…drugs! A study of the multiple identities of prostitution and addiction"[2] conducted by an association that is part of the National Coordination of Reception Facilities (C.N.C.A.). The research, in the wake of a geographic breakdown of the area,[3] through interviews with people selling themselves on the street, surveyed the relationship between prostitution and psychoactive substances, both illegal and legal, and defined the types of use/abuse existing among the different prostitute categories.
The total number of interviewees working on the street was 51.

Tab.8 – Characteristics and numbers of the sample identified in the qualitative study (semi-structured interviews)

Targets found	**Number of interviews**	**Characteristics (age range)**
Italian	6	23-43 years.
Albanian	5	18-29 years.
Nigerian	5	23-29 years.
Eastern European (Russian, Moldavian, Ukrainian, Croatian and Romanian)	12	22-29 years.
South American (Venezuelan)	3	34-57 years.
Transsexuals (7 Italian and 4 Brazilian)	11	Italian: 22-31 years. Brazilian: slightly under and over 40 years.
Men	9	17-35 years.
Total interviewed	**51**	

The study brought to light a considerable use of psychoactive substances among persons prostituting themselves on the streets, this use being extremely diversified as far as methods, substance type and persons involved. In particular, certain distinctive traits based on the original culture emerge.

[2] For further information concerning the research see:
On the Road Association (by), Prostitution... drugs! A study of the multiple identities of prostitution and addiction, Martinsicuro, On the Road, 2003.

[3] The area surveyed is made up of Abruzzo areas most affected by prostitution.

Substances	Use/abuse
Multi-combination	Combining "every type of substance", from alcohol to amphetamines, from opium derivations to speed (att.vuol dire speedball? Vedi italiano). It is not possible to trace the most frequently used specific combination, given the vastness of combined use. The multi-combination use phenomenon is very common among Italian and South American transsexuals.
Cocaine	For the most part, pure cocaine (chlorhydrate), rarely reported is the use of crack or cocaine-derived substances. Transversal to many targets.
Heroin	It is the substance particularly used by males and transsexuals, many of whom don't define themselves as addicted.
Cannabinoids	Mostly used by Albanian women in both journeys arriving into Italy and in the places and circuits where they are kept under surveillance and exploited. Places where relationships often develop.
Psycho-pharmaceuticals, amphetamines	Considerable use of pharmaceutical remedies, psycho-pharmaceuticals and amphetamines of various kinds: amphetamines for the younger, mostly males, psycho-pharmaceuticals for transsexuals, prescription psycho-pharmaceuticals for women.
Alcohol	Substance greatly used by prostitutes coming from Eastern Europe.
Other substances	Large use of pharmaceutical remedies of various kinds, mainly amphetamines, benzodiazepines (flunitrazepam), anorectics and speed (vedi sopra) of various sorts. Even though use is transversal to all prostitute target groups, exceptionally large use of said substances is reported among transsexuals and women.

The use of psychoactive substances originates in various motivations, ranging from a "comforting" purpose, as a way to withstand the stress of working on the street, to reasons mostly associated with the constant search for transgression and alteration of the mind, all the way to addiction where drug abuse becomes the cause of and primary reason for prostitution. We must also not underestimate the conditions in which use becomes "blackmail": the substance becomes either the immediate reason for getting money (drug-addicted street prostitutes) or payment for sexual performance by clients and protectors alike.

In the relationship between prostitution and the use of narcotic substances, we must take a close look at the intrinsic connection between clients, work context and prostitution activity: it is, in fact, most apparent how strong the pressure for use is, or simply how many invitations for use there are from clients.

Besides surveying the correlation between prostitution and drugs, the study also analysed the Services' response to addictions by means of a questionnaire provided to social workers and operators intended to shed light on experiences, practices and operating methods adopted by those Services that deal directly or indirectly with prostitution and/or with subjects who use substances and persons prostituting themselves.

Possible guidelines emerging from the study results, even though restricted to a modest sample, include a need to promote special activities by street units and various services that prostitutes may turn to: a contact through which use or abuse of psychoactive substances is seen as a serious issue. In addition, the study shows the needs to develop the skills of service operators, raise awareness of efforts against addiction (rehabilitation centres, low-threshold facilities, etc.), and the need to sensitize and train law-enforcement agencies, as shown by the research, appear great necessity.

Another study conducted by Magliana '80 Cooperative with the support of the National Institute of Health surveyed the number of prostitutes among drug addicts using a qualitative study and attempted to determine the scale of illegal psychoactive substance use in a sample of around 160 foreign prostitutes. Results show that about 60% of female addicts have at least once performed sexual intercourse in exchange for money or drugs; 85.7% reported having performed sexual activities under the influence of drugs. An analysis involving non-E.U. prostitutes recruited outside of the drug-addiction environment shows that in most cases they denied use of illegal substances and admitted to an occasional use of cannabis and the abuse of alcohol. More in-depth qualitative interviews show, on the contrary, an even closer connection between activities related to prostitution and drug use.

3. PREVENTION

Overview

As part of the activities promoted by the Monitoring Office of the National Department for Drugs Policy two studies were undertaken on initiatives to prevent the use and abuse of drugs, which considered prevention activities undertaken in schools and in local communities respectively.

1. The first study, on prevention activities in schools, carried out during the current academic year, is based on a questionnaire sent to the school heads and saw the involvement of 487 institutes chosen in such a way as to present a representative sample of high schools in Italy
2. The second study concerned prevention activities set in local communities. In this case a representative sample was made of the 541 public drug addiction services that were reported active in 2004. A questionnaire was sent to the managers and directors of these structures and in their expert capacity they were asked to respond to a questionnaire on the activities undertaken in their areas in terms of universal prevention (excluding school level), selective and indicated prevention (excluding school level), prevention and treatment of drug-related infectious diseases, prevention of drug-related deaths, and the social reintegration of (former) drug users.

These two studies enabled the formation of an overview of what is being done in Italy in this field, which is characterised by a great number and variety of initiatives, projects, key players, sources of financing, and principals.

3.1 Universal prevention

3.1.1 School based prevention

Among the varied activities for which it is responsible, the Student Office of the Ministry of Education, Universities and Research (MIUR) has continued to handle measures aimed at health education and addiction prevention.

In this context, a seminar was held to introduce the second-level survey on "The Condition of Childhood and Adolescence in Italy." The survey, conducted by six research groups, was aimed at supporting implementation of adequate strategies for promoting the development of children and adolescents as persons and as active members of society. The study performed analyses of the variables affecting the wellbeing of minors and of practices suitable for preventing hardship in its various forms and expressions. Within this overall perspective, the programme was broken down into six survey areas:

1. The condition of childhood and adolescence in Italian society, referring in particular to: the living environment and situations of social hardship; mass media culture; episodes of criminality, bullying and violence acted out or suffered; peer group behaviours.

2. The condition of childhood and adolescence in Italian schools, especially in relation to the educational process, the phenomenon of school dropouts, and integration of the handicapped in school.

3. The condition of childhood and adolescence in the family: the family's configuration and organisation; analysis of family policy, the impact on minors of the separation of parents and the educational absence of the parents; the presence of psycho-social hardship and violence within the family; factors of wellbeing and normalcy.
4. The condition of foreign minors in Italy, with special attention to the characteristics of immigration, social integration and school placement.
5. The minors and illness, an area aimed at monitoring the health status of minors in Italy; the incidence of major acute and chronic diseases in the growth years, the incidence and causes of mortality, the hospitalised minors.
6. At-risk behaviours in the growth years, with particular attention to suicidal conduct, abusive behaviours (drugs, alcohol, tobacco), sexual behaviours, abnormal eating behaviours, violent sports, doping and leisure time management. A summary of the study was published on the MIUR's Internet site.
These topics are points of reference for planning preventive measures.

Monitoring of the project "Missione Salute" (Mission Health) was begun in 2004; this is an initiative of the MIUR and the Health Ministry for students, families and teachers. In 2003 all students attending the last two years of secondary school were given six brochures, dealing with the following topics: eating, sexuality, addictions, doping, donating blood and organs, first aid, and accident risks. Instructors used the brochures as starting points on which to base preventive measures. In most schools, these student activities were begun in the 2003/2004 school year, along with nationwide monitoring with the involvement of teachers as contacts for health education at the regional level. Early data show that 1,871 senior secondary schools dealt with topics relating to drugs, alcohol, tobacco and doping using the tools provided to them by the Mission Health programme. In all, 6,346 projects on all topics were carried out. As part of the prevention of youth marginalisation, the EDUMONITOR Internet site was created; it allows analysis of the activities and measures implemented in the schools. Using this online system, the Regional School Offices will be able to find out in detail what activities are carried out by the schools in terms of health education and prevention of marginalisation. The monitoring, begun in the 2000/2001 school year in six geographic areas, will be expanded to schools nationwide in 2005.
Another project promoted by MIUR is the planning, creation and operation over a three-year period of 20 community centres to promote participation by young people, intended to provide

opportunities focusing on young people as they mature and become socialised, and aimed at preventing all forms of youth marginalisation, including addictions and dropping out of school. In particular, the activities of the centres will be aimed primarily at young people between the ages of 13 and 18, and their families. The choice of 20 community centres will ensure service in the main metropolitan areas and in the Regional and Provincial capitals. The various areas of activity include:

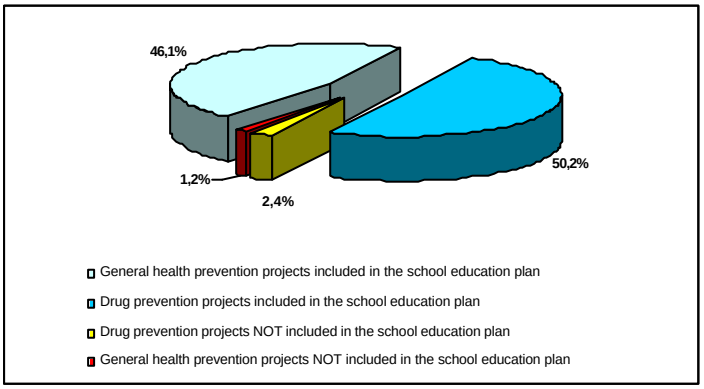
- counselling and support for young people;
- education and training;
- counselling and support for families;
- culture, sports and recreation.

In addition to the projects promoted directly by the MIUR, we should mention the many initiatives in the field of prevention carried out by the schools, as called for by Law 309/90 on drug addiction.

The sample of schools participating in the survey promoted by the Monitoring Office of the National Department for Anti-drug Policies consists of 125 high schools, 100 artistic high schools, 127 vocational schools, and 135 technical schools, for a total of 487 institutions chosen using the same criteria as for the ESPAD survey. School principals were asked to respond, by filling out a special questionnaire, to questions relating to the prevention activities carried out in their school.

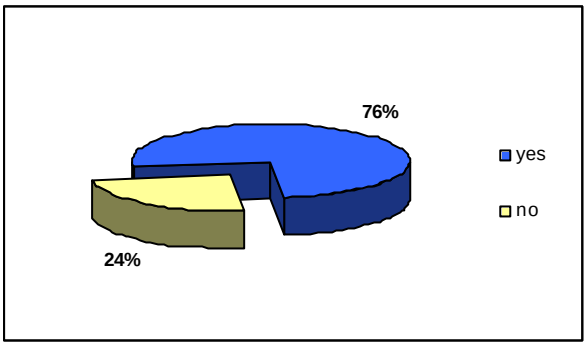
In the 487 schools participating in this survey, 1,177 general health-related prevention projects were reported: the data show that each school has an average of two prevention projects per year. Of these, some 52% directly or indirectly involve preventing the use and abuse of legal and/or illegal substances. More than 90% of these were included in the curriculum plan (P.O.F.)(see Graph 3.1).

Graph 3.1 Prevention activities conducted in the sample schools



In addition, the same survey reveals that 76% of the sample schools included drug-related prevention projects in their curriculum plans (P.O.F.).

Graph 3.2: Schools including legal and illegal substance use prevention projects in the curriculum plan



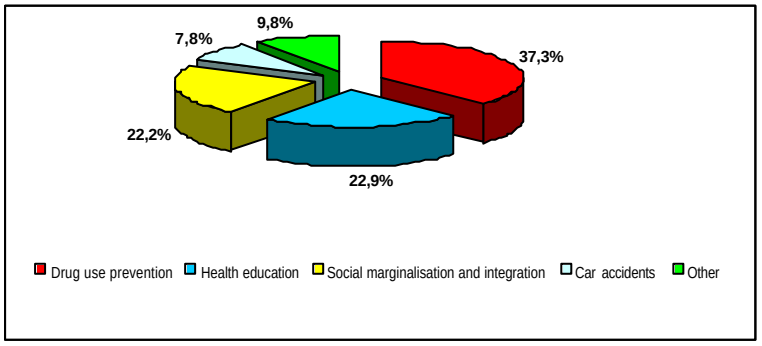
Almost all the health-related prevention projects are cross-disciplinary, in that they involve multiple topics: for example, a project on preventing traffic accidents may include topics and/or forms on preventing alcoholism or the use of illegal substances. Single-topic projects are rare.

It may be worthwhile to determine the weight and significance that problems associated with preventing substance use and abuse have in school prevention activities. Analysis of the types of projects implemented, including those in collaboration with other institutions, reveals five main topical macro-areas:

- Use of legal and illegal substances (illegal substances, alcohol, inhalants, doping substances, steroids) and prevention of at-risk behaviour
- Health education in general: eating; contraception; mental health; sex education
- Integration, social marginalisation, dropping out, immigration
- Prevention of traffic accidents
- Other (sports, theatre, etc.).

The following graph shows the importance given to the various prevention activities conducted in the sample schools

Graph 3.3: Preventive measures by topical macro-area



As we can see, the topics directly associated with preventing substance use, in terms of importance, represent one-third of the topics dealt with as part of health-related prevention activities in the sample schools, whereas topics relating to preventing social marginalisation and to integration, directly associated with preventing substance use, represent 22%.

3.1.2 Family based prevention

Various evidence indicates that dysfunctions in the relational dynamics of the family and problems in interpersonal relationships inside it may be major risk factors leading adolescents to experiment with illegal psychoactive substances and to develop substance-use disorders. In particular, little parental involvement in the lives of children, a lack of monitoring and supervision and of clear rules in family life seem to be important forerunners of substance use.
Difficulty in emotional communication, in managing conflicts and/or problematic temperaments by parents may lay the foundation for conditions of psychological vulnerability with regard to

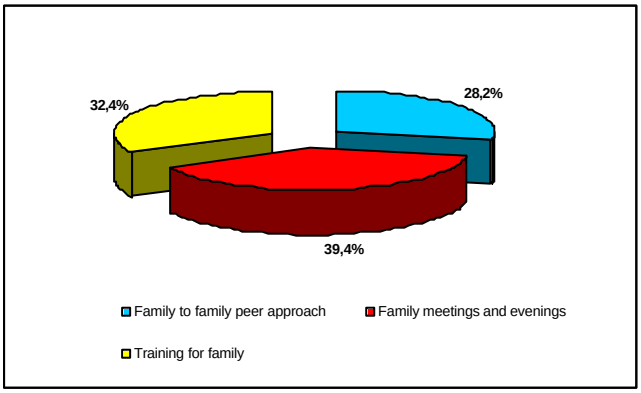
substance addictions. The “chaotic” family, with psychiatric disorders, serious relational dysfunctions and substance use in the home have a serious impact on young people resorting to the use of drugs and alcohol abuse .

Family-level prevention programmes are aimed at promoting both the educational function of the family vis-à-vis minors and, in the case of self-help, the positive potentials and wellbeing of families through their direct participation in promoting health and physical and mental self-protection. These approaches should promote a better family climate, facilitate relationships and communication in the family and the teacher-parent relationship, in addition to permitting early identification of risk factors, strengthening protection factors, offering social and educational support, and improving the family’s educational style by making it easier to create a sense of belonging. Offering parents more appropriate relational tools, a broader awareness regarding children’s educational needs, and suggestions for reinforcing the sense of belonging to the family has, according to the scientific literature, demonstrated important results in reducing the use of illegal psychoactive drugs.

The questionnaire given to the sample’s experts separated preventive measures that targeted the family and called for interventions within the family context from those carried out in the region (neighbourhood, district, macro-area).

The family-level universal prevention projects examined can be divided into three main groups: self- and mutual help among families, meetings with families and parents, training for families. The various types of intervention break down in a fairly consistent manner, with a slight prevalence (39%) of those projects involving meetings with families and parents.

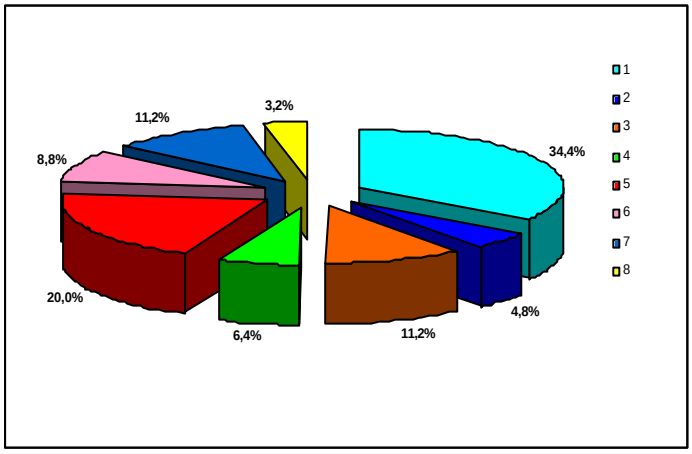
Graph 3.4: Family-level universal prevention: main types of intervention



3.1.3 Community based prevention

Responses from our sample show that all local governments provide drug prevention measures. These efforts are usually cross-disciplinary and involve various sectors of civil society, institutions, local governments and agencies.
The need to develop drug-prevention plans is included in social-policy documents by 75% of municipalities.
Of the prevention projects implemented, 34% directly involve prevention of substance use, whilst indirect prevention projects are intended to promote coming together (meeting and counselling centres for young people and available recreational and cultural spaces) (31%) and to strengthen neighbourhood support systems, prevention programmes carried out by peer groups in unstructured contexts, training programmes for subjects active in their neighbourhood, networking systems, and, finally, media use programmes that include Internet (35%).

Graph 3.5: Local community-level universal prevention: main types of intervention



Legend: 1: immigrants 2: convicted minors or those with legal problems 3: the homeless 4: young people in foster care or in communities 5: students with social marginalisation or scholastic problems 6: those who go to stadiums, parties, concerts, raves; 7: young people in decaying neighbourhoods; 8: subjects seeking thrills with social behavioural disorders, aggressive and contrary behaviours 9:gym-goers.

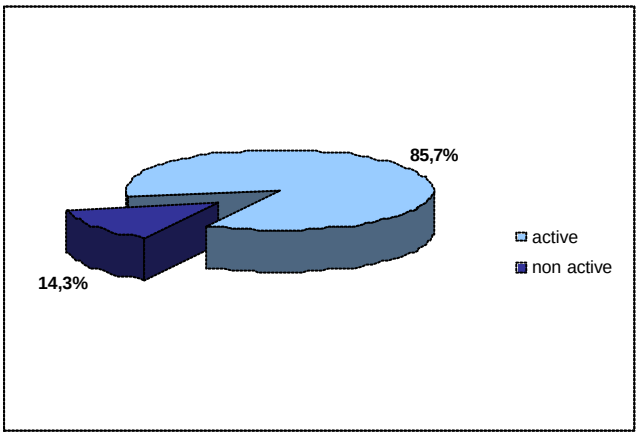
3.2 Selective and indicated prevention

Selective and indicated prevention activities involve subgroups of individuals (target groups) who belong to particular population segments identified based on environmental, psychological, social and biological factors, generally associated with the risk of substance use.
Early identification of at-risk conditions, whether it is wished to consider temper and character traits or whether childhood and adolescent pathologies are identified in a neuro-psychiatric context (indicated prevention), or whether it is wished to analyse problematic factors in the environment and interpersonal relationships (selective prevention), requires specific investments of human resources and training. Appropriate responses must be provided and the causal psycho-biological sequences capable of promoting a willingness to try psychoactive substances must be interrupted. In particular, conducts of neglect and abuse during childhood, conditions of marginality and isolation, trauma and persistent stress, as well as states of individual vulnerability, must become elective targets for indicated prevention, which is still not very widespread.
The same can be said regarding the attention needed for those subgroups of pre-adolescents and adolescents who have already tried substances, starting with legal ones, and who require specific interventions.
The following paragraphs will examine selective and indicated prevention measures implemented in schools, recreational environments, local communities, and at-risk families.

3.2.1 Preventing substance use in recreational settings

Particular attention is given to substance use in recreational settings (parties, concerts, discos, pubs), since the easy availability/accessibility to substances other than heroin has radically impacted the choice of drugs by young people. Scant social disapproval and failure to perceive the risks of these substances, together with an insufficient amount of information on conditions of vulnerability and "individual variability" promote the spread of drug taking, the easy recruitment of new drug takers, a higher level of abuse, and a higher likelihood of multiple addictions. Hence the need to implement specific prevention projects in this area. About 86% of the public addiction facility managers interviewed replied that in their own area there are projects in place for preventing the use of psychoactive substances in recreational settings.

Graph 3.6: Prevention Projects in recreational settings

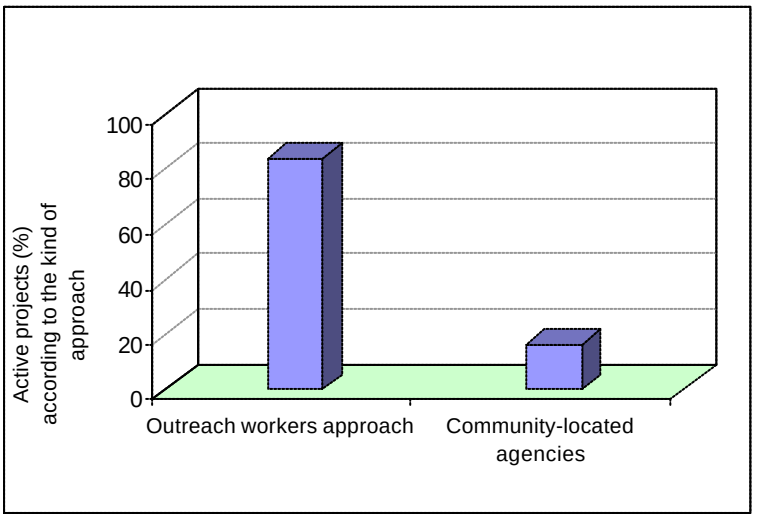


This type of prevention in most cases occurs (Graph 3.7) through workers who intervene directly in recreational settings (84%). For example, for adolescents, favoured places for intervention include discos and their immediate vicinities, pubs, and other gathering places for the age group in question.

Prevention workers have the task of creating collaborative relationships with night-spot managers and owners to allow the presence of workers on the premises, and providing informational talks and information spots. In addition, these efforts target the direct involvement of adolescents belonging to the target population in certain phases of the project by training "raw workers." The purpose is to increase the circulation of information on substances, risks and strategies for peer crisis management, to provide greater and more knowledgeable understanding of the risks associated with substance use, to promote consideration and awareness of styles of entertainment and on the concepts of limits and risks.

Prevention activities that use as their main channel of approach the facilities and organisations operating at the local level represent 16% of interventions.

Graph 3.7: Type of approach used in prevention in recreational settings



3.2.2 Efforts aimed at at-risk groups

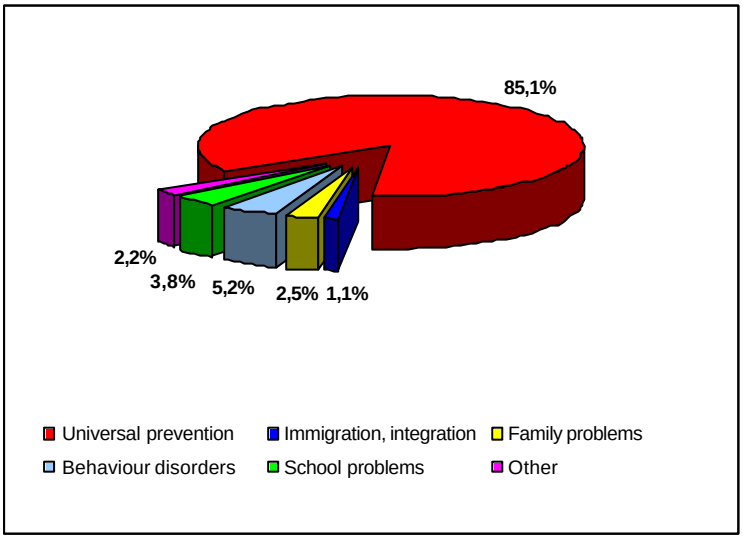
Selective and targeted school-level prevention measures

The survey conducted by questionnaire sent to the principals of a representative sample of schools shows, first, that indicated prevention measures in schools mainly involve projects intended to prevent aggression towards self or others, better tolerance for frustrations, removal from situations of social hardship, overcoming any form of marginalisation and personal maladjustment.

Indeed, as can be seen from the survey, some 85% of the projects in schools are directed at students in general and fall under the category of universal prevention, whereas some 15% are aimed at subgroups of students with special problems or characteristics (selective and targeted prevention).

We also note that the main subgroups at which selective prevention in schools is aimed are students with social behavioural problems, school problems, family problems, or immigrant students or those belonging to ethnic groups.

Graph 3.8: Distribution of prevention measures by target group

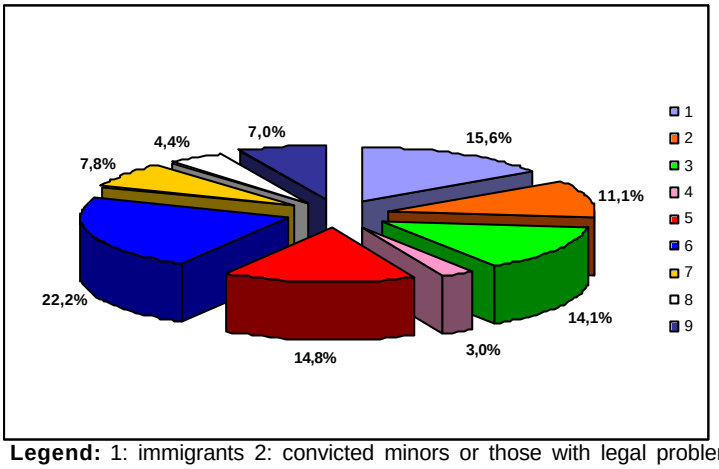


In this regard we note the experimental projects developed by the MIUR, which test the mentoring function, for preventing juvenile hardship with particular reference to students having difficulty in relating to others, poor scholastic performance, and hyperactivity. The model utilised calls for involving a student and a mentor in a one-to-one approach, improving the quality of the time that the child spends in school by means of a mentor-friend, a person not involved in school and family dynamics. This methodology helps the child to build a spontaneous learning process that takes into account his own viewpoint (subjective dimension) and the viewpoint of the other (empathy), and to come up with one or more solutions to solve the conflict (problem solving).

Efforts aimed at-risk groups at the local community level

Among at-risk groups, the target group for which the greatest number of measures are taken is that of those who go to stadiums and other recreational sites (22.2%), probably because of the greater ease of access by workers to the target groups and because of the lower project costs. Following this group, with similar figures, are projects on behalf of immigrants, students with social marginalisation and/or scholastic problems, and the homeless.

Graph 3.9: Selective and indicated prevention: percentage distribution by at-risk subgroup

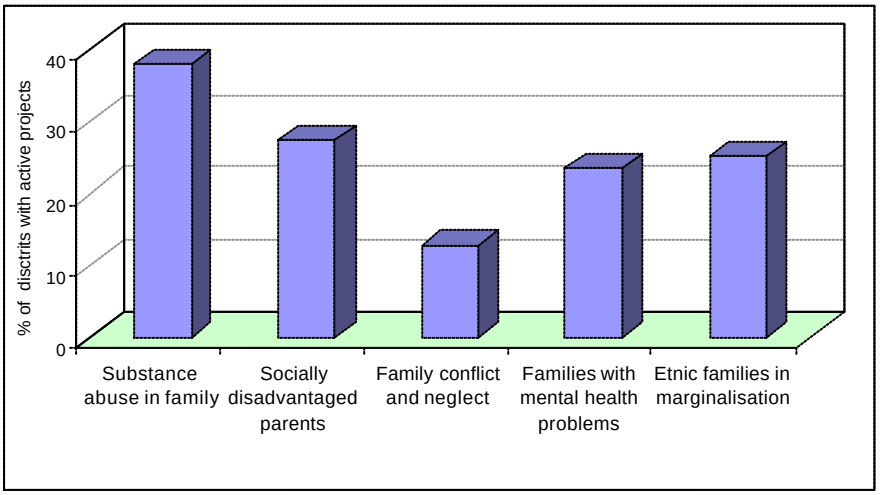


Legend: 1: immigrants 2: convicted minors or those with legal problems 3: the homeless 4: young people in foster care or in communities 5: students with social marginalisation or scholastic problems 6: those who go to stadiums, parties, concerts, raves; 7: young people in decaying neighbourhoods; 8: subjects seeking thrills with social behavioural disorders, aggressive and contrary behaviours 9:gym-goers.

3.2.3 Efforts aimed at at-risk families

The purpose of measures relating to family problems is to support nuclear families in difficulty, especially in order to overcome problems that make it difficult, especially in the case of single-parent families or families with multiple problems, to adequately play the parental role and hence to help, support and deal with one's own children in an appropriate manner. The priority is to protect the children, motherhood and immigrant families or those belonging to ethnic groups, since often people are forced to live in situations of family discord, social isolation because of economic, intra-family, social, occupational and linguistic-cultural difficulties.
Of the sample experts, 50% state that there are selective prevention programmes in their area on behalf of families.
In addition, 38% state that there are projects to detect substance abuse in the family (including alcohol); 27% report that measures are in place on behalf of nuclear families with socially disadvantaged parents; 25% on behalf of families belonging to ethnic groups; 23% on behalf of nuclear families with mental health problems; and, finally, 13% for family conflicts and neglect of children.

Graph 3.10: Types of local prevention for at-risk families



It can be truly difficult for institutions to contact these problem families: they avoid contact with the school and with teachers; often they are unavailable when social workers visit the home, and they reluctantly contact the offices of counsellors. A mixture of shame and modesty regarding the

various forms of hardship, stigmatisation and social isolation along with the lack of specifically dedicated financial and human resources, make it difficult to implement measures for those who have the greatest need of them. In this regard, alternative strategies should be implemented in order to reach these most difficult families, using innovative techniques, forms of self-help, and contacts that can make use of social and not just institutional networks.

4. PROBLEM DRUG USE

Overview

The profile of those in treatment (who turn to care services), with reference to the main characteristics such as nationality, level of education, employment and housing status (where they live and who with) was analysed for the first time by means of a sample study with data taken from the individual records (single subjects). This analysis was carried out, as part of the initiatives to reorganise the data reporting system for drug addiction services of the Italian national health service, on a selected sample of 32,370 people representing 19% of all those who started a course of treatment during 2004, with the collection of data in relation to the type of substance leading to the treatment and set out by gender and age group.

4.1 Prevalence and incidence estimates

Prevalence estimates

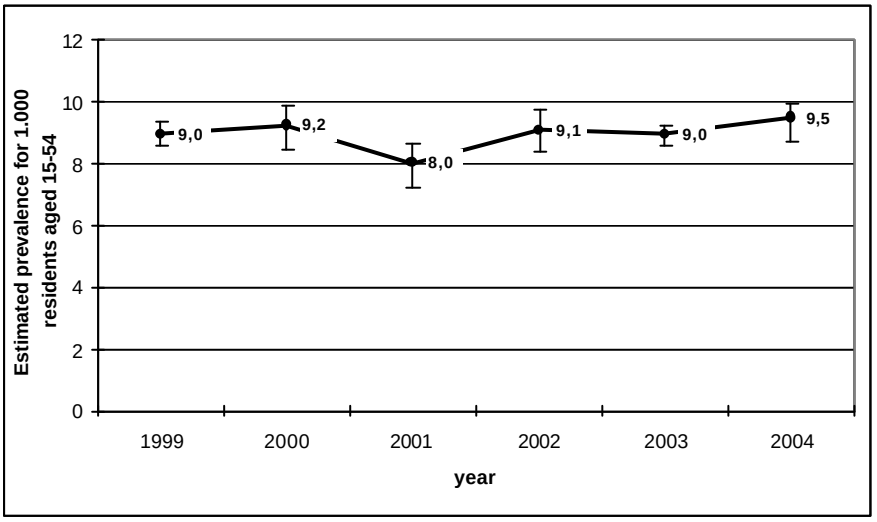
From the figures shown in table 1 it can be seen that the estimated number of people dependent on opiates (heroin) is between 273,903 (estimate given by the capture-recapture method) and 311,814 (estimate based on the demographic indicator method). The mid-point of the two estimates, i.e. 292.858, indicates the number of people with heroin problem use, abuse and dependency.
This figure enables the estimate to be made that during 2004 fewer than 50% of these people were treated in local service structures. In other words, we may state that in 2004, fewer than half the people with health problems related to heroin dependency sought treatment at specialist service structures.

Table 1: estimated prevalent cases for 2004 (absolute values and variation interval)

Year	Method of multiplier of cautions/ drug related deaths	Method of the demographic indicator	Capture/ recapture method	Method of the multivariate indicator	Variation interval of the estimate
2004	297,282	311,814	273,903	308,098	273,903 – 311,814

In addition by comparing the value of the estimate to the number of residents in Italy aged between 15 and 54, we obtain the size of the prevalence estimated a national level, for the year 2004, with figures between 8.7 and 9.9 people every thousand residents. This figure enables a comparison to be made between the Italian situation and that of other European countries which sees us together with Denmark, Luxembourg, Portugal and the United Kingdom in the mid to high band for prevalence (6-10 cases every 1000 inhabitants), and with higher figures than Germany, Spain, Greece, the Netherlands, the Czech Republic, Poland and Slovenia which have lower estimates falling in the mid to low band (1-5 cases every 1000 inhabitants). The analysis of the trend in estimates over time reveals (graph 4.1) a basic stability in the prevalence values except for in 2001.

Graph 4.1: Trend over time in estimated prevalence (median values and variation interval)



Source: Institute of Clinical Physiology, National Research Council

Estimates of the incidence of heroin use in the population (new users)

Besides knowing the overall number of people who in a given year have health problems arising from their being or having been heroin addicts, it is also important to estimate the number of "new" users who each year become heroin addicts. This estimate is closely related to the number of new subjects who start a course of treatment during the year. The ratio of the number of estimated subjects and the actual number recorded of new referrals to the heroin addiction services, indicates that for over 98% of these a course of treatment is started. In other words, almost all the "new" heroin addicts start (on average within five to six years of the start of their addiction) a therapeutic programme at the drug addiction services.

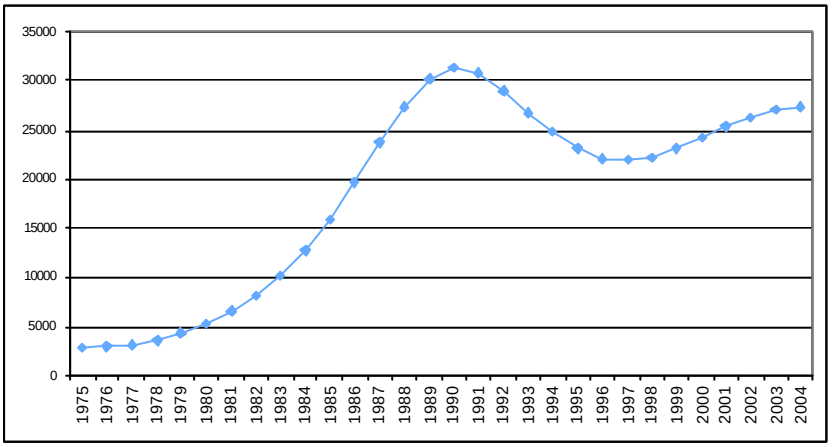
Comparing these people with the population at risk (aged 15-54), it can be ascertained that approximately 9 people out of 10,000 aged 15 to 54 started to use heroin in 2004.

Table 2: Estimate of the number of people who started to use heroin in Italy in 2004 (absolute values of the estimates and variation interval)

Year	Incidence estimate using Back-Calculation method	Variation interval of the estimate
2004	27,366	26,669 – 28,043

In order to assess any changes in the number of "new" heroin users over the years, there follows the representation of case incidents in the period 1975-2004.

Graph 4.2: Incidence curve for Italy (absolute values of the estimates)



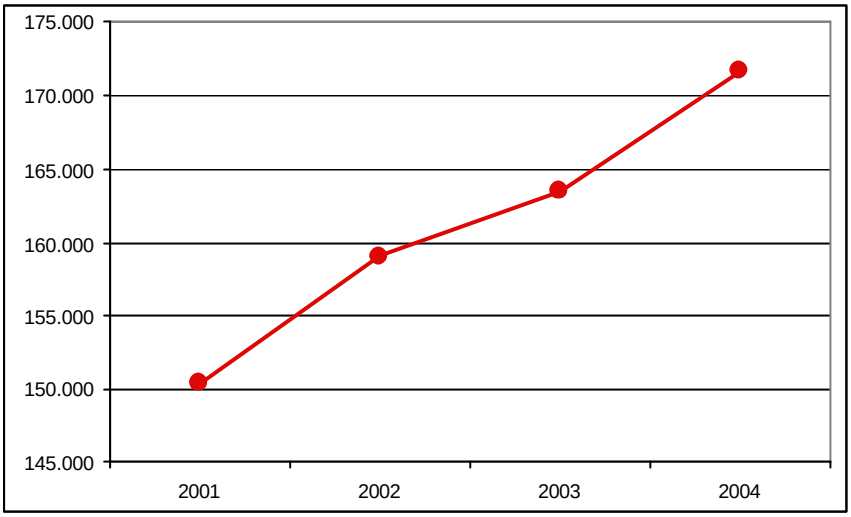
Source: Institute of Clinical Physiology, National Research Council.

Graph 42 shows that, from the mid 1970s, the number of new heroin addicts started to grow gradually until reaching a peak of approximately 31,000 in 1990. Subsequently, a falling trend can be seen, reaching the lowest point of approximately 22,000 heroin addicts in 1997, then starting to rise again over the last eight years (reaching 27,366 in the year under review). The modest increase seen in 2004 compared to the previous year does not seem significant.

4.2 Profile of clients in treatment

In 2004 people treated at local drug addiction services numbered[4] 171,724 and showed a rising trend over several years (Graph 4.3). If the numeric data is compared to the resident population aged between 15 and 54, in 2004 for every 10,000 inhabitants there would be approximately 55 people in treatment with drug addiction services.

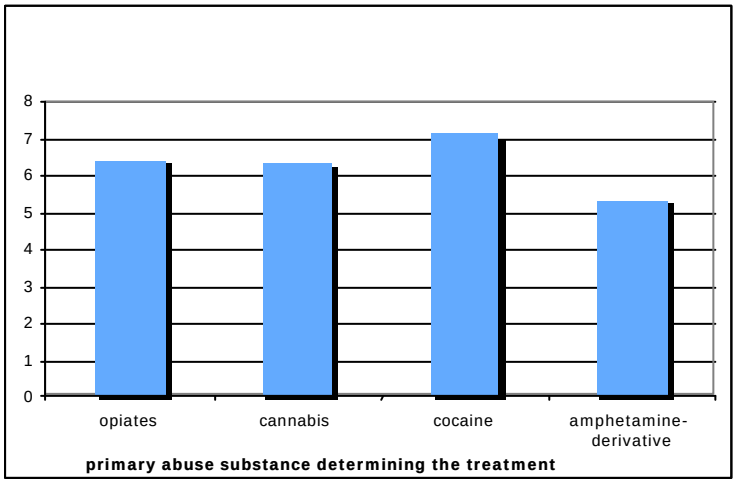
Graph 4.3 – Distribution of the total number of people under the care of the drug addiction services: 2001-2004.



Based on Italian Ministry of Health figures.

Those turning to the services for the first time to commence a course of treatment have for several years now represented about 20% of the total number of people in treatment. This figure indicates that around 80% of the population seeking treatment is composed of people who are already familiar to the services, who are continuing treatment started in previous years, or who are returning for new treatment owing to a relapse into drug use problems. Analysis of the data recorded for individuals confirms that 20.9% of those in treatment during 2004 had not previously undergone any treatment for addiction to psychotropic drugs. In terms of organising the services differently, the data relating to the long time period (in average over 6 years) between first drug use and the start of treatment (graph 4.4), seems of some significance.

Graph 4.4 – Interval between first drug use and access to treatment services



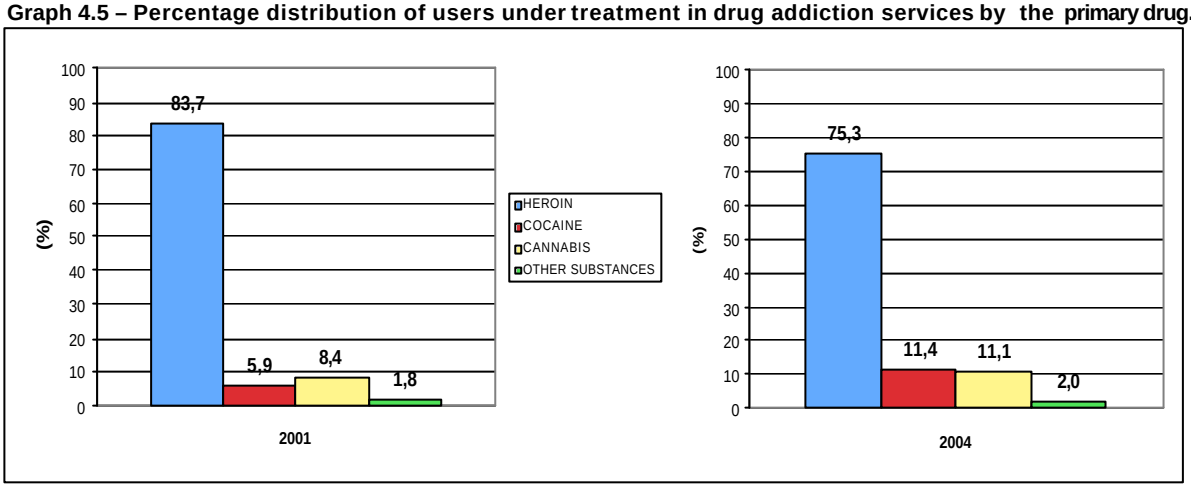
Based on sampling data from the Regions.

[4] This estimate was made on the basis of the data provided by the Ministry of Health, with around 94% of the overall services present throughout Italy, and by applying in all the provinces with partial coverage the average number of users at a provincial level.

4.2.1 Profile of clients in treatment by substance used

In 2004 users of local drug addiction services continued to be largely heroin users; from graph 4.5 we may see how this share has dropped significantly over the years, falling from 84% in 2001 to 75% in 2004. Although heroin continues to represent the main drug among addicts who undertake treatment, in recent years there has been a significant increase in the share of those admitted to treatment for primary cocaine use. In 2001 they represented 6% of overall users, last year they reached approximately 12%. Also those undertaking treatment for cannabis use increased from 8.4% in 2001 to approximately 11% in 2004. The distribution observed from the field study figures, in other words through the figures gathered on individuals, confirms the findings of the aggregate flow (75.3% opiates, 13.4% cannabis, 10.5% cocaine, 0.8% amphetamine-derivates, 0.1% hallucinogens).

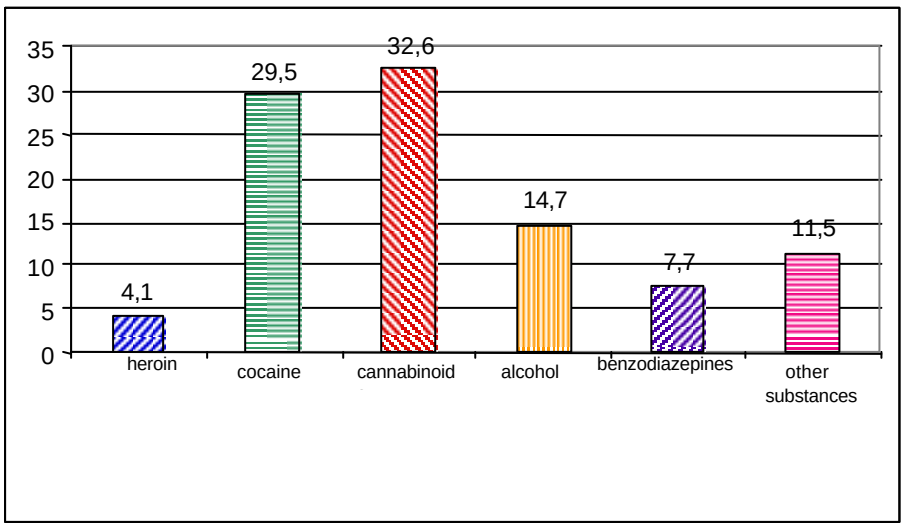
Graph 4.5 – Percentage distribution of users under treatment in drug addiction services by the primary drug. 2001-2004.



Based on Italian Ministry of Health figures.

The most common method for taking heroin continues to be by injection (around 68% of users), while as for cocaine injection is used by just around 12% of users. This figure is confirmed also through the analysis of the field study (the use of injected heroin is recorded for 72% of subjects and the use of injected cocaine for 10%). Although heroin is still the main drug among addicts who turn to the services, among the drugs declared as secondary, shown in graph 4.6, there are significant shares for cannabis (32.6%), cocaine (29.5%) and to a lesser extent alcohol and benzodiazepine (respectively 14.7% and 7.7%).

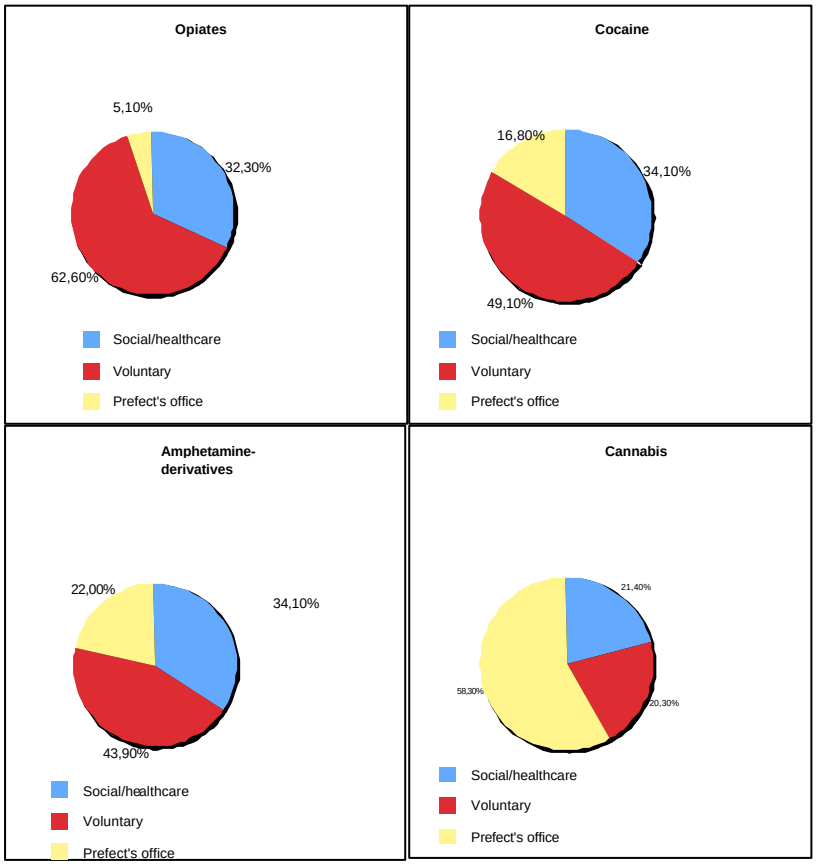
Graph 4.6 - Percentage distribution of users in treatment in the drug addiction services by the secondary substance abuse in 2004



Based on Italian Ministry of Health figures.

As can be seen, around a third of the patients who use the services give cocaine as the secondary drug, i.e. as a drug which accompanies their heroin addiction. If this percentage (29.5%) is added to that for cocaine as the primary drug of choice (11.4%), it is clear that over 40% of service patients may be cocaine users, abusers or addicts. The consequences in terms of the relationship between patients and operators, and the behavioural and psychiatric issues are different from those that the professional staff of public and private services are trained to face. New clinical programmes, new pharmacological and psychosocial strategies, and the related training opportunities, must be implemented in relation to this change. The current data collection system does not enable an understanding of whether those subject to therapeutic treatment for drugs other than heroin turn to the service for their addictions, psychiatric and behavioural disturbances, following pressure from relatives or following referral by the local Prefect's office (*Prefettura*). As part of the field study carried out by the Regions and Autonomous Provinces, it was possible to investigate the channels for directing patients to the services which determine the demand for treatment in relation to the primary drug. Graph 4.7 shows how among heroin addicts the demand is largely caused by a voluntary choice (63%) or arises from a social/healthcare structure (32%). Also for cocaine addicts the channels for directing them to the services are similar to those for heroin addicts, but of increasing importance is the number of people (17%) who are sent by local Prefect following a police caution. This means of accessing service structures is becoming increasingly important in the case of amphetamine-derivatives (22%), and the main channel for accessing treatment (59%). in the case of cannabis Note should also be made - for the various types of drugs the use, abuse or dependency on which leads to the activation of a structured therapeutic programme - of the referral by other social/healthcare services (family doctors, hospitals, social services, prisons), which ranges from 34% for cocaine and amphetamine-derivates to 21% for cannabis.

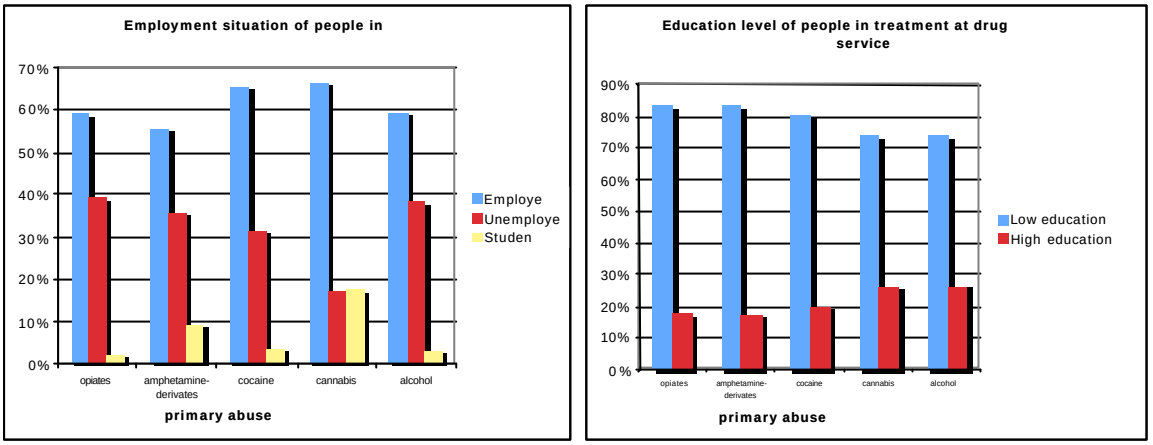
Graph 4.7 - Percentage distribution of users under the care of the drug addiction services on the basis of the means ofreferral and the drug determining the treatment (2004).



Based on sample figures from the Regions.

The education and employment level in relation to the drug determining the treatment are shown in graph 4.8. Higher employment levels seems to be a feature of patients using the Services for problems connected to the use of cocaine, compared to heroin addicts, alcoholics and consumers of amphetamine-derivatives. Likewise, increasing levels of higher education are seen among patients who turn to the Services for cocaine, cannabis and alcohol, compared with those who use heroin or amphetamine-derivates. Thus the social and cultural features of care service patients do not sufficiently evidence the possible differences in relation to the drug of choice: it is likely that cocaine addicts who do not turn to care Services could have less evident social and cultural characteristics than heroin addicts.

Graph 4.8- Percentage distribution of users under the care of the drug addiction services on the basis of education level, employment and drug determining their treatment (2004).



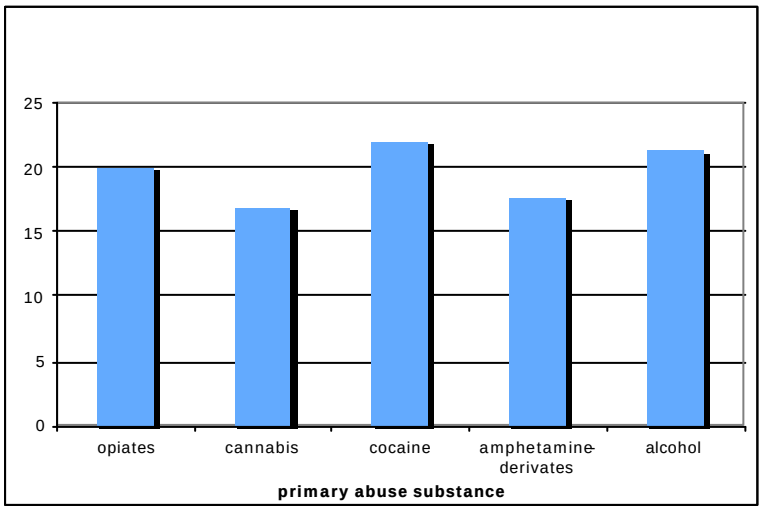
Based on sample figures from the Regions.

Other features of people in treatment

Hereafter are the findings from the analysis of the data acquired, in accordance with the standard recording protocol for demand for treatment proposed by the E.M.C.D.D.A., on people in care for 2004. The data refer to the aforementioned sample of public treatment structures.

Graph 4.9 shows the average age of people when they first used the drug which led to the request for treatment in 2004. It can be seen that people with cannabis and amphetamine-derivates as their primary drug have an average age for first contact with cannabis and amphetamine-derivatives respectively (between 16 and 18) which is 4 years younger than that for people who requested treatment for primary abuse of cocaine and alcohol (between 21 and 22). The first contact with heroin comes at around 19.

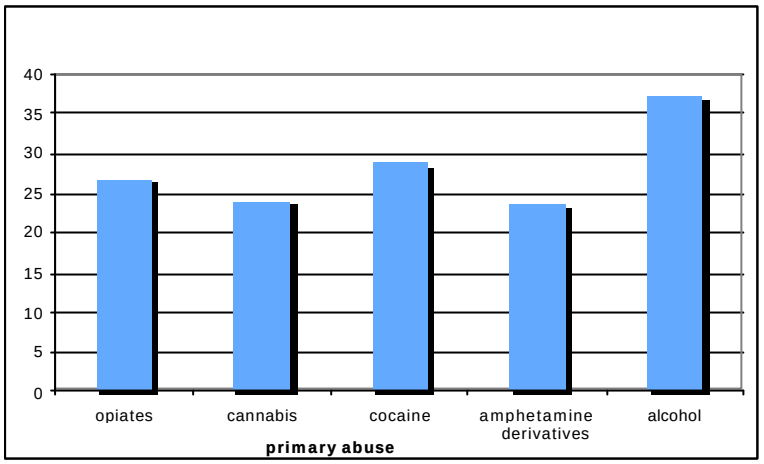
Graph 4.9 Average age of first use of primary abuse substance people in treatment at drug addiction



Based on sample figures from the Regions.

Graph 4.10 illustrates the average age which people had when they undertook their first treatment with the drug addiction services. The youngest are on average those who come to the service with a treatment request for cannabis and amphetamine-derivatives (24), around 26 for people using heroin as their primary drug and around 29 for those seeking treatment for cocaine abuse. Those requesting treatment for problems related to alcohol abuse come very late to the Services.

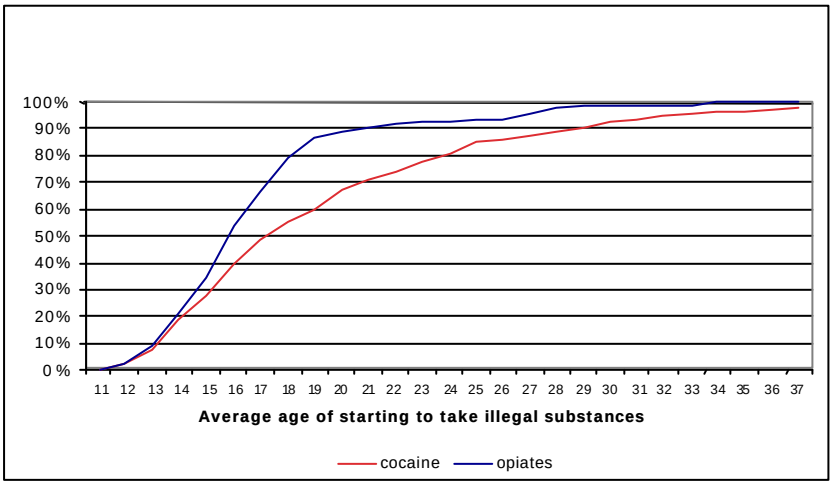
Graph 4.10 Average age of first referral to drug addiction services for people in treatment



Based on sample figures from the Regions.

Graph 4.11 shows the age for the start of taking illegal substances (in particular cannabis) of people requesting treatment at the drug addiction services for opiates and cocaine. The assessment of the starting age for the use of substances, which shows the first approach to experimenting with psycho-active effects and with associated lifestyles, is an important indicator of "seriousness", suggesting the belonging of patients to possibly more or less vulnerable population clusters. As can be seen, people declaring cocaine as their drug appear to have made contact with the drug later than those who have developed a heroin addiction. If we consider people who are addicted to cocaine, it may be noted that just over 50% had started to use illegal substances before the age of 18; on the contrary, among heroin addicts around 85% of patients started to use illegal substances before 18.

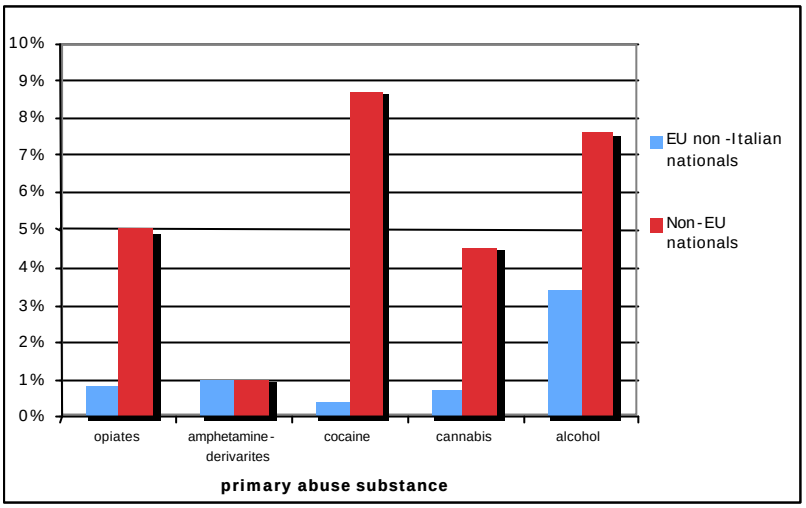
Graph 4.11 Starting age for the taking of illegal substances and the substance of choice for people in treatment



Based on sample figures from the Regions.

Graph 4.12 shows the percentage distribution of foreigners seeking treatment at the drug addiction services Over 90% of Italian requests are not shown in the graph. Around 5% of the requests for treatment for opiates come from non-EU nationals; the treatment requests from non-EU nationals include shares of less than 5% for cannabis, a little over 8% for cocaine and over 7% for alcohol.

Graph 4.12 Percentage distribution of users under the care of the drug addiction services by nationality on the basis of the drug determining the treatment

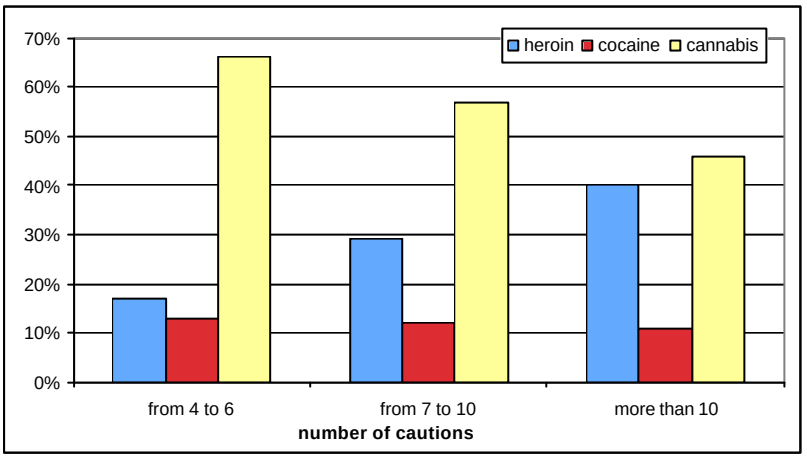


Based on sample figures from the Regions

4.3 Main characteristics and patterns of use from non-treatment sources

This section analyses those people who have several referrals to the local Prefect's office for the handling of illicit drugs, with the intention of identifying the features of problem drug users through the use of data sources that do not directly refer to services for the treatment of addiction Specifically it refers to 9,649 individuals, who, besides being referred to the Prefect during 2004, have been frequently cautioned also in the previous period (1999-2003): of these around 83% were cautioned between 4 and 6 times, 15% from 7 to 10 times and the remaining 2% more than 10 times. The analysis carried out on the basis of the number of referrals and the type of drug associated with the referrals shows use/abuse of drugs that vary on the basis of the various subgroups considered. While there is a marked fall seen in the case of cannabis, the percentage for which falls from the subgroup of individuals who received between 4 and 6 cautions (around 66%) to those with more than 10 (almost 44%), an opposite trend is seen for heroin the share of which rises from 17% to 40%. On the other hand, the result for cocaine is stable at around 12% (graph 4.13).

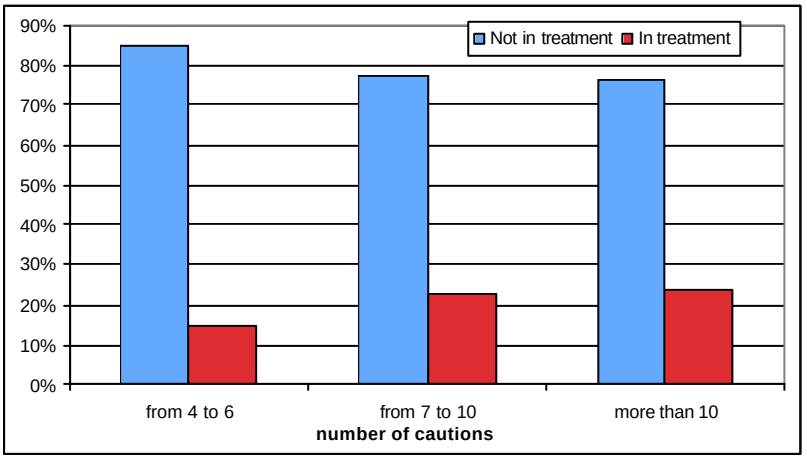
Graph 4.13: Distribution of people cautioned to the local Prefect's office on the basis of the number of cautions and the drug.



Figures based on data from the Centre for Documentation and Statistics (D.C.D.S.)

It is possible to highlight important differences between the 3 subgroups also through the analysis of the people referred to the services for addictions (graph 4.14): here too the highest percentages of individuals for whom a therapeutic programme was started are those who received more than 7 cautions (the figure falls from around 25% for those with more than 7 cautions to 14% for those who have received between 4 and 6).

Graph 4.14: Distribution of people referred to the local Prefect's office on the basis of the number of cautions and the substance.



Figures based on data from the Centre for Documentation and Statistics (D.C.D.S.)

These figures could lead to a hypothesis of how it is within groups of individuals who have received the greatest number of cautions that we find a higher percentage of users of substances that require particular attention owing to their problematic nature. The fact that with the rise in cautions there is no corresponding rise in the percentage of those cautioned for cocaine, as instead happens with heroin, suggests that the police can identify more easily and therefore report more regularly to the Prefect users such as heroin addicts who stand out more owing to their lifestyle and cultural characteristics. In this regard, cocaine users would appear less easy to identify and less well-known to the police with a consequent reduction in the recording of cocaine itself among those regularly reported to the Prefect.

5. DRUG RELATED TREATMENTS

Overview

This chapter aims to consider residential (inpatient) treatments and separate them from the section on “Drug free treatment”: it is in fact well-known that in Italy it is the private therapeutic communities that organise residential therapeutic and rehabilitative programmes and that these initiatives in recent times can no longer be considered as drug-free, i.e. just psychosocial. Communities offering therapy in most cases use opioiod agonists in decreasing doses, as well as prescription psycho-pharmaceuticals aimed at treating attendant psychiatric disturbances. Therefore, we have first set out the psychosocial initiatives implemented in public (outpatient) services unaccompanied by pharmacological treatment and after, in the section on “Medically assisted treatment”, pharmacological programmes started by the care services for drug addictions. It should be noted that the phrase “Medically assisted treatment”, used in the guidelines to refer to pharmacological programmes, could be changed into “Pharmacologically assisted treatment”, since the medical programme also includes psychosocial and rehabilitative services which do not necessarily include the administering of pharmaceuticals.

5.1 Treatment system

Research undertaken by the Extraordinary Commissioner for Anti-Drug Policies which was finished during 2004 collected data on the organisation of drug addiction services with the help of the Regions. The evidence obtained makes it possible to record the distribution of organisational models, the size of the body, as well as the various forms of cooperation between the public and private services. From the figures various approaches can be seen, as well as different levels of organisation. The departmental structure as an organised body capable of coordinating the various stages of programmes, orienting and planning the use of resources and adding in the specific contributions of various professions and operating units, appears to be that adopted, albeit with various hierarchical and organisational models, by 13 Regions and envisaged by most of the others (Table 1).

The organization of structural Departments, equipped with real budget management independence, is limited to a minority of the Regions. In some other Regions organisational strategies are implemented which exclude the structured and complex set-up of the Department, perhaps with the aim of maintaining greater integration with other socio-sanitary areas and with local authorities.

The structure of the Department seems to encourage relations with the accredited private sector which is an essential part of the therapeutic and rehabilitative programmes and has a joint role in the management of the organization, of the operative units and of the individual patients. In this regard in most Regions the Departmental Committees include a sizeable representation of members of the therapeutic communities. Despite this, the relationship between the public and private services remains hierarchical and still refers to a condition defined in previous decades as “auxiliary”. Overcoming this condition could happen within the departmental structures themselves thanks to processes to increasingly improve the qualifications of all the professionals involved.

In many Regions the Departments have available permanent technical groups that can ensure continuity in the functional relations between the various disciplines of the Departments themselves, the operative units and the trans-institutional figures involved in the clinical and rehabilitation programme for drug addicts: the need for the Department to have close relations with hospitals, the sections and the services of mental health departments, infectious disease centres, family doctors, as well as the structures of the local Prefect’s office (*Prefetture*), the prison services, the social services at local authorities and the magistracy, requires the definition of stable key figures among the professional staff in the Departments of various Regions.

Table 1- Features of Regional Departments.

Regions and Autonomous Provinces	Department YES/NO	Dept. Type			Committee members			
		Structural	Functional	Integrated	Drug service managers	Therapeutic community managers	Department Director	Local authorities
Piedmont	YES DGR 8/ and 39/2	definition stage	definition stage	definition stage	definition stage	definition stage	definition stage	definition stage
Valle d'Aosta	NO (Drug addiction services under mental health dept)		X		X			
Lombardy	YES		X		X	X	X	
Aut. Prov.Trento	Planned		X		X			
Aut. Prov. Bolzano	NO							
Veneto	YES		X		X	X	X	
Friuli Venezia-Giulia	YES	X						
Liguria	YES		X		X	X	X	
Emilia Romagna	NO (company programme)		X (programme)		X	X	Programme manager	
Tuscany	YES		X		X	X	X	X
The Marches	YES	X			X	X	X	1 local & social service coord.
Umbria								
Latium	YES (Frosinone province)		X (Amatrice)	X	?	?	?	?
Abruzzo	NO (envisaged by Regional law)	X			X	X	X	
Molise	YES		X		X		X	
Campania	YES	X			X	X	X	
Apulia	YES	X			X	X	X	
Basilicata	NO (single Regional Dept planned)		X planned					
Calabria	YES		X		X		X	
Sicily	YES (partly) (existence of documents)		X		X	X	X	X (Legal representatives)
Sardinia	YES (planned)		X		X	X	X	

It is interesting how the ratio between professional service staff (public and private) and the number of users seems to indicate a difference between the Regions in investments in human resources within their drug addiction services (Table 2).
Specifically, this ratio is under 10 users per professional staff member in Valle d'Aosta, Piedmont, the Autonomous Province of Bolzano, Tuscany, Abruzzo and Basilicata. The workload is, on the other hand, very high for operators in Emilia Romagna and Apulia (25 users per professional staff member), in the Autonomous Province of Trento (27) and in Sicily, where it stands at 38 users per professional staff member.

Table 2- Regional distribution of the number of users and professional staff involved in treatment.

Regions and Autonomous Provinces	users	drug service staff	private sector staff	total professional staff	no. of users per professional staff member
Piedmont	13,992	797	1,028	1,825	8
Valle d'Aosta	479	32	44	76	6
Lombardy	32,188	990	1,400	2,390	13
Aut. Prov. Trento	919	34	0	34	27
Aut. Prov. Bolzano	863	65	46	111	8
Veneto	13,280	432	689	1,121	12
Friuli Venezia-Giulia	2,813	132	0	132	21
Liguria	8,818	260	240	500	18
Emilia Romagna	14,946	604	0	604	25
Tuscany	12,049	569	1,060	1,629	7
The Marches	4,447	192	261	453	10
Umbria	-	-	-	-	-
Latium	12,529	547	0	547	23
Abruzzo	3,980	124	347	471	8
Molise	927	57	0	57	16
Campania	19,227	722	363	1,085	18
Apulia	10,699	428	0	428	25
Basilicata	1,024	70	57	127	8
Calabria	5,132	187	199	386	13
Sicily	11,457	455 (exclusively)	300	300	38
Sardinia	5,724	263	192	455	13

In most Regions, however, the structured framework inherent in diagnostic processes and the sequences of the therapy treatments are still not fully developed (Table 3).

There is still an inadequate structure for information flows at the regional Observatories which have been launched in about half the Regions.
This omission, which translates into different ways of collecting data and different protocols for medical records, makes comparison and assessment of the outcomes of treatments difficult.

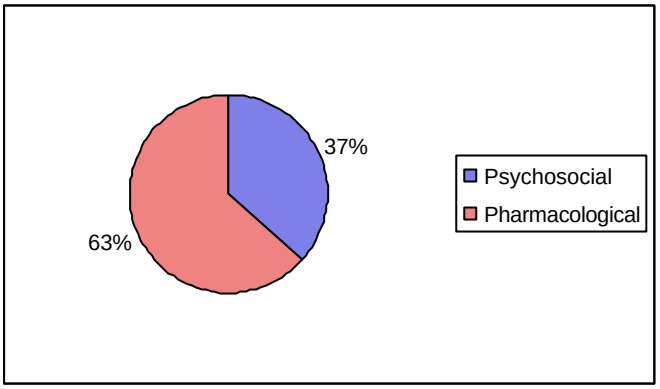
Table 3-Regional distribution of activities for planning, assisting, and assessing actions

Regions and Autonomous Provinces	Coordination tools with business strategies and indications		Assistance processes presence of guidelines on:				Existence of Regional Observatory	System for assessing outcome of treatment	
	permanent groups verification of alignments	codified and planned verification periods	diagnostic processes	therapeutic processes	prevention activity	reintegration activity		indicators of drug addiction services' effectiveness (post- treatment)	Indicators of COMMUNITIES effectiveness (post-treatment)
Piedmont	definition stage	definition stage	NO	NO	NO	NO	YES	NO	NO all at definition stage
Valle d'Aosta	YES	YES	NO	NO	NO	NO	YES	NO	NO
Lombardy	YES (Dept. Cttee)	YES (Dept Cttee)	YES	YES	YES	testing	under construction	YES	YES
Aut. Prov. Of Trento	YES	YES	NO	NO	NO	NO	NO	NO	NO
Aut. Prov. of Bolzano	NO	YES	NO	NO	YES	YES	YES	NO	NO
Veneto	not relevant	YES	NO	NO	NO	NO	YES	YES (implementation)	YES (implementation)
Friuli Venezia-Giulia	NO	YES	NO	NO	NO	NO	NO	YES	NO
Liguria	NO	YES	definition stage	definition stage	definition stage	definition stage	YES	to be developed	to be developed
Emilia Romagna	YES	YES	YES	YES	YES	YES	YES	NO	NO
Tuscany	YES	YES	YES	YES	YES	YES	YES	YES	YES
The Marches	YES	NO	YES planned	YES planned	YES planned	YES planned	NO	NO	NO
Umbria									
Latium	YES	YES	NO	NO	NO	NO	YES but not implemented	YES	YES (DGR 716/)
Abruzzo	YES	YES	NO	NO	NO	NO	YES (planned)	NO	NO
Molise		YES	YES	YES	YES	YES			
Campania	YES	YES	NO	NO	NO	NO	YES	NO	NO
Apulia	NO	NO	YES	YES	NO	NO	NO	NO	NO
Basilicata	YES		NO	NO	NO	NO	NO	NO	NO
Calabria	YES	NO	YES	YES	NO	NO	NO	NO	NO
Sicily	NO	YES	NO	NO	NO	NO	YES	NO	NO
Sardinia	NO	NO	NO	NO	NO	NO	NO	NO	NO

5.2 Outpatient drug-free treatment (psychosocial interventions)

According to evidence from data from the Ministry of Health, in 2004 the number of people subject to purely psychosocial and/or rehabilitative treatments was 46,432 (almost 37% of the total number treated), slightly up on 2001, when the total was 45,095.

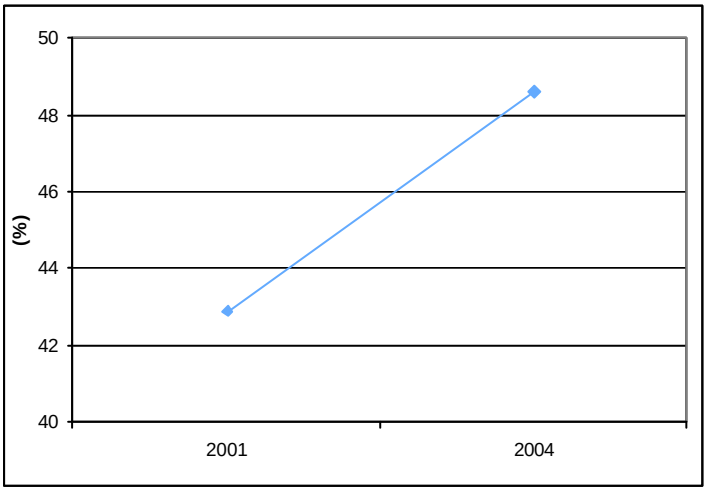
Graph 5.1 - Percentage distribution of types of treatment under the care of the drug addiction services: 2004



Based on Italian Ministry of Health figures.

The psychosocial treatments represent just under 49% overall of all the treatments[5] provided, a percentage which has increased markedly since 2001, as shown in Graph 5.2.

Graph 5.2 - Percentage distribution of psychosocial treatments supplied at drug addiction services: 2001-2004

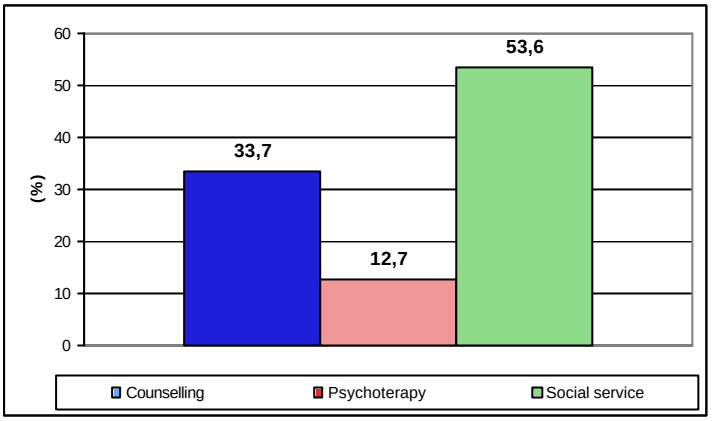


Based on Italian Ministry of Health figures.

Specifically more than half of these treatments were social service programmes; then there are psychological support programmes and, to a lesser extent, psychotherapy (Graph 5.3). This distribution has not significantly changed compared to the previous four years.

[5] It should be recalled that a user can be subjected to more than one type of treatment.

Graph 5.3 - Percentage distribution of types of psychosocial and/or rehabilitative treatment in 2004

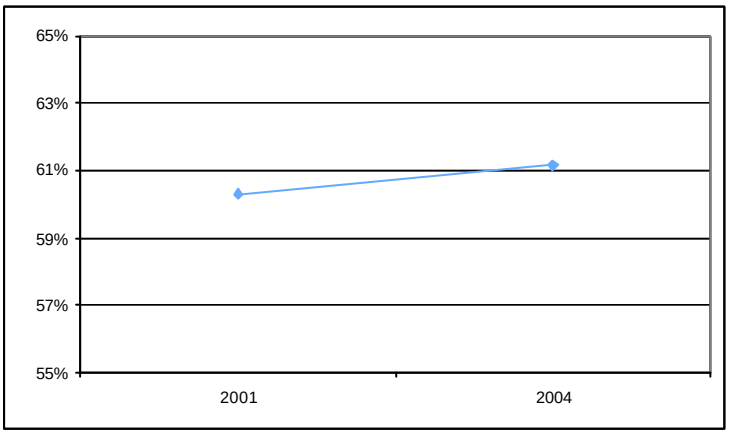


Based on Italian Ministry of Health figures.

5.3 Pharmacological treatments provided at public services

On the basis of the data supplied by the Ministry of Health, in 2004 pharmacological treatments represented approximately 61% of all treatments supplied, slightly up on 2001 (Graph 5.4).

Graph 5.4 - Percentage distribution of pharmacological treatments supplied at drug addiction services: 2001-2004

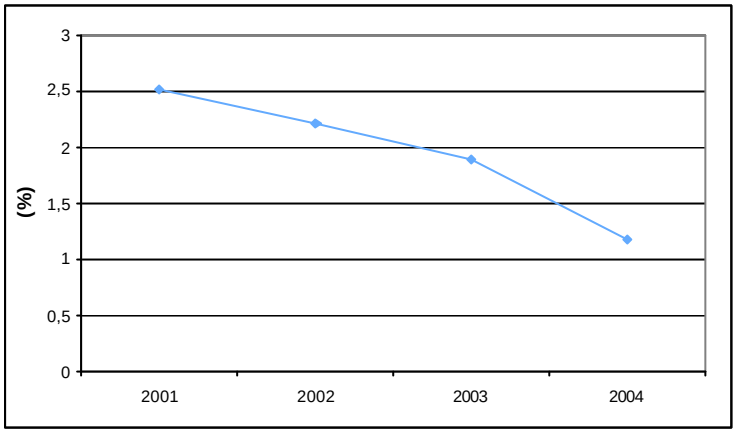


Based on Italian Ministry of Health figures.

5.3.1 Withdrawal treatment using non narcotic drugs

Over the whole four-year period, there was a constant fall in treatments with clonidine, which fell from around 3% of pharmacological programmes implemented in 2001 to 1% in 2004 (Graph 5.5).

Graph 5.5 - Percentage distribution of treatment with clonidine. 2001-2004



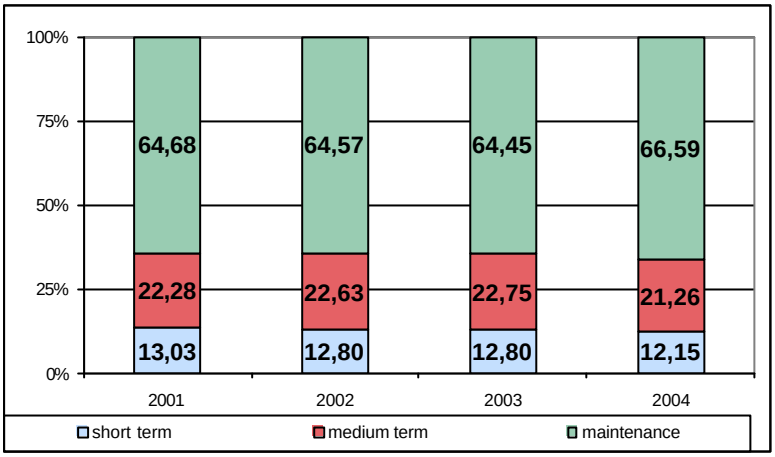
Based on Italian Ministry of Health figures.

The increasing reduction in strategies aimed at opiate withdrawal through non narcotic drugs, and therefore of the possibility of treating the withdrawal and interrupting the physical dependency in just a few days, is probably influenced by various factors. On the one hand, a review of the scientific literature which does not take account of the different types of patients reduces accessibility for a fairly large portion of drug addicts who could benefit from withdrawal with clonidine and the consequent treatment with antagonists: these patients are those who are most socially integrated, with strong future plans, a high level of motivation and solid family support. On the other hand, the services suffer from the reduction of human and economic resources which are essential for the use of forms of withdrawal through non narcotic drugs and fit the use of opiate agonists as the drug of choice for most pharmacological treatments. The risk of an unvoluntary selection among patients could be avoided if the services were set up to offer the widest possible range of treatments which correspond in tailored fashion to the clinical needs and social expectations of patients.

5.3.2 Treatment with prescribed opioid agonists

Without any significant differences being seen over the four-year period, pharmacological treatments were carried out in around 82% of cases through therapy with methadone (in decreasing doses over the medium and long term). Since 2001 (Graph 5.6), there has been an increase, albeit limited (2%), in the share of long-term therapies compared to a slight fall in medium-term and decreasing dose therapies (1% each).

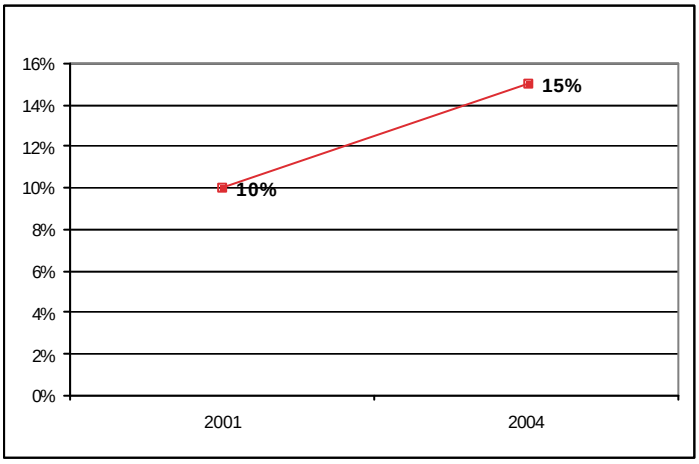
Graph 5.6 - Percentage distribution of types of treatment with methadone carried out in 2001-2004



Based on Italian Ministry of Health figures

In relation to treatments with buprenorphine, in the four-year period considered there was a significant increase: the share of users treated with this drug rose from 10% in 2001 to 15% in 2004.

Graph 5.7 - Percentage distribution of subjects treated with buprenorphine. 2001-2004.



Based on Italian Ministry of Health figures

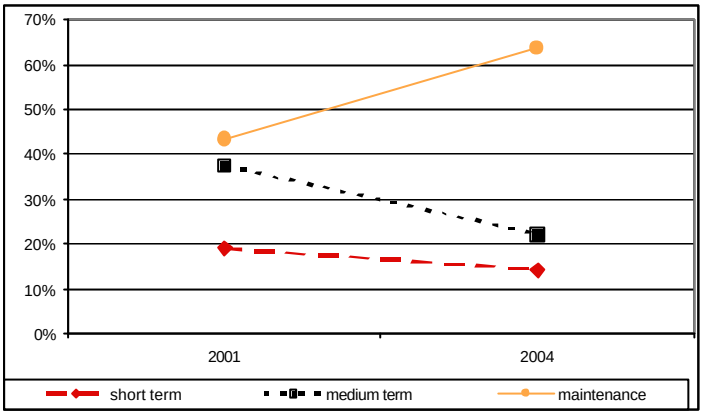
Also among treatments with buprenorphine, however, those lasting for more than six months (Graph 5.8) were the most common, followed by medium-term treatments and, to a lesser extent, those with decreasing doses (less than a month).
In addition, the analysis of their treatment over the years shows a marked increase in long-term treatments (from 42% in 2001 to 64% in 2004) against a similarly marked drop in medium-term and reducing dose treatments.

Opioid agonists are used increasingly with the aim of stabilising heroin addict patients away from their compulsive condition for heroin. These drugs, although substituting heroin on the opiate receptors in the brain, do not produce the intense high typical of heroin: the patient who during their taking of methadone or buprenorphine does not turn to heroin for some months is helped to reduce the “conditioning” produced by the taking of street opiates and to break the circuit of compulsion.
Moreover, an important distinction, with related organisational strategies and differentiated settings, should be made between “low threshold” methadone and buprenorphine, administered to patients who have still not undertaken a structured programme of therapy, and methadone and buprenorphine included in rigorous clinical programmes and intensive motivational therapies. In any case, the administration of narcotic drugs should be accompanied by frequent and appropriate

toxicological urine tests that can help both clinical monitoring and the acceptance of medical and legal responsibility by the prescribing doctor.

The introduction of buprenorphine among the therapeutic possibilities for the treatment of heroin addiction allows the use of a partial opiate agonist, which has a pharmacological profile that is different from methadone, and the possible identification of specific types of patients in relation to the outcome of the various treatments.

Graph 5.8 - Percentage distribution of types of treatment with buprenorphine. 2001-2004

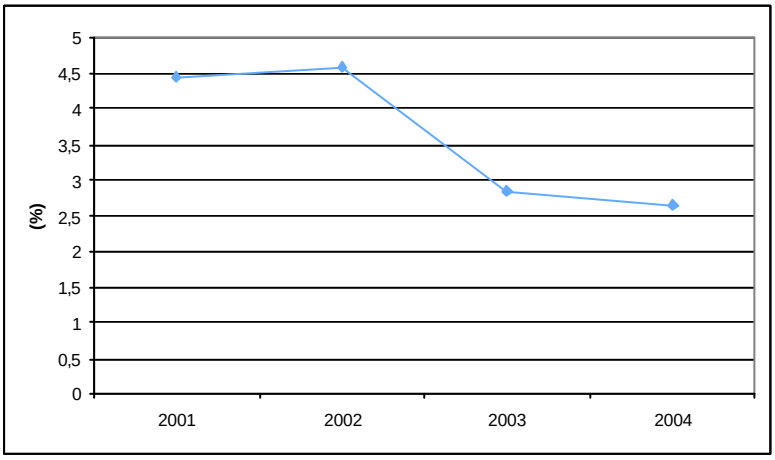


Based on Italian Ministry of Health figures

5.3.3 Treatments with opioid antagonists

From the analysis of the data relating to the administration of naltrexone, it is possible to see a significant variation in the period 2002-2003, in which the share of this type of treatment fell from almost 5% to less than 3% (Graph 5.9).

Graph 5.9 - Percentage distribution of treatment with naltrexone. 2001-2004



Based on Italian Ministry of Health figures

The drop in the use of naltrexone in the treatment of drug addicts could be connected, on the one hand, to the limited availability of patients to take the drug, but also to the difficulty for the services to structure clinical programmes, aimed at complete withdrawal from drugs, that would be appropriate for specific sub-groups of the population of heroin addicts. Naltrexone, associated with cognitive-behavioural therapy, family therapy and selective psychopharmacological programmes for any psychiatric comorbidity has demonstrated good results in motivated patients, with less serious forms of dependency, good family support and strong social integration. In these people with greater individual resources, in younger patients, in the phase of reintegration following prison and the therapeutic community, during the first diagnostic assessment naltrexone could be of

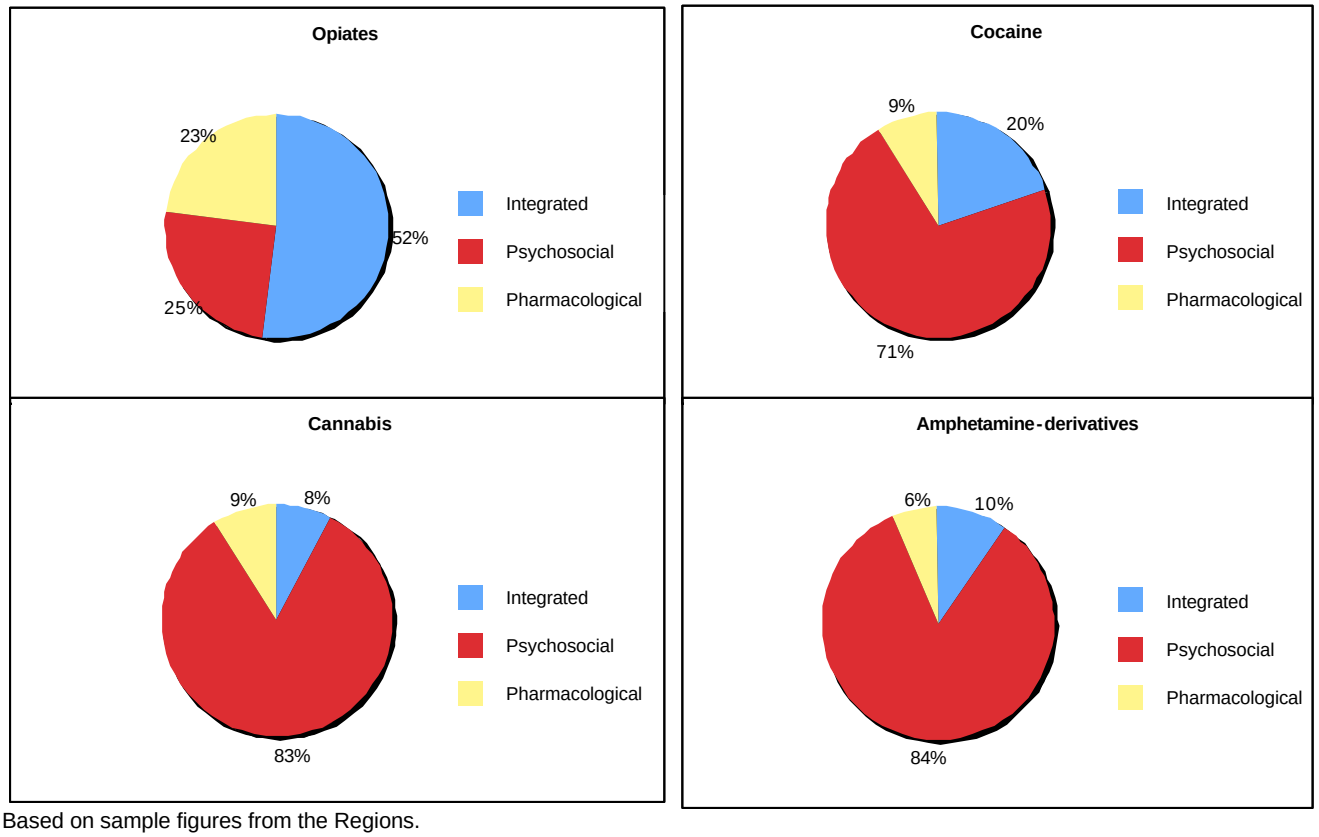
particular use, but it requires a significant deployment of interpersonal and socio-educative resources by the services' professional staff.

5.3.4 Integrated pharmacological treatments

With the new reporting system which the Regions, Autonomous Provinces and the Ministry of Health are developing, it will be possible to examine the various types of treatment started in relation to the drug leading to the treatment (graph 5.10).

It is important to note the high level of psychosocial treatments started with people who had cocaine, cannabis and amphetamine-derivates as their primary drugs. The limited availability of specific drugs for the treatment of the disturbances caused by these substances and the lack of a rationale based on scientific evidence to support its use drives the services to favour psychotherapy and interpersonal treatments. Considering the new prospects in the treatment of addictive disturbances, we may hold that an illegal drug must not be mechanically set against a prescribable therapy, but that targeted selective psychopharmacological programmes could be useful in curing complex forms of self-medication. As is clear from graph 10, the share of patients in treatment for dependency on opiates who make use of a pharmacological therapy supplemented with psychosocial activities is around 50%, while 23% of patients receive only the pharmacological treatment. Therefore, for a percentage of patients methadone and buprenorphine are not integrated with psychological support, counselling and individual or group psychotherapy. In addition, among those being treated with a supplement of methadone (or buprenorphine) and psychosocial therapy, the extent of those who receive only social support remains to be seen. Such support, although it must be considered a therapeutic treatment in its own right, cannot on its own meet all the psychological/behavioural or psychiatric issues of patients. In this regard there are clear indications from the scientific literature in this sector which underline the importance of integrating the pharmacological therapy with an intensive psychosocial therapy, applied in accordance with accredited methodologies, with very important consequences on the measurement of the effectiveness of treatments.

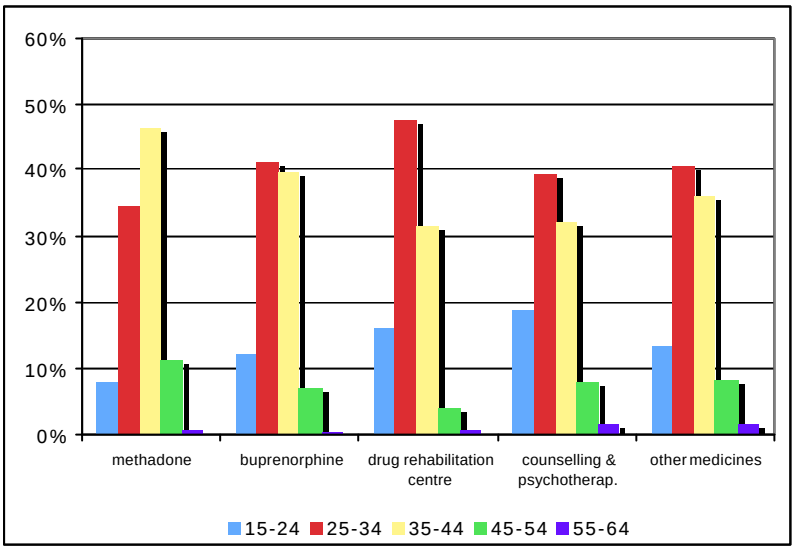
Graph 5.10 - Percentage distribution of users in care at drug addiction services on the basis of the type of treatment and the substance leading to the treatment (2004).



Based on sample figures from the Regions.

Specific features of patients in treatment at public and private services can be recorded in relation to their age, the referring structure, and their education level and employment situation. As is clear from graph 5.11, people aged between 35 and 44 are particularly represented among patients on methadone, while young adults (25-34) constitute a greater percentage among patients in therapeutic communities. A certain difference in age distribution also appears among those treated with methadone (who more frequently belong to the higher age groups) and those in therapy with buprenorphine (who more frequently belong to younger age groups).

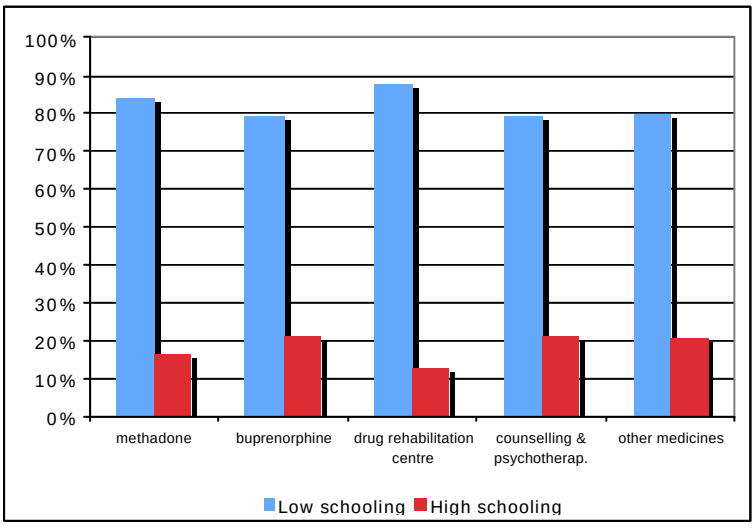
Graph 5.11 - Type of treatments and age groups



Based on sample figures from the Regions.

Graph 5.12 shows lower percentages of people with high education levels among patients sent to therapeutic communities. Patients on buprenorphine appear to have higher education levels than those on methadone.

Graph 5.12- Type of treatments and education level

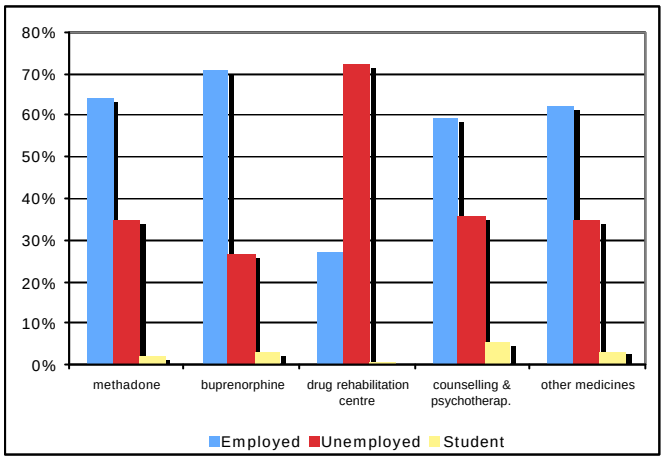


Based on sample figures from the Regions.

Also in relation to employment status there are differences between patients in the type of treatment: unemployed people are strongly represented among patients involved in residential treatments in communities. More employed people appear among patients treated with buprenorhine and in this case seem more integrated socially than those being treated with

methadone. Those accessing psychosocial support treatments such as counselling or psychotherapy appear in their turn more socially integrated and with higher employment levels.

Graph 5.13- Type of treatments and employment

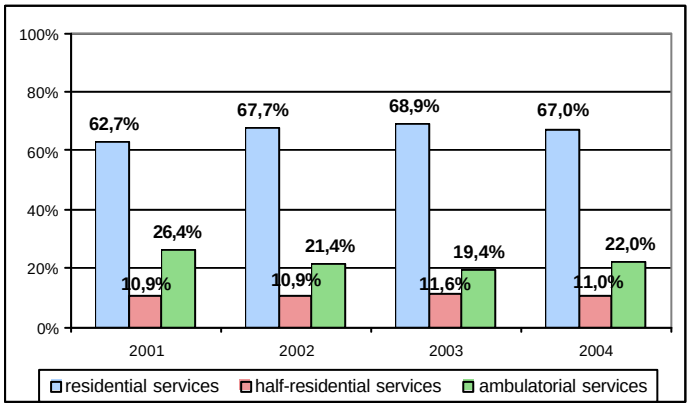


Based on sample figures from the Regions.

5.4 Treatments at private structures

17,143 people in 2004 were sent to social/rehabilitative structures in the private sector (residential, semi-residential or initial treatment) for therapeutic treatment and social reintegration. Compared to the previous four-year period, the share of people treated at social/rehabilitative structures tended to fall, from around 13% in 2001 to 12% recorded in subsequent years, to stand at the current approximate 10%. According to Interior Ministry analysis of the figures sent by 1,230 social/rehabilitative structures (788 residential structures, 224 semi-residential and 218 out-patient centres), people in treatment are distributed with 67% in residential structures, 11% in semi-residential and 22% in out-patient centres.
While since 2001 there was a gradual increase in the share of people present in residential structures set against a fall mainly in those in treatment at out-patient centres of the private sector, in 2004 this trend seemed to take a different turn (Graph 5.14).

Graph 5.14 - Percentage distribution of users in treatment at private structures, by type of structure, at 31 December 2001-2004.



Based on Interior Ministry figures - DCDS.

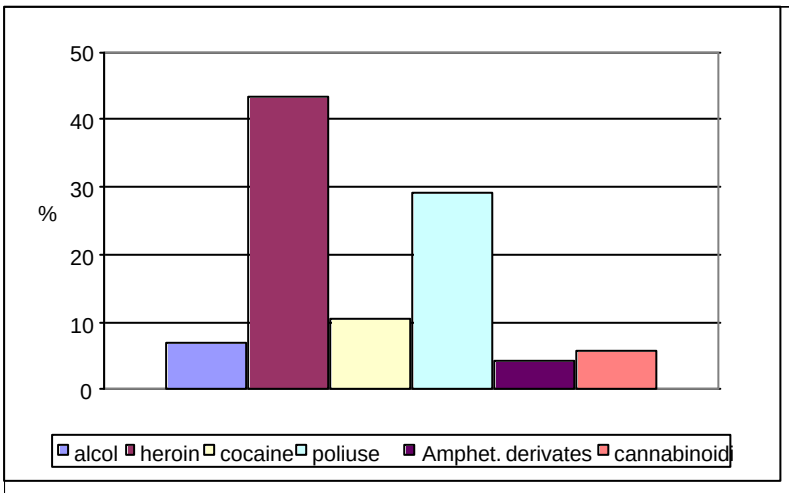
The methods used by the therapeutic communities and, more generally, by private sector structures include behavioural and cognitive therapy, relationship therapy, group psychotherapy, group self-help therapy, psychological and educative support and individual psychotherapy, family therapy and support for family dynamics, ergotherapy and various forms of professional training and social reintegration. The programmes at the private sector structures which use these

methodologies in a variety of ways take place in a climate of human and value centred relationships that seek to find a sense of personal identity, and develop vocational aspects and related skills.
In this field too the profound changes in the phenomenon, new use and the clinical features of new patients require the structuring of new strategies, changes in relational dynamics, different recovery times and more varied forms compared to "classic" programmes. The use of drugs in communities and in private sector structures is gradually spreading: some centres deal directly with withdrawal through drugs; others manage programmes with methadone and buprenorphine; yet others arrange for medications for psychiatric disturbances through selective psychopharmacological initiatives.
On the one hand, a sub-group of communities are specifically dedicated to patients with psychiatric comorbidity, but most Centres find themselves accepting patients who have had to turn to residential treatment owing to the complexity of their symptoms and the high risk of relapse: among the patients in residential treatment generally a high percentage are affected by more serious psychiatric disturbances or by personality disorders associated with drug dependency, also outside of specialist communities.

5.4.1 Sample-based assessment in Centres of the Italian Federation of Therapeutic Communities (FICT)

Here below are some figures relating to a sample of people (3,216) recorded at therapeutic communities in the network of the Italian Federation of Therapeutic Communities (FICT). The Centres which took part in the sample-based assessment (Arezzo, Avellino, Belluno, Bologna, Bolzano, Caltanissetta, Caserta, Catanzaro, Civitavecchia, Cosenza, Cremona, Florence, Genoa, Jesi, La Spezia, Mantua, Mestre, Modena, Parma, Pescara, Piacenza Pistoia, Prato, Reggio Calabria, Reggio Emilia, Turin CTS, Trento, Treviso, Varese, Vercelli, Schio and Viterbo) supplied information on the distribution of users by abuse substance, socio/demographical profile, related infectious diseases, the presence of psychiatric disturbances, intervention methodologies, as well as the various types of pharmacological treatment used.

Graph 5.15- Percentage distribution of users according to the abuse substance. Sample from FICT centres



Based on FICT figures

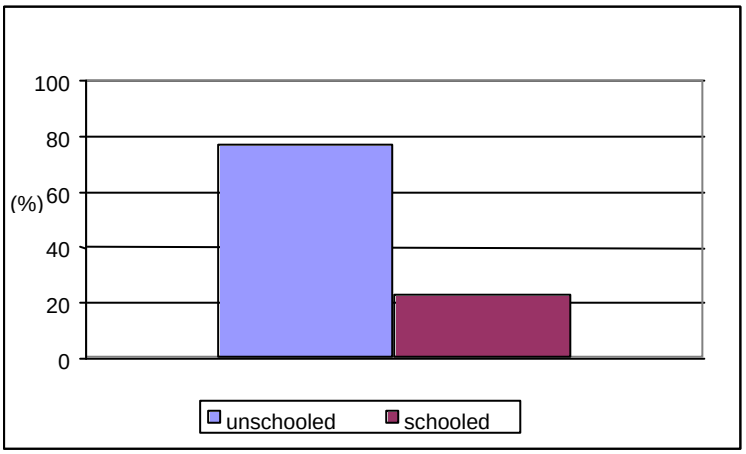
As is clear from graph 5.15, while the use of residential treatment continues to prevail for heroin addiction, significant percentages of patients from FICT therapeutic communities show a history of multiple abuse or cocaine addiction. If it is considered that multiple abuse normally includes also psycho-stimulants, it may be considered that, for around half of patients, the disturbances from the use of cocaine and amphetamine-derivates require specific treatment.

Graph 5.16- Distribution of users according to employment status. Sample from FICT centres

Based on FICT figures

The low percentage of people with stable employment in FICT communities, compared to the figures for public out-patient clinics, leads to an idea of why the need to use residential treatment falls on those patients with the greatest social disadvantages, who are less integrated and possess limited professional skills. For these people the possibility of benefiting from out-patient therapy is very limited and the Community offers important resources to prepare them for integration into the labour market.

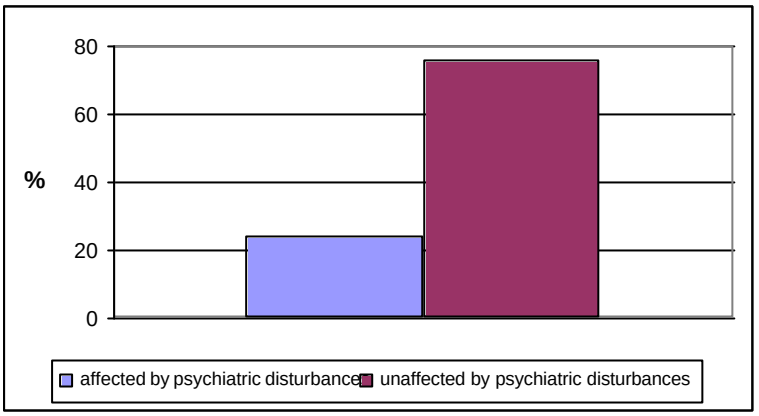
Graph 5.17 - Percentage distribution of users according to education level. Sample from FICT Centres



Based on FICT figures

In the same way, the levels of education among patients who turn to residential treatment suggest that it is the socially and interpersonally disadvantaged who turn most frequently to the communities in the FICT network: just one fifth of the patients has a school leaving certificate or degree and the majority of the others have a history of academic failure and early abandonment of their studies. The community, therefore, also takes on the role of facilitating a second chance and possibility in the field of culture, language, and interpersonal communication.

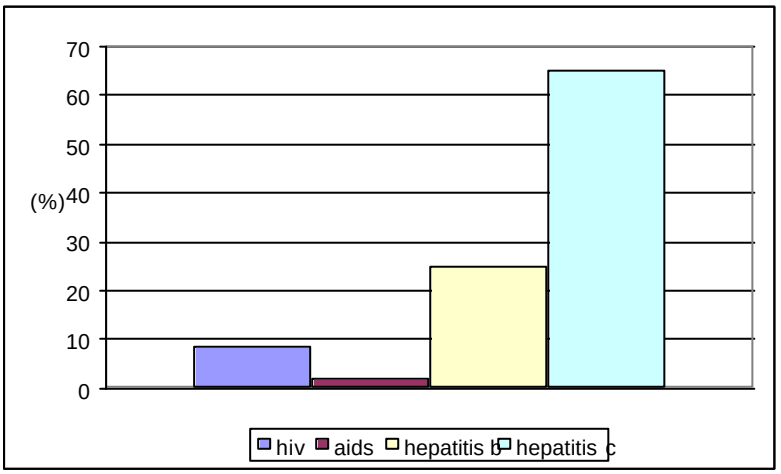
Graph 5.18 - Percentage distribution of users according to psychiatric comorbidity. Sample from FICT centres



Based on FICT figures

FICT therapeutic communities take patients over 20% of whom are affected by psychiatric disturbances connected to drug abuse, independently from the specific attribution of residential treatment owing to the dual diagnosis. If in these more specialised structures there is a concentration of patients with psychiatric comorbidity, in reality the spread of these problems is such as to affect those communities which are not officially deputised to dual diagnosis. Generally, it is the most serious patients who need residential treatment, including those obviously with psychiatric disturbances. This issue requires specific skills, the presence of adequately prepared professionals and much greater financial resources than those considered for a simple pedagogic/rehabilitative programme.

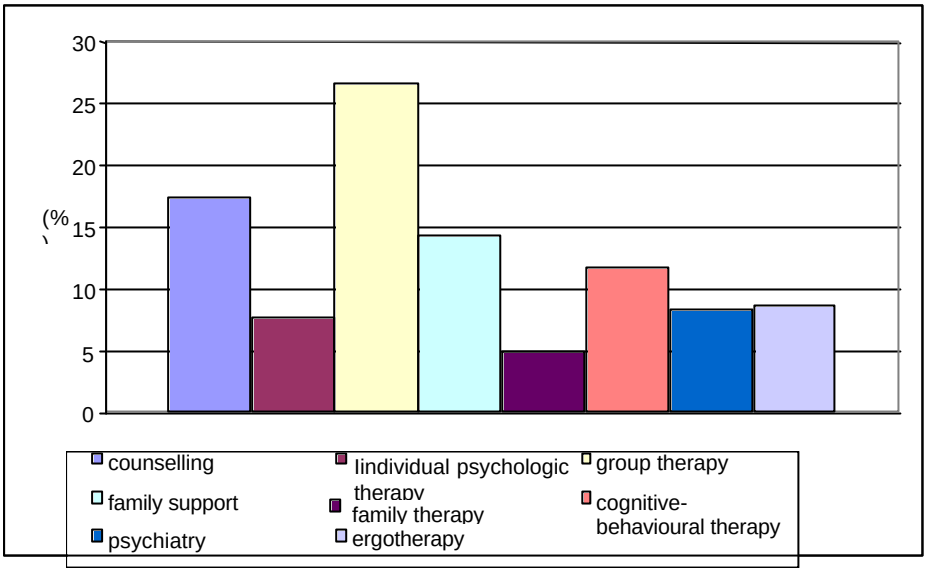
Graph 5.19 - Percentage distribution of users according to infectious diseases. Sample from FICT centres



Based on FICT figures

The percentage of hepatitis C positive patients is very high, as is likewise recorded in public services. These patients can develop aggressive or active forms of hepatitis with very serious consequences regarding the development of chronic hepatitis and life expectancy. The percentage of HIV positive patients has fallen, as also in drug addiction services.

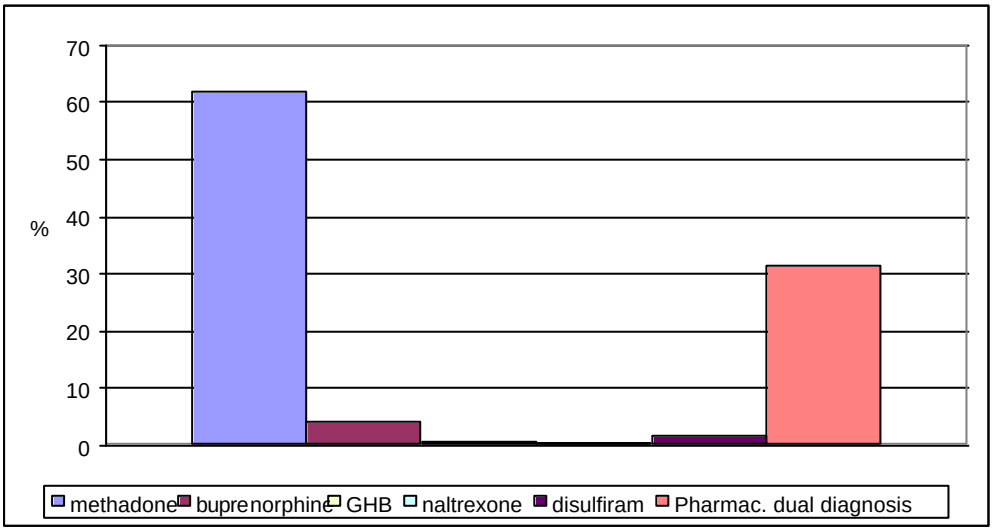
Graph 5.20 - Percentage distribution of psychosocial programmes. Sample from FICT centres



Based on FICT figures

The range of psychosocial activities offered by FICT's clinical/rehabilitative programmes appears highly varied: in this field the most popular are group therapy, individual counselling and support for families of patients.

Graph 5.21 - Percentage distribution of pharmacological initiatives



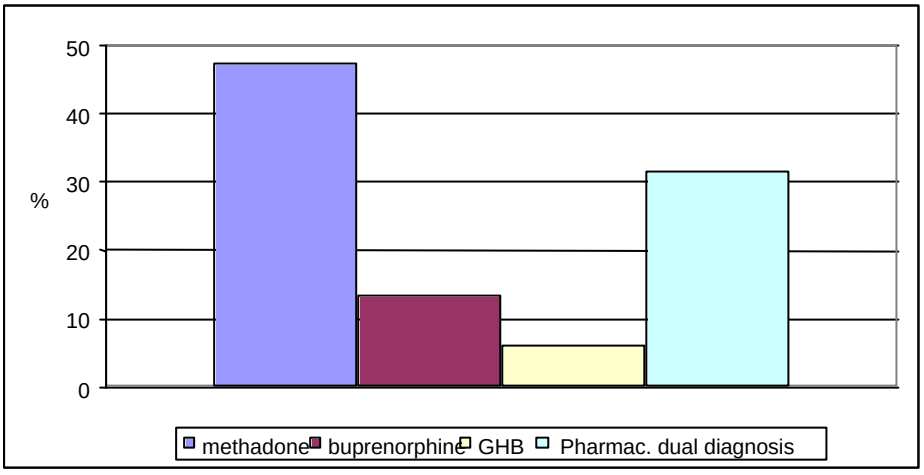
Based on FICT figures

Also the pharmacological approach started in therapeutic communities in FICT Centres seems important. It involves around a fifth of patients: as part of an integrated treatment programme, and in agreement with the public therapeutic structures with which a synergy-based plan of therapeutic strategies is developed, also opiate agonist drugs, such as methadone and buprenorphine, are used in the care of heroin addicts. The appropriate diagnosis in the sector of psychiatric comorbidity is matched by a specific psycho- pharmacological programme associated with therapy for addictive disturbances.

5.4.2 Sample-based assessment in the Centres of the "Comunità Emmanuel"

Taking into consideration also the figures recorded by the "Comunità Emmanuel", it can be seen how the private sector residential structures are making full use of the pharmacological instruments to be combined with psychosocial programmes for the treatment of drug use disturbances: also in the case of the "Comunità Emmanuel" the pharmacological programmes, out of a sample of 495 people, include methadone, buprenorphine and selective psychopharmacological therapies for psychiatric comorbidity.

Graph 5.22 - Percentage distribution of types of drugs used for pharmacological programmes at Centres of the "Comunità Emmanuel"

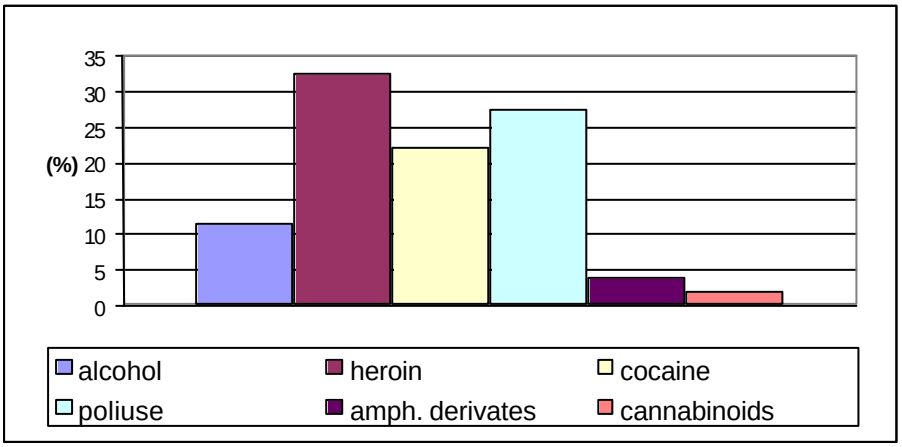


Based on Comunità Emmanuel figures

5.4.3 Sample-based assessment in the Centres of the "Comunità Incontro"

According to the assessment of a sample of patients of some Centres of the "Comunità Incontro" (502 people) and in keeping with the findings in other communities, the use of residential treatment mainly occurs for heroin use, even if for around 20% of people the therapeutic programme is aimed at multiple abuse treatment.

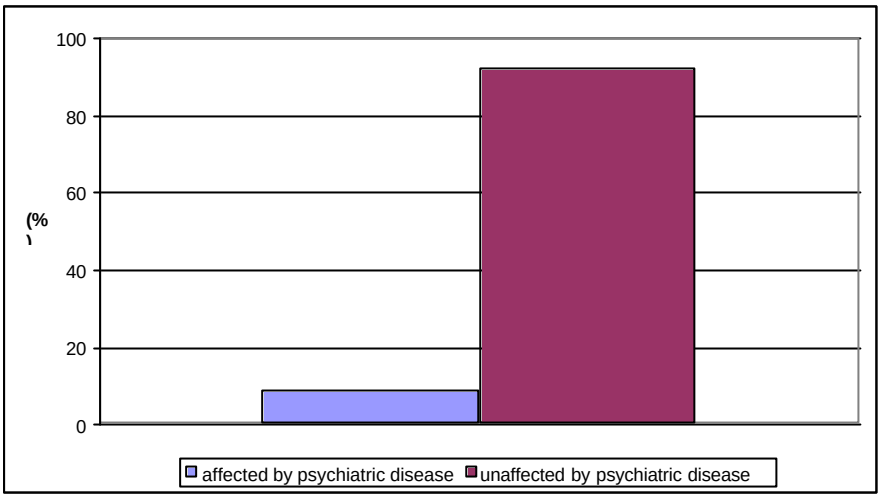
Graph 5.23- Percentage distribution of users according to abuse substance. "Comunità Incontro"



Based on "Comunità Incontro" figures

The most commonly used therapeutic methodologies at Centres of the "Comunità Incontro" include counselling, group therapy and family support.

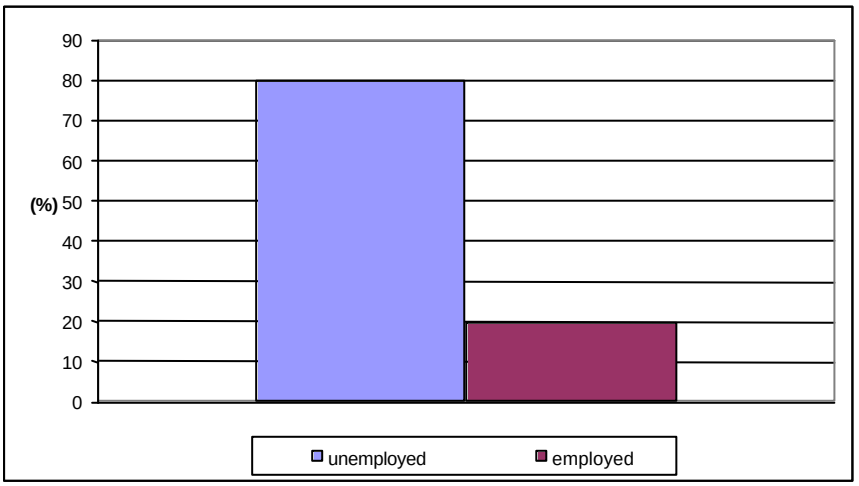
Graph 5.24- Percentage distribution of users according to their psychiatric disease in the centres of the "Comunità Incontro"



Based on Comunità Incontro figures

9% of people (46 out of 502) in the structures of the Comunità Incontro which took part in the sample-based assessment are affected by psychiatric disturbances linked to drug abuse (by which is meant not only patients hospitalised in specific structures for dual diagnosis treatment, but also all the patients for whom a psychiatric diagnosis has been made regardless of the characteristics of the structure).

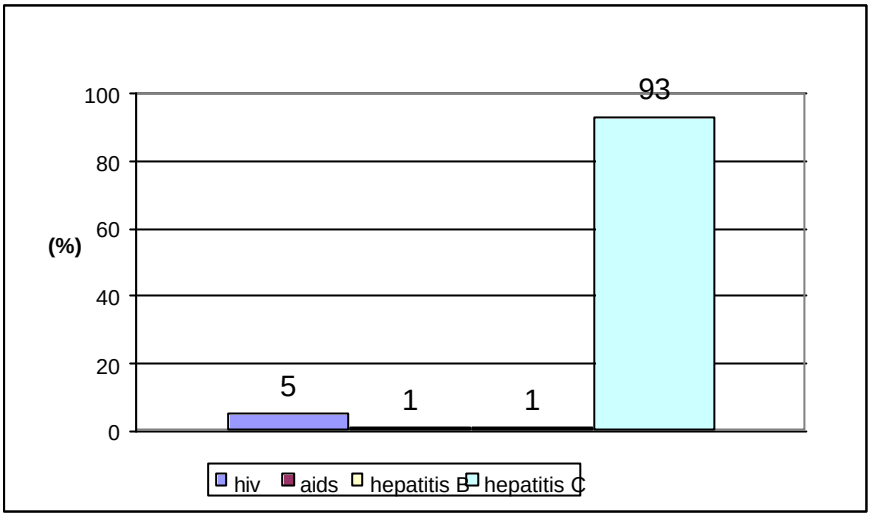
Graph 5.25 - Percentage distribution of users according to employment status. Comunità Incontro



Based on "Comunità Incontro" figures

The data relating to the employment status of people in the structures of the "Comunità Incontro" shows that a high percentage (around 80%) of those present in the residential structures are not involved in the labour market and, therefore, the community can offer valid support also in relation to the return to work.

Graph 5.26- Percentage distribution of users according to infectious diseases. "Comunità Incontro"



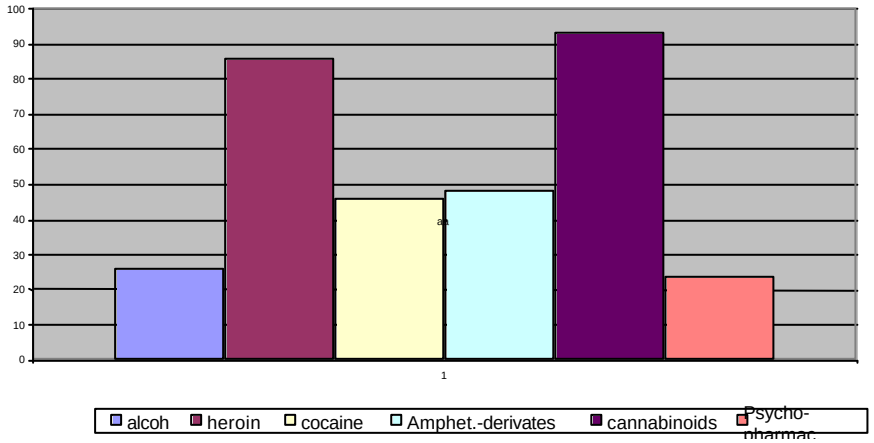
Based on "Comunità Incontro" figures

The percentage of hepatitis C is very high among people turning to residential treatment in the centres of the "Comunità Incontro", while the percentage of HIV positive people is very low, in line with the national trend.

5.4.4 Sample-based assessment in the Centres of the "Comunità di S. Patrignano"

The figures recorded by the "Comunità di San Patrignano" in relation to 1,739 people enable an analysis of the distribution of users by abuse substance, socio-demographic profile, related infectious diseases, presence of psychiatric disturbances, types of programme, besides the various types of pharmacological treatment used within the community itself.

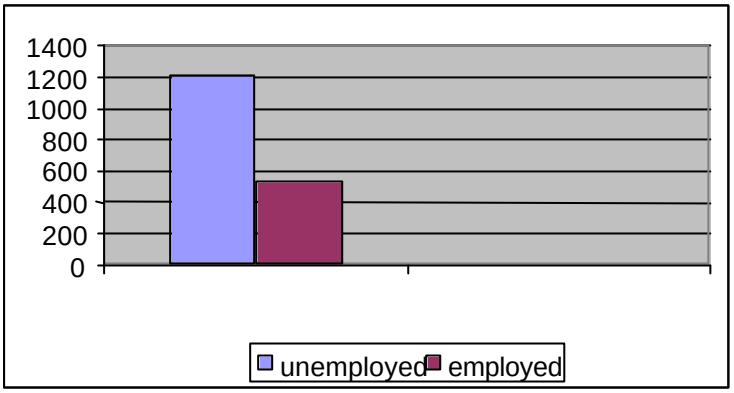
Graph 5.27 - Abuse substance referred to in case history. "Comunità di San Patrignano"



Based on "Comunità di S. Patrignano" figures

As is shown by graph 5.27, use of residential treatment is no longer exclusively linked to heroin addiction, in that significant percentages of patients at the "Comunità di San Patrignano" have case histories of dependency on other substances, especially cannabis, amphetamine-derivatives and cocaine. In most cases users abuse more than one substance at the same time. With regard to the age, high percentages of users (around 46% and 35%) are respectively in the 25-34 and 35-44 age ranges, while the remainder (around 14%) consists of young people aged 15 to 24, and finally people aged 45 to 54 (around 5%).

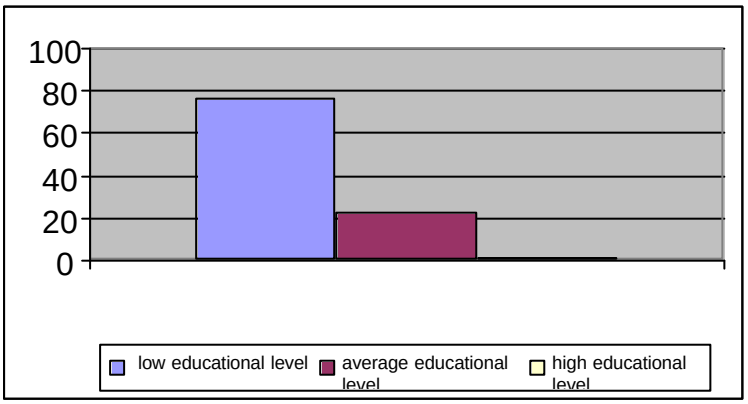
Graph 5.28 - Distribution of users according to employment status. "Comunità di San Patrignano"



Based on "Comunità di S. Patrignano" figures

The figure on the low percentage of people with stable employment in the "Comunità di San Patrignano", compared to the findings in out-patient public services, confirms the previous statement regarding the greater use of residential treatment by more socially disadvantaged people.

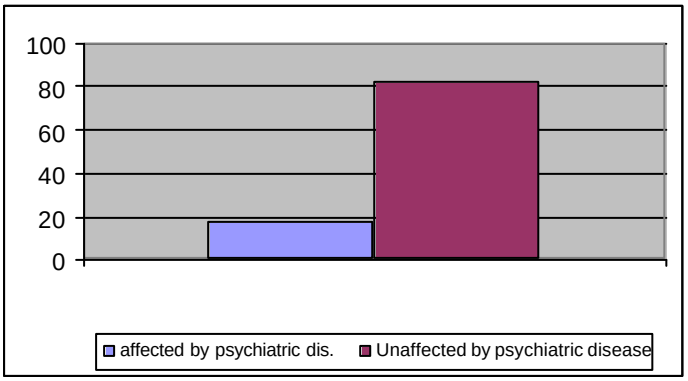
Graph 5.29- Percentage distribution of users according to education level. "Comunità di San Patrignano"



Based on "Comunità di S. Patrignano" figures

The high level of unemployment among those in care within the "Comunità di S. Patrignano" is accompanied by a low education level which affects around 77% of users, and also confirms the role that the community can play in encouraging the development of personal skills, in promoting cultural opportunities, as well as in social reintegration.

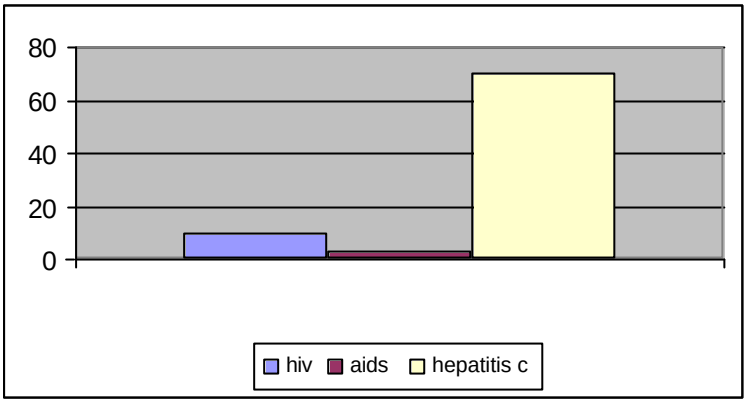
Graph 5.30 - Percentage distribution of users according to psychiatric comorbidity. "Comunità di San Patrignano"



Based on "Comunità di S. Patrignano" figures

Around 17% of patients in the "Comunità di San Patrignano" before entering the community had been in psychiatric centres or under the care of mental health services. Considering gender differences, it emerges that women (around 26%) experienced psychiatric comorbidity more commonly than men (around 14%). It is presumed that the figure is anyway underestimated, in consideration of the fear on the part of patients and their families that revealing a "psychiatric background" might in some way preclude their chances of joining the community.

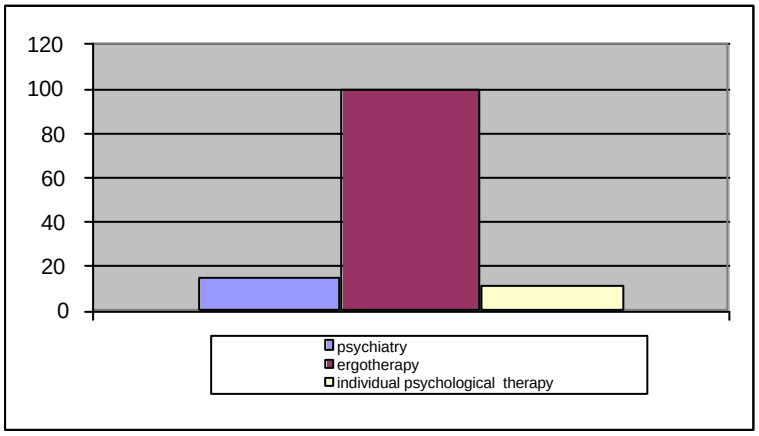
Graph 5.31 - Percentage distribution of users according to infectious diseases. "Comunità di San Patrignano"



Based on "Comunità di S. Patrignano" figures

The quite modest percentage of those affected by HIV and even more so of patients who have contracted AIDS (around 3%), as recorded at drug addiction services and other communities, is confirmation that over the years prevention among drug addicts has been particularly effective, also thanks to the continuing work in this regard of the public and private services with which users come into contact. In relation to the gender differences there is a higher percentage of infected women (15%) than men (8%).
The percentage of people affected with hepatitis C remains high, as recorded in the public services, with minor variations among men and women. The comparison of data relating to HIV and hepatitis C (a decrease in the first illness and an increase in the second with the same behavioural risks) must give pause for thought on the need to analyse in more detail the ways of transmitting hepatitis C.

Graph 5.32 - Percentage distribution of psychosocial programmes. "Comunità di San Patrignano"



Based on "Comunità di S. Patrignano" figures

In the "Comunità di San Patrignano" psychosocial programmes make up an important factor in the recovery of patients; in particular ergotherapy is encouraged and this involves all users, followed by psychiatry used in about 15% of cases of patients who are in therapy for anxiety-depression,

not linked to the suspension of drugs. Finally, 11% of patients benefit from individual psychological therapy, which also includes group therapy understood as involvement in work, sport and in other recreational activities.
Since there is psychiatric comorbidity, the psychosocial programmes are accompanied by pharmacological therapy; this involves around 9% of patients in the "Comunità" who are treated with psycho-pharmaceuticals (anti-depressants, neuroleptics and tranquillisers).

[6] It should be recalled that a user can be subjected to more than one type of treatment.

6. HEALTH CORRELATES AND CONSEQUENCES

Overview

The data relating to drug-related deaths was taken from 2 sources: the General Death Registry of ISTAT and the special Registry of the Anti-drug Services Central Command.
From the analysis of the data it can be seen that deaths by overdose recorded in 2004 totalled 441, without any significant change on the previous two years.
In relation to the infections found in drug addiction care service users, the data supplied by the Ministry of Health on HIV infected cases shows a steady, albeit minimal, fall in relation to the previous years.
The trend in positive results for hepatitis B and hepatitis C in the period 2001-2004 among users of drug addiction services was largely in line with previous years.

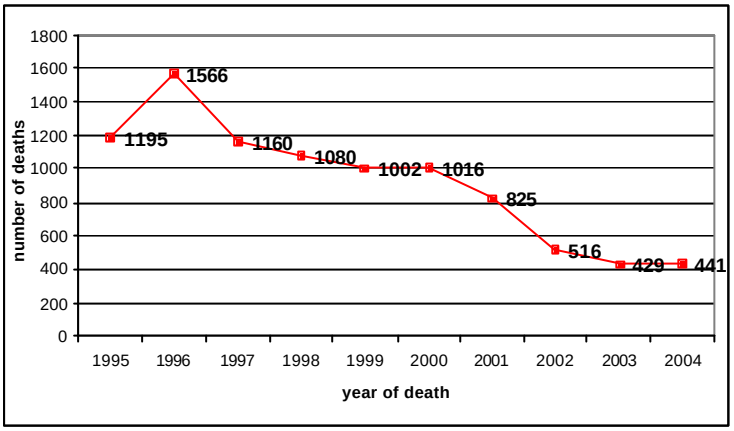
An important statistic recorded for the first time in 2004 concerns the percentage of drug addicts among new HIV positive cases or in other words the case history of HIV positive subjects, diagnosed in 20 infectious disease wards and institutes in 2004 by “La Sapienza” University of Rome.
The data coincides with the information seen in the international literature which shows, compared to the past, a fall in the number of drug addicts among new HIV positive cases.

In relation to psychiatric problems, there is evidence of the emergence of a high percentage of psychiatric disturbances associated with drug abuse problems. The problem of the combined presence of a psychiatric disturbance associated with or pre-existing to drug abuse problems, and which is capable of taking on its own clinical path, is a challenge for drug addiction treatment services and also a strong call for the involvement of official psychiatry in this assistance sector.

6.1 Drug related deaths

In Italy there are two separate institutions that measure deaths related to the use of drugs: the ISTAT General Mortality Register and the DCSA (Central Anti-drug Services Department) Special Register.
An analysis of the data provided by the DCSA related to deaths presumably caused by acute intoxication (that is, deduced on the basis of solely circumstantial evidence), shows that there were 441 deaths by *overdose* in 2004, a figure that shows no significance difference from the preceding two years. This stability follows the progressive decrease in deaths that began during the second half of the nineties. (Graph 6.1).

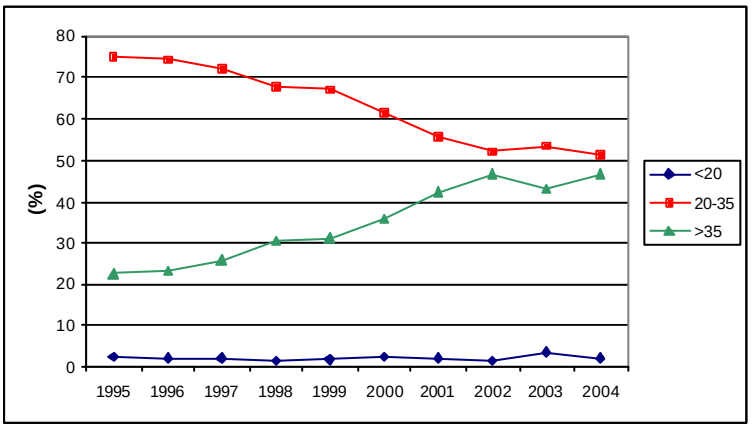
Graph 6.1 – Distribution by year of drug related deaths



Based on data from the Ministry of Internal Affairs - DCSA

The analysis indicates an overall increase in the percentage of deaths of over 35 year olds compared with an overall decrease in the deaths of subjects aged between 20 and 35, who, nevertheless, still represent the highest percentage. The very low percentage of under 20 year-olds (less than 5 % of total deaths) has not undergone a significant change (Graph 6.2).

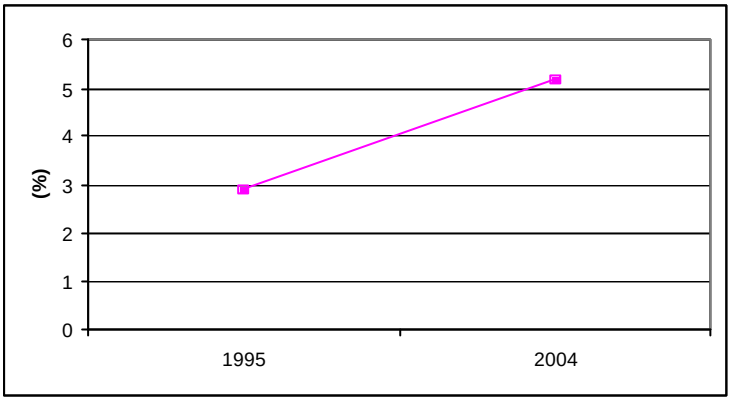
Graph 6.2 – Percentage distribution by age group of drug related deaths



Based on data from the Ministry of Internal Affairs – DCSA

In conclusion, an analysis of deaths on the basis of nationality shows how, although almost all the deaths refer to Italians, the percentage of foreigners among the deaths in 2004 rose significantly to reach the highest amount in an entire decade, equal to 5% (Graph 6.3).

Graph 6.3 – Percentage distribution of foreigner deaths



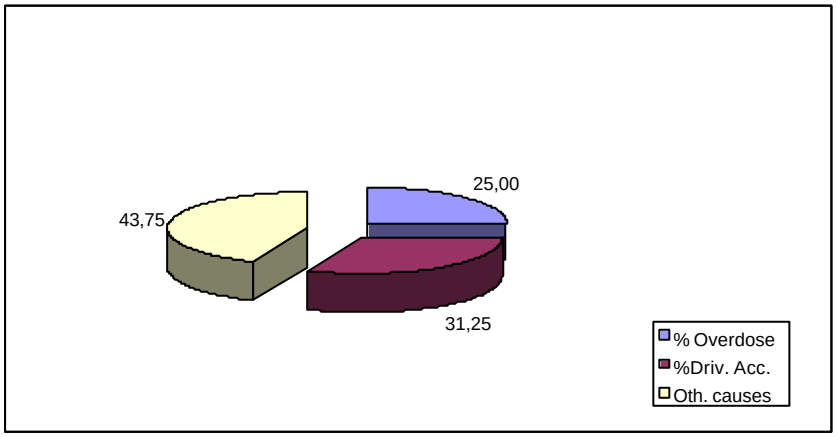
Based on data from the Ministry of Internal Affairs – DCSA

Forensic toxicology

Interesting data regarding drug related deaths comes from the Forensic Toxicology Section of the University of Milan (Prof. Franco Lodi). In particular the data refers to corpses that are shown by the post-mortem autopsy to be positive for cocaine and morphine.

The cause of death of approximately 25% of the cases testing positive for cocaine can be attributed to overdose, while 31% were caused by driving accidents. The remaining 43% of the deaths were due to other causes (suicide, homicide, fire).

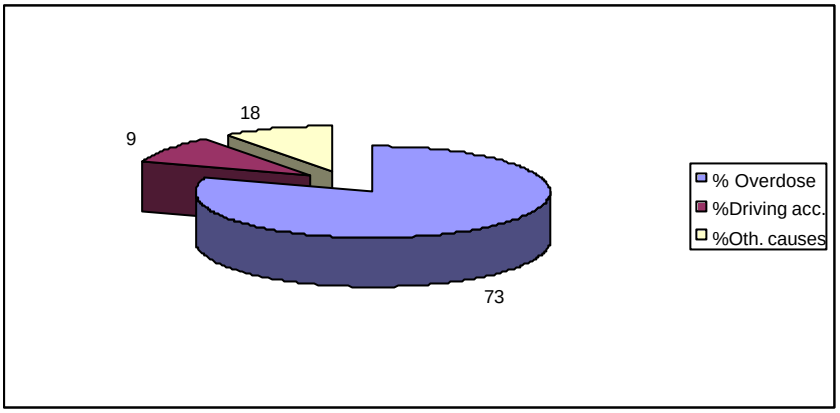
Graph 6.4 – Percentage testing positive for cocaine in relation to the cause of death



Based on data from the Forensic Toxicology Section of the University of Milan

The percentages in relation to the cause of death of subjects testing positive for opiates (heroin) are quite different. In fact, in most of the cases, (approximately 73%) the deaths can be attributed to overdose, while only in 9% of the cases is death caused by driving accidents or other causes.

Graph 6.5 Percentage testing positive for oppiates in relation to the cause of death



Based on data from the Forensic Toxicology Section of the University of Milan

6.2 Drug related infectious diseases

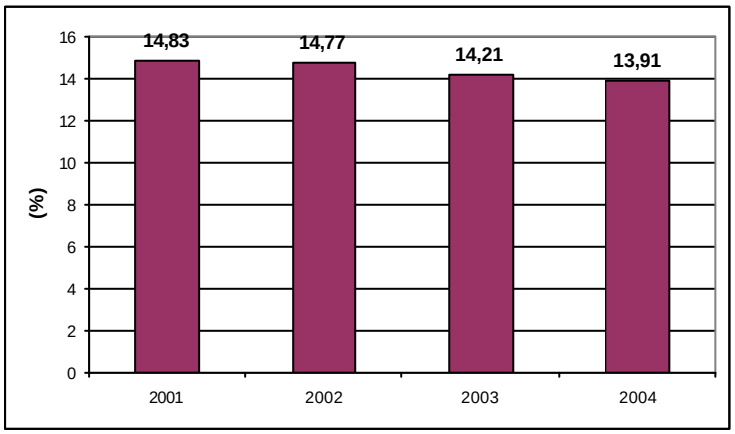
Infections in the Ser. T.

The flow of data used to establish this figure has been supplied by the Ministry of Health. It refers to the entire Services for Drug Addiction population that took part in the test during the year.

HIV/AIDS

In 2004, 67,683 HIV tests were conducted on Ser.T. users (a group that includes both new arrivals and subjects that have been undergoing treatment for several years). Of these, 13.9% were positive. The situation indicates (graph 6.6) a constant decrease, albeit minimal, compared to earlier years.

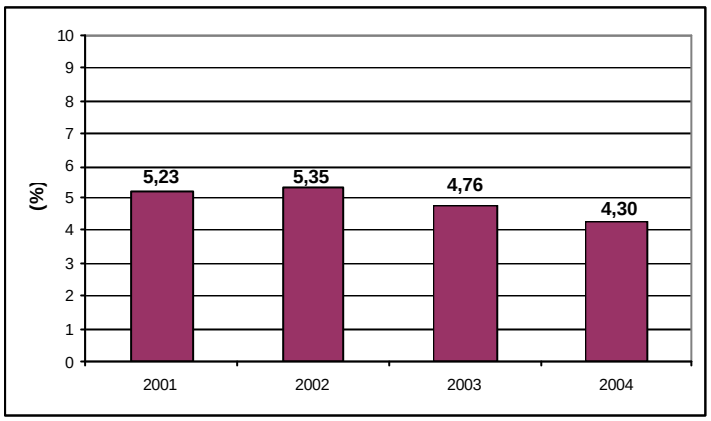
Graph 6.6 – Percentage distribution of those testing HIV positive among users being treated at Ser.T. between 2001 and 2004



Based on data from the Ministry of Health

In particular, the percentage of HIV positivity noted among new users (incidental cases) is decidedly lower than that of old users (prevalent cases) tested in the same year (in 2004 the results are 4.3% and 16% respectively, as can be seen in graphs 6.7 and 6.8). The percentage for new users is decreasing (graph 6.7). In fact, national data shows that in the four years between 2001 and 2004 the percentage dropped from 5.2% to 4.3%. Only in 2002 was there a slight increase over the preceding years with a percentage of new HIV positive users equal to 5.4 %.

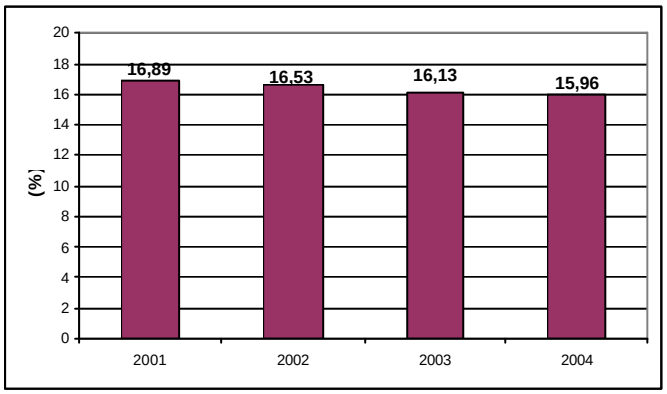
Graph 6.7 – Percentage distribution of those testing HIV positive among new users being treated at Ser.T. between 2001 and 2004.



Based on data from the Ministry of Health

The analysis conducted on a national level on users already being treated shows that in 2004 16% were HIV positive. This number is basically in line with the decreasing percentage, albeit slight, registered in the last four years (18.9% in 2001 compared to the current 16%).

Graph 6.8: Percentage distribution of those testing HIV positive among users already under treatment at Ser.T. between 2001 and 2004

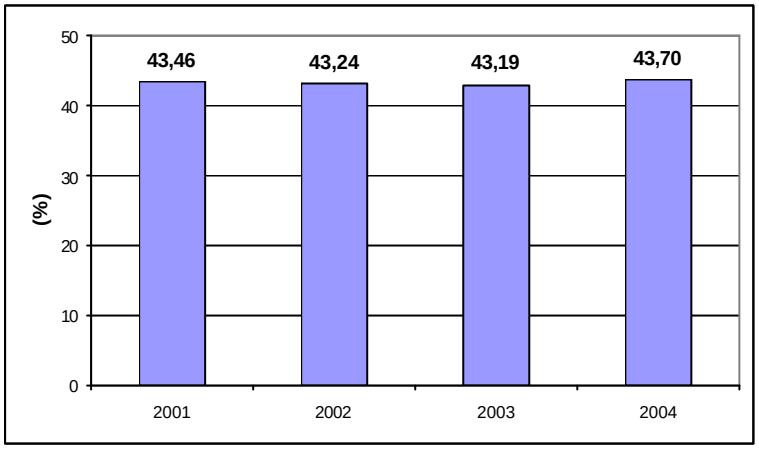


Based on data from the Ministry of Health

Viral hepatitis

The percentage of subjects testing positive for hepatitis B between 2001 and 2004 among the users of the Ser.T. is basically unchanged from preceding years, with figures of around 43% (Graph 6.9).

Graph 6.9: Percentage distribution of those testing positive for hepatitis B among users being treated at Ser.T. between 2001 and 2004

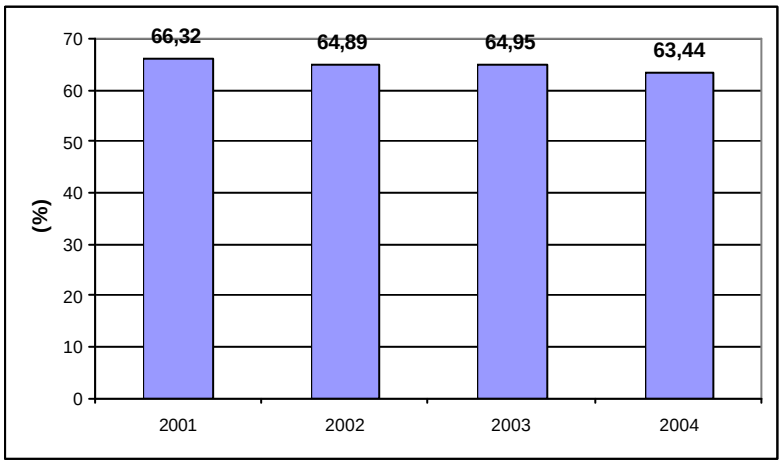


Based on data from the Ministry of Health

No significant difference in contagiousness either among new users or those already under treatment is noticeable in the period between 2001 and 2004. The first are constantly positive with values close to 23%, while the second reach percentages close to 50%.

The analysis carried out regarding hepatitis C indicates a stable situation over the years, with high HIV positivity values, reaching approximately 63% in 2004 (Graph 6.10).

Graph 6.10: Percentage distribution of those testing positive for hepatitis C among users being treated at Ser.T. between 2001 and 2004



Based on data from the Ministry of Health

There was an alarmingly high positivity of subjects to the hepatitis C test among users already undergoing treatment, with values coming close to 70%, indiscriminately for both men and women.

Infections in prisons

Data from the Department of Penitentiary Administration that refers to a sample of 2,051 individuals entering prison in 2004 with an infectious disease shows that 1,994 tested positive to psychotropic substance use. Of these, 35.2% were foreign. Almost 44% of the cases were between 25 and 44 years old (Table 1).

Table 1: Distribution by age of subjects entering prison with an infectious disease – 2004

Age group	subjects	%
15-24	314	15,70%
25-34	870	43,60%
35-44	606	30,40%
45-54	156	7,80%
>54	48	2,40%
Total	1994	

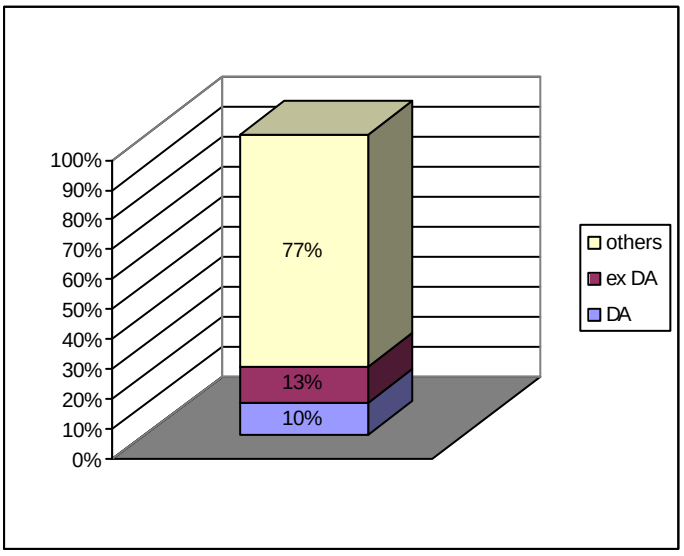
Based upon data from the Ministry of Justice. Department of penitentiary administration

Of the 708 individuals tested for the HIV virus for which the result is known, 86 were positive, equal to 12.1% (this data is in substantial agreement with that relative to the Ser.T. population that tested positive in 2004 – 13.42%). 5.8% of the subjects were between 15 and 24 years old, 30.2% were between 25 and 34, and 5.8% were between 44 and 54. No HIV positivity was noted among the 10 prisoners over the age of 55.
Of the 409 individuals tested for hepatitis B and the 657 tested for the hepatitis C antigene, 37.7% and 46.4% respectively tested positive.
As we saw with HIV, of the prisoners that tested positive to hepatitis C, the two age brackets with the highest number of cases were those between 25 and 34 (41.3%) and 35 and 44 (45.9%).
Finally, as far as tuberculosis is concerned, 3.9% of the 1,187 individuals tested proved positive to the active infection, while 1.6% of the 1,267 cases testing the previous presence of the infection were positive.

Percentage of drug addicts among new HIV positive individuals

The data refers to the cases of HIV positive subjects diagnosed in twenty Departments and Institutes for Infectious Diseases in 2004, as evaluated by the Faculty of Clinical Immunology and Allergies of the Umberto I Hospital – "La Sapienza" University of Rome (Prof. F.Aiuti, Dr. C. Fimiani).

Graph 6.11 – Percentage distribution by drug dependency of HIV positive subjects in 20 departments and institutions for infectious diseases – 2004



Based on data from the Faculty of Clinical Immunology and Allergies of the Umberto I Hospital – "La Sapienza" University of Rome. (Prof. F.Aiuti, Dr.C. Fimiani).

Of the 1,366 cases studied, 142 (10.4%) were classified as drug addicts and 172 (12.6%) as ex drug addicts (Graph 6.11).
The remaining 77% was made up of individuals who contracted the disease through sexual behaviour.
This data is in accordance with the information presented in international literature that shows a reduction in the number of drug addicts among new HIV positive individuals compared to previous years.
The highest percentage of infection in the subjects examined is caused by sexual behaviour. A possible interpretation of this information may be that the presence of specific services dedicated to the prevention and treatment of drug addiction keeps drug addicts on their guards and vigilant. If the percentage of heroin addicts exposed to the virus was once extremely high, today the condition of those who test HIV positive is very different. The risks seem higher today for those drug addicts not undergoing treatment or who are not able to heed the indications provided in the prevention campaigns because of invalidating psychiatric disorders.

6.3 Psychiatric Comorbidity

Surveys taken recently regarding the prevalence of psychiatric comorbidity among drug addicts in Italy present values that are not entirely dissimilar from those registered by the international scientific community. Problems caused by the presence of a psychiatric disorder associated with, or pre-existing to disturbances caused by drug use, take on an independent clinical significance and create difficulties for the services aimed at curing drug addiction. In addition, these cases require the involvement of official psychiatry during treatment. The therapeutic-rehabilitative management of a case becomes more difficult when there are serious mental disturbances associated with addictive behaviour. The risk of relapse is higher, and the conditioning of the drugs appears supported by possible self medication strategies. Recent epidemiological evaluations carried out by Italian scholars (Carrà and Clerici, to be published) summarise the research of the past years demonstrating that approximately 30% of the individuals undergoing treatment for opiate addiction at therapeutic centres are affected by a serious mental disorder, 59% of them by a personality disorder. One study conducted by Pani and collaborators in the above mentioned review indicates a prevalence of mental disorders in 54% of the patients undergoing methadone treatment and personality disorders in 43%. A study carried out by the Region of Lombardy that studied 606 heroin addicts undergoing treatment at drug addiction centres, showed that 17.8% of them displayed only the symptomatology of the addictive disturbance. 24.6% were affected by a greater mental disorder and 55.8% by a personality disorder (Clerici and Carta, 1996). In a national survey (Pozzi et al., 1997), a psychiatric disturbance was diagnosed in 32% of the patients undergoing treatment for drug addiction: 10% of these were psychotic disorders, 63% were mood swings, 19% were anxiety disorders and 8% comprised other mental disorders. A study undertaken by various centres in Emilia Romagna tested 265 patients (Gerra et al., 2003) and showed that 43.4% of the patients under maintenance treatment with methadone were affected by psychiatric comorbidity. In particular 19% were affected by depression, 8% by general anxiety, 5.8% by psychoses and 10.8% by an alcohol dependency. 37.7% of these patients were also suffering from personality disorders of the dramatic cluster that comprises antisocial personality disorders and borderline personality disorders. In another evaluation carried out on 76 patients being treated with buprenorphine in a drug addiction centre, 23.7% showed serious psychiatric disorders and 35.4% displayed personality disorders. (Gerra et al., 2004). If we consider the problem of psychiatric comorbidity in prisons, the situation to be tackled becomes even more serious and dramatic. A study sponsored by the Ministry of Justice carried out in 2003 in institutions in Padua and Rome (Regina Coeli) (Berto et. al., 2005) shows that among the drug addicts tested, 50.8% had serious psychiatric disturbances and 45.8% suffered from personality disorders. As we can see from these epidemiological elements, the number of drug addicts requiring specific diagnostic attention, and therefore requiring therapeutic intervention aimed specifically at the psychiatric problem, is extremely high. Treating the addictive disturbance in pharmacological or psychosocial terms without taking these psychiatric problems into account has caused a reduction in the effectiveness of the interventions. The present situation in the private

and public centres, the training of the professionals operating in this sector and the diagnostic-therapeutic techniques used must be updated to respond to the essential needs of the patients addicted to drugs. In this regard a close collaboration between Addiction Departments, Therapeutic Centres and Mental Health Departments can lead to the creation of appropriate intervention protocols and more extensive appointment procedures, perhaps through common training for professionals.

Several Italian studies: percentage of psychiatric comorbidity among drug addicts

	Serious psychiatric disorders	Personality disorders
Carrà and Clerici	30%	59%
Pani and coll.	54%	43%
Clerici and Carta	26,4%	55,8%
Pozzi et al.	32%	-
Gerra et al.	32,8%	37,7%
Gerra et al.	23,7%	35,4%
Berto et al.	50,8%	45,8%

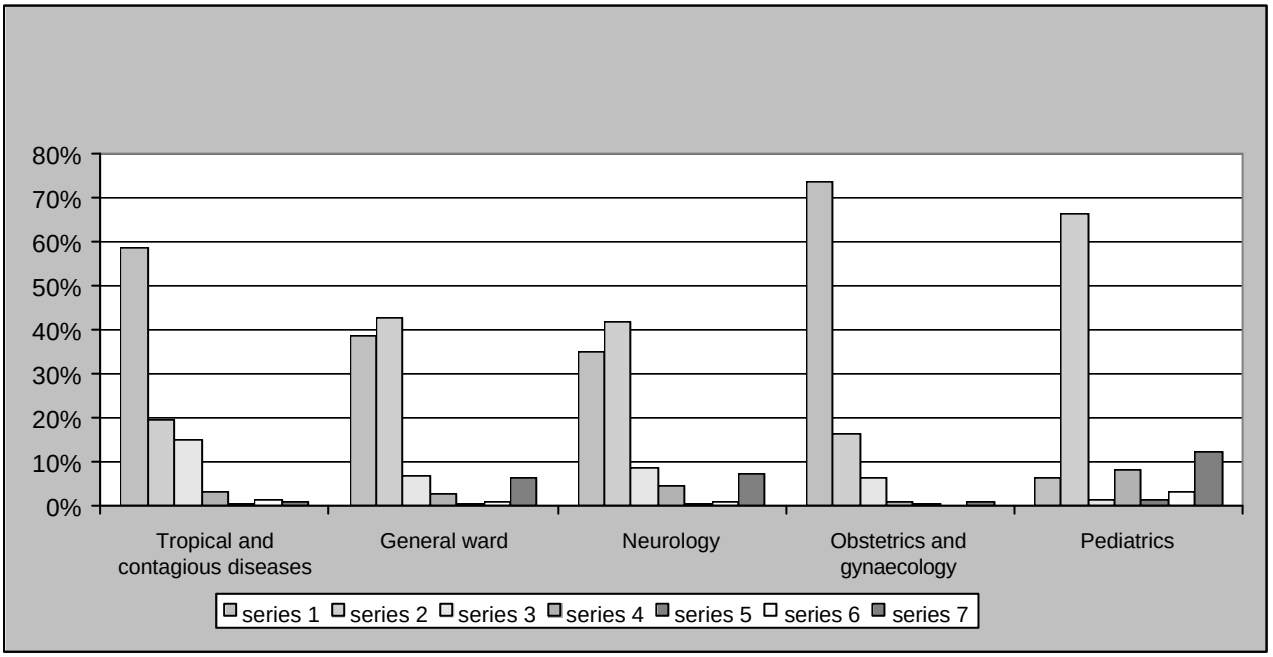
6.4 Other drug related health correlates and consequences

6.4.1 Somatic comorbidity, non-fatal drug emergencies, other health consequences

This paragraph examines the recourse to Italian hospitals for reasons linked to disturbances caused by substance abuse.
The Hospital Release Forms (SDO) for patients with diagnoses (codified on the basis of ICD9-CN) linked to the use of drugs will be taken into consideration.
We will be examining forms relative to hospital stays in Italy during the three year period from 2001-2003 that bear the diagnosis “psychosis induced by drugs”, addiction/abuse of drugs”, “drug addiction during pregnancy and drug damage to the fetus or newborn” and “poisoning”.
Between 2001 and 2003 there were 84,024 hospitalisations in clinics and hospitals in Italy with the main or concurrent diagnosis relative to the use of psychotropic substances.
The release forms with the diagnosis (main or concurrent) linked to the use of drugs are equal to 2.15 per thousand of the collective national total in the studied period.
Hospitalisations in clinics represent merely 5.4% of the total. 46.8% of the hospitalisations considered have the main diagnosis linked to the use of drugs while the remaining 53.2% have a drug related diagnosis among the secondary or concurrent diagnosis.
If we consider all the hospitalisations in the three years of the study, we can see that the most frequent diagnoses (either main or concurrent) are relative to “drug addiction” (32,978), followed by “poisoning due to psychotropic substances” (21,605) and “drug abuse without addiction” (18,700).
The distribution by substance (on the total number of hospitalisations for which information regarding the substance used is available) and the typology of drug related diagnosis shows how 81.8% of the “drug addiction” diagnoses are due to the use of opiates. The sedative-barbiturate-hypnotics category encompasses 32% of hospitalisations and the most common diagnosis is “poisoning”. 7.8% of hospitalisations are caused by cocaine with the most frequent diagnoses being “drug addiction” (209) and “drug abuse” (2,040). Cannabinoids (5.6% of hospitalisations), most frequently carry the “drug abuse” diagnosis.
If we consider the percentage distribution of the psychotropic substances being abused as revealed by the hospital release forms for the three years under consideration, a decrease can be seen in the diagnoses indicating abuse of opiates (from 49.0 in 2001 to 44.9 in 2003).
On the other hand, the forms indicating cocaine increase from 2001 (5.7%) to 2002 (7.9%) and again in 2003 (9.9%). In addition, there is a percentage increase in the release forms with diagnoses that refer to the abuse of cannabinoids (from 4.9% to 6.3%) in the same three-year period.
An analysis of the hospital release forms shows that the youngest age bracket is prevalently linked to sedative-barbiturate-hypnotics (72.4%) and to anti-depressants (12.4%). In the three successive age groups, the most prevalent substance is opiates at 36.6% for the 15-24 age group, 56.6% for

the 25-34 group and 59.6% in the 35-44 bracket. In the two older age groups, the drug category most often diagnosed is once again sedative-barbiturate-hypnotics. Hospitalisations for the abuse of anti-depressants also increase for this age group.
Cocaine is particularly present in the 25-34 age group (10.2%), with cannabinoids at 15.0% and hallucinogens at 3.7% among those aged 15-24.
Among the variables found on the hospital release forms, we can analyse the "discipline code" that indicates into which department the patient was admitted.
There are 125 different discipline codes. Only 62 of these 125 are present on the forms from 2001, 2002 and 2003 relative to drug related hospitalisations. Of these 62 only 10 have a total hospitalisation percentage greater or equal to 1%. The highest percentage of hospitalisations belongs to the departments of general medicine (28.9%), psychiatry (26.3%) and tropical and contagious diseases (12.2%), followed by neurology (7.5%) and the general ward (5.6). The other wards considered have a percentage of hospitalisations below 5%.
In all the departments the most common substances revealed by the diagnoses were opiates and sedative-barbiturate-hypnotics. In particular, in the department of obstetrics and gynaecology and the department for tropical and contagious diseases, 73.9 and 58.9 percent respectively of drug related diagnoses refer to opiates. In the pediatric ward, 66.5% of the hospitalisations were relative to sedative-barbiturate-hypnotics (Graph 6.12).

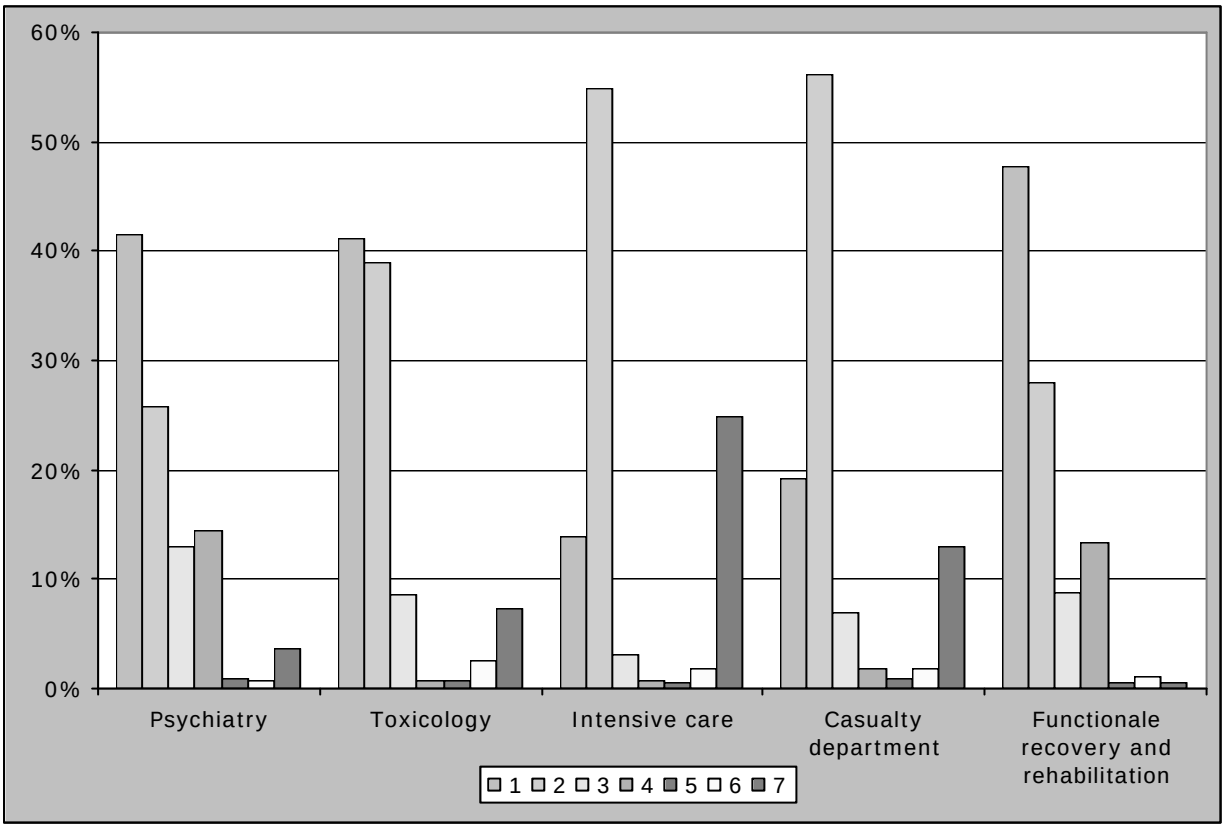
Graph 6.12 – Percentage distribution of hospitalisations with drug related diagnoses by department and abused substance



Based on data from the Ministry of Health

Legend: 1=Opiates, 2= Sedative-barbiturate-hypnotics, 3=Cocaine, 4=Cannabinoids, 5=Amphetamines, 6=Hallucinogens, 7=Anti-depressants, 8= Mixed substances, unclassified.

Based on data from the Ministry of Health



Evaluations based on the hospital release forms can underestimate the phenomenon of hospitalisation conditioned by the use of illegal drugs. In many cases the pathologies that induce hospitalisation are not referred to substance use, either because of the lack of a diagnosis or because of a form of negation on the part of the patients and the professionals operating in the hospital. It is well known that acute psychiatric disorders that lead to urgent hospitalisation in a psychiatry ward are not always evaluated through the proper toxicological exams. The diagnosis is simple “schizophrenia” and the patient obviously does not reveal that he has assumed cocaine and ketamine together.

Despite this possible miscalculation, the elevated number of hospitalisations for known drug related problems demonstrates the impact this phenomenon is having on this sector and allows one to imagine the probable repercussions on costs, coordination and management.

In order to combat these probable repercussions the addiction centres must be re-qualified. Forms of collaboration must be established and well-defined between Ser.T., therapeutic centres and hospitals, with the aim to establishing treatment continuity, saving of resources and improvement in the diagnostic-therapeutic approach.

It is of utmost importance that a system be found to safeguard the nation’s health with respect to organic drug-related diseases and infectious pathologies. This system should be created in harmony with the Divisions of General Medicine and Infectious Diseases.

The relationship between public and private-social services, general ward and psychiatry diagnosis and treatment wards should be favoured, with the aim to provide drug addicts with specific and appropriate clinical solutions. The increasing use of psycho-stimulants could, in the future, condition an intensive recourse to diagnosis and treatment, as already seen by the increased prevalence of cocaine among those hospitalised in psychiatric wards, with additional health and functional problems that are already evident today.

Pregnancies in patients addicted to drugs could benefit from the relationship between public and private-social services and the departments of gynaecology and obstetrics, with the establishment of protocols that do not limit themselves to dealing exclusively with the emergency of the abstinency in the child about to be born.

Finally, if public and private-social services were qualified to manage facilities in clinics for the treatment of withdrawal, as many already are in various departments, these patients' need for hospitalization would be significantly reduced. This, in turn, would lead to substantial savings for the National Health System.

6.4.2 Driving accidents

The information provided in the following paragraph is based on the National Institute of Health (Dr. Teodora Macchia and Dr. Franco Taggi).

Since July 2003 the Highway Code has been under revision. In the new version there are two important additions that differentiate it from the previous: the introduction of a points system on the driving license and the possibility for the Police Force to perform random and arbitrary checks on the roads to uncover those who are driving while under the influence of alcohol (art. 186) or under the influence of other substances (art. 187).

During the International Road Safety Exhibition, held at Riva del Garda in October 2005, the new laws and their effectiveness were discussed. The results of this first year (July 2003-June 2004) have been made official, and the data indicates a decrease in driving accidents (–8%), injuries (–10%) and deaths (–18%).
The official ISTAT-ACI data relative to 2004 is supplied below.
Table 1 shows the percentage variations registered in driving accidents compared to 2003.

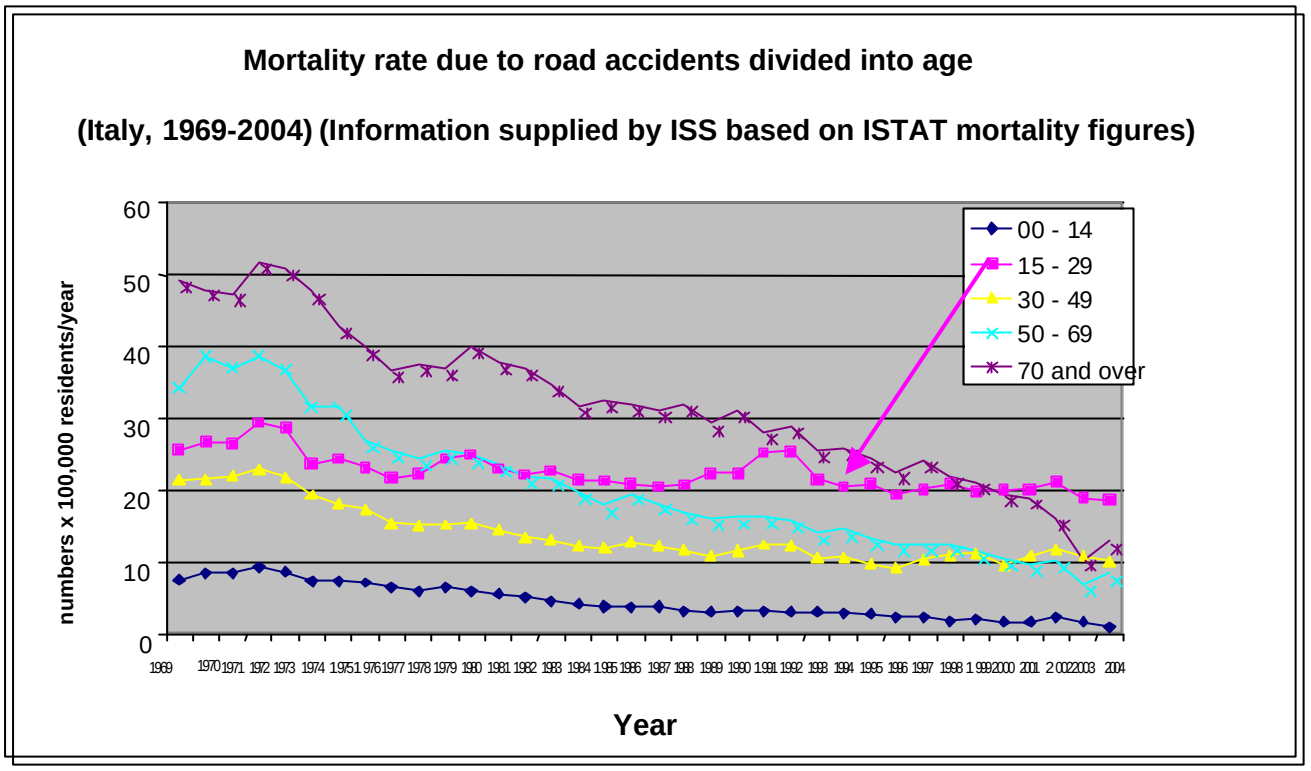
Table 1. Number of driving accidents, deaths and injuries in Italy in 2004 compared with 2003.

2004 vs. 2003	(N°)	(%)
Driving accidents	224.553	- 3.1
Deaths	5.625	- 7.3
Injuries	316.630	- 3.3

The social cost, 33,706 million euros in 2004, is lower (- 5%) than in the previous year, although as it still represents 2.5% of the GNP it is quite high.
A greater number of accidents (75.7%), with 41.1% of deaths, was registered on urban streets compared to highways where there were 6.2% of accidents with 11.4% of deaths.

On the basis of this evidence we can only hope that the check point activity and the investigations carried out by the Municipal and Local Police will be intensified.
Although we are beginning to see a reduction in driving accidents, the youngest age bracket is still the group that is most involved. According to the data supplied by the National Institute of Health that includes the latest figures available for Italy (2004) relative to deaths caused by driving accidents, it is the 15-29 age bracket (the group that is also most involved in the use of illegal psychotropic substances) that continues to keep the risks elevated. In this part of the population, approximately 20 individuals per year for every 100,000 residents would lose their lives on the roads. (figure 1).

Figure 1. Mortality rate due to road accidents divided into age



The mortality risk from driving accidents is twenty times higher for those under thirty than for the rest of the population. In 2004, data registered for individuals between 25 and 29 years of age showed 32,722 injuries and 481 deaths. Between the ages of 21 and 24 the deaths amounted to 395.

Driving accidents and psychoactive substances

Despite the lack of official estimates obtained by extensive sample surveys in our country, the evidence gathered by international scientific literature indicates that the risk of driving accidents is closely linked to the use of illegal or unprescribed psychotropic substances, to alcohol abuse, and to the consequent inability of car and motorcycle drivers to drive or ride properly, particularly on Friday, Saturday and Sunday nights.

The relationship between the use of substances and automobile driving dysfunctions is quite complex and does not only involve the effect of the drug on one's driving performance. One must also consider the acute action of the drug, the possible problems inherent in habitual use, the personality of the consumer, the socio-cultural context and the sum of the environmental and road conditions. Bearing this in mind, the prevention campaigns must take account of the complexity of the factors that together can cause an accident, considering both a target that is at risk for various other reasons that may compromise his or her health, as well as other general population sub groups.

If we examine the effects of the drugs themselves on accidents, the evidence indicates ever more clearly how dangerous they are, even those that are considered superficially less problematic. Recent studies show how cannabis can increase the number of highway fatalities, compromising behind the wheel performance, both when the substance is taken alone and when it is taken in conjunction with alcohol. Contrary to what one might expect, it is not the chronic cannabis smokers who have developed a dependency who are at the greatest risk, but rather the occasional smokers, those who use the substance only on the weekends. In fact, those who smoke cannabinoids daily develop a tolerance to the drug's effects on their psychomotor capacities, while those who use the drugs less frequently are more sensitive to the substance and how it compromises their ability to drive a motor vehicle. The smoking of cannabis has been placed in correlation with those accidents in which the smoker is the active protagonist behind the wheel of

the vehicle that has caused the accident because of his incorrect behaviour. In addition, these studies also highlight the fact that even though the use of cannabis is most certainly linked to an increase in driving accidents, when the behavioural characteristics and the personality of the smoker are evaluated, these are shown to influence the number of accidents to the greatest degree. Cannabis compromises one's psychomotor performance leading to a reduction of reactions when driving a road vehicle. This situation is substantially aggravated if high dosages are used, if alcohol is consumed in conjunction with marijuana, and in cases where a more intense or committed performance is required. Psychotropic substance abusers who have been arrested or who have caused a driving accident tend to continue to violate the code again and again. This is particularly true among subjects who were very young at the time of their first offence, indicating once again that behavioural characteristics play an essential role in determining the frequency of the phenomenon.

In Italy we do not have a clear idea of the relationship between psychotropic substance abuse and driving accidents. When the latest regulations will come into effect, we should be able to carry out toxicological examinations after a driving accident that will allow us to construct a valid epidemiologic picture to be used as a point of reference.

We do have, however, indications regarding positivity to alcohol and other psychotropic substances provided by examinations carried out on the highways.

Table 2. Accidents reported during 2004.

Accidents reported (Italy, 2004, Data ISTAT-ACI)	In urban areas		In extraurban areas		Total accidents	Total deaths
	Total accidents	Fatal accidents	Total accidents	Fatal accidents		
Abnormal for alcohol intoxication	2.180	34	870	59	3.050	93
Abnormal for ingestion of hallucinogenic or psychotropic substances	162	7	60	4	222	11
Total alcohol + substances	**2.342**	**41**	**930**	**63**	**3.272**	**104**
					-	-
Total circumstances relative to the psycho-physical state of the driver	**4.121**	**145**	**1.659**	**149**	5.780	294

There were 3,050 driving accidents caused by alcohol abuse and 222 caused by the use of narcotics.

Table 3 shows the number of fines given by the Highway Police – Ministry of Internal Affairs and the Military Police (Carabinieri) – Ministry for the Defense for driving under the influence of alcohol (art. 186 highway code) and for driving under the influence of narcotics.

Table 3. Fines related to articles. 186 and 187 given by Police Forces in 2004.

	Art. 186 (no. fines)	Art. 187
Highway Police	26.579	1.238
Military Police (Carabinieri)	19.537	10.071

Source: ISTAT-ACI

The official statistics tell us nothing, however, about the typology of the substance and the incidence of poly-abuse. In the early application phase of the new highway code, a collaboration was instated between the Ministry of Internal Affairs (Highway Police and Police Health Management) and the National Institute of Health to outline procedures relative to preliminary examinations on a biological sample in the field. An aliquot of approximately 150 samples of saliva that tested positive for alcohol and or drugs was sent to the National Institute of Health to be analysed in the laboratory. The biological material was accompanied by a form that had been filled out at the scene containing the alcoholimetrical data of the subject under examination. Although the data obtained has no epidemiological value considering the size of the sample to be further examined by the methodology to be applied on a national level, it has provided us with some

interesting information. In particular this information regards the age of those testing positive, (seven out of ten were under 29 years of age), the prevalence of cocaine in the blood (around 45% of the youngest subjects tested positive), the high percentage of alcohol in the blood (exceeding legal limits in ¾ of the samples) and the high percentage of poly-consumers among young adults (87% under 35) (fig.3). Figure 2 shows the age of the subjects who tested positive to one or more substances and their blood alcohol level. The figure also includes the percentage of those testing positive to narcotic substances in relation to the blood alcohol level (more or less than 0.5 grams per litre) and the age group (under or over 29). It is interesting to note that in the youngest subjects, drugs are present even when there is a very low blood alcohol level.

Figure 2 Age of subjects who tested positive to one or more substances divided into blood alcohol levels

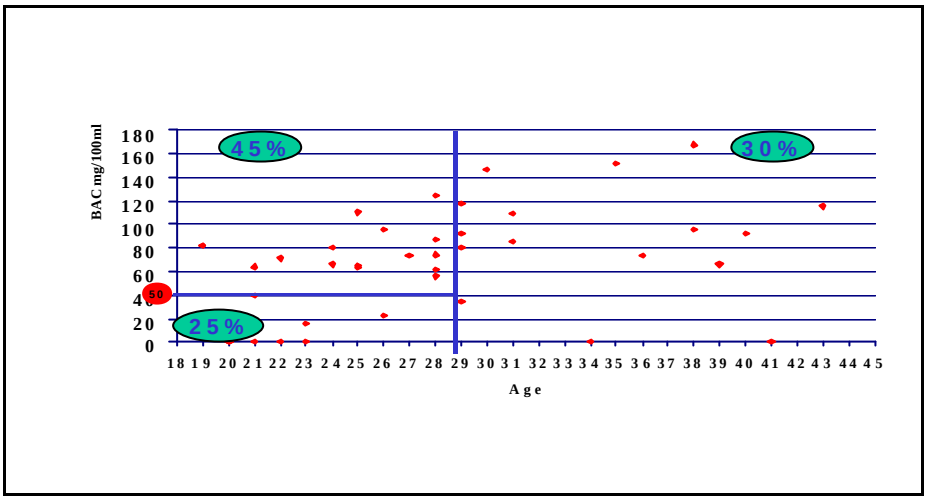
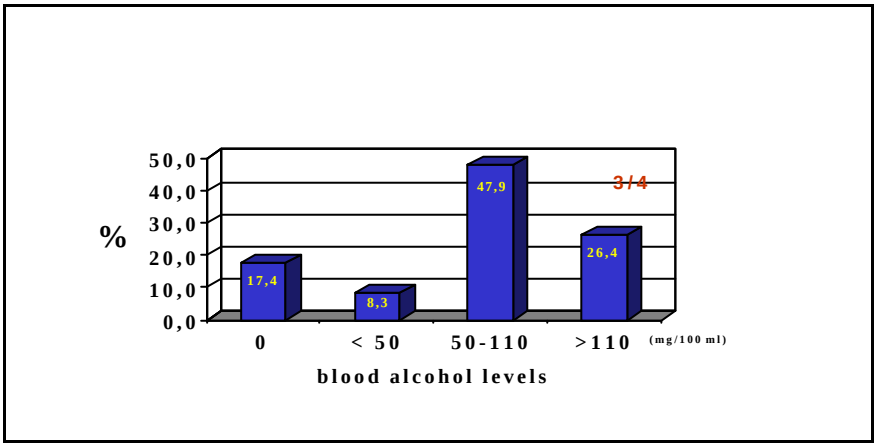


Figure 3. Percentage of subjects divided into blood alcohol levels (Ministry of Interior-ISS)



An experimental project entitled “Respect the road don’t let your life go up in smoke” carried out by the local police from seven towns near Brescia and coordinated by the local police force from Bagnolo Mella, in conjunction with the Military Police (Carabinieri) in the project area (with a population of approximately 42,000 inhabitants) allows us to make some considerations that could become fundamental for more extensive interventions designed to combat driving accidents. The initiative seeks to teach the younger generation not to drive in altered psychophysical states caused by the use of alcohol and drugs. The activities are aimed at control, prevention, repression and education. The general public and schools are directly involved in this project that tries to promote correct behaviour and maintain highway safety and legality, as well as combat alcohol and drug abuse.

In quantitative terms, table 4 summarises a part of the results that were obtained by the project using a particularly effective approach to test blood alcohol levels and the presence of psychotropic substances in the biological fluids. The data relative to police checks and road accidents on the weekend (during the hours from 8PM to 6AM on Fridays, Saturdays and Sundays) in the project area relative to 2003 and 2004 are compared to those of 2002, the year before the "Respect the road - Don't let your life go up in smoke" project was inaugurated.

Table 4. Some results obtained by the 2003 and 2004 project compared to 2002

	2002	2003	2004
No. Accidents during the weekend evening/night	32 (1 fatal)	12	11
No. Subjects tested		4685	4018
No. Licences revoked for:			
Art. 186		97	112
Art. 187		33	73
No. "Patrols" aimed irregularly in trafficked road arteries (0.00- 06.00, at least 8-10 Police officers)		45	43
Reduction of accidents		- 62 %	- 66 %.

These results are very encouraging and suggest that intervening with more constant checks, educating the population, in particular the younger generations, to the significance of such activities, supporting the checks with information and education to allow the value of the application of the laws in terms of prevention and determent to come forth and monitoring the results of the current activities will significantly contribute to the reduction of driving accidents. In this way some members of the youngest generation will have a sustainable reason to say "No" to drugs in the face of peer pressure.

(*) Data supplied by the Local Police forces of Bagnolo Mella, Roncadelle, Capriano del Colle, Mairano, Azzano Mella, Flero and Poncarale.

7. RESPONSES RELATING TO HEALTH CORRELATES AND CONSEQUENCES

Overview

The following data represent the replies given by the directors of a representative sample of the 541 Italian public drug addiction services in their role as co-ordinators of prevention initiatives in the drugs field.

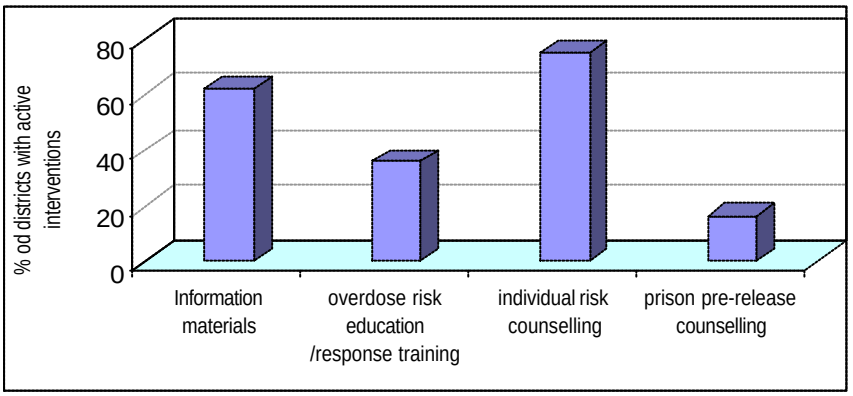
7.1 Prevention of drug-related deaths

In recent years there has been a drop in deaths from drugs. It is likely that this positive change is due to a decline in injection drug use and to more controlled drug use, the increased availability of emergency intervention with Naloxone, the increased effectiveness of prevention efforts, and the protective effects of treatments for heroin addiction at the agencies providing services.
Interventions aimed at reducing mortality by acute drug intoxication have been broken down in relation to:

1. type of activity
2. contexts involving distribution of informational materials for prevention of emergencies and death from acute intoxication
3. educational efforts in emergency response skills for substance abusers

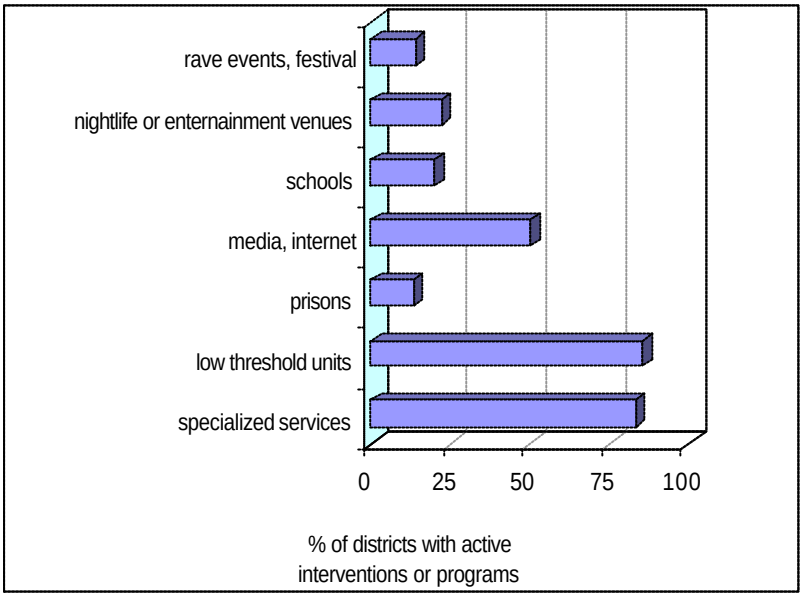
The responses from the sample reveal that individual counselling and the distribution of informational materials are the two main channels used to heighten informational efforts among substance abusers in order to prevent drug-related deaths.

Graph 7.1 – Types of intervention for preventing drug-related deaths



The informational materials (flyers, brochures, multimedia materials) created ad hoc to prevent emergencies and deaths from acute intoxication from the use of substances contain information on at-risk behaviours and on the mechanisms of overdose, on methods to avoid it, on the medical and legal consequences of intervention, and, in some cases, on the correct use of Naloxone.
The materials are distributed through the mass media and Internet and in low-threshold facilities (85%), in the specialised agencies (80%), in discos (22%), in schools (19%), and to a lesser extent at rave parties, concerts and festivals (14%). It should be noted that there is very little distribution of informational materials in prisons (13%).

Graph 7.2 – Settings where information materials are disseminated



Based on CNR data

Programmes to prevent death by acute intoxication also include those promoting access to and possession of Naloxone.
Substance users may in fact receive Naloxone at home (37% of the facilities contacted), especially those considered more at risk, i.e., users of narcotic substances who have survived an overdose or who experience frequent episodes of overdose, substance users who complete treatment (high risk in the days immediately following suspension of the therapy), and substance users who are about to leave prison (high risk in the days immediately following release).

These programmes are based on the assumption that substance users experiencing acute intoxication themselves or in others are capable of providing aid by applying those few types of assistance that may lead to saving a life. These are people perfectly capable of recognising an overdose and of administering Naloxone; such action can be considered legitimate if it is necessary. In any case, the need always to send the person treated to First Aid upon regaining consciousness after the administration of Naloxone needs to be underscored.

Another way to prevent deaths from acute substance intoxication, albeit an indirect one, is represented by article 81 of Law 309/90, which calls for a reduction in penalty in the case of those who, while prosecutable under law for having caused or at least facilitated the use of substances and causing acute intoxication in the taker, provided assistance to the victim and promptly informed the health authorities or the police.

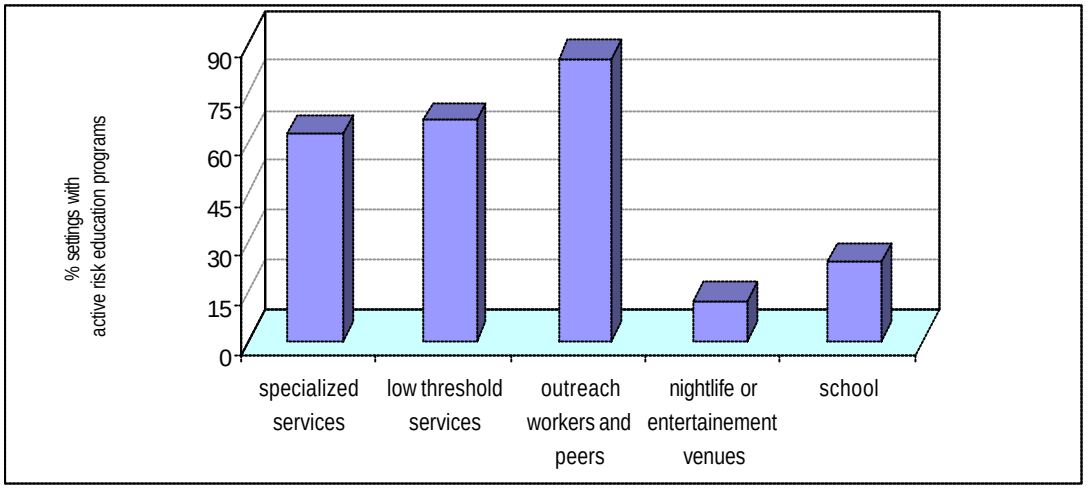
7.2 Prevention and treatment drug-related infectious diseases

The following data represent the responses provided by the directors of a representative sample of 541 Italian public facilities for drug addiction in their capacity as coordinators of drug prevention efforts.

7.2.1 Prevention

The survey shows that the main tools used in educational interventions to protect against the risk of drug-related infectious diseases are street units or peer groups operating in at-risk contexts (85%), low-threshold facilities (66%), and specialised facilities (62%). In addition, schools and discos represent another intervention context.

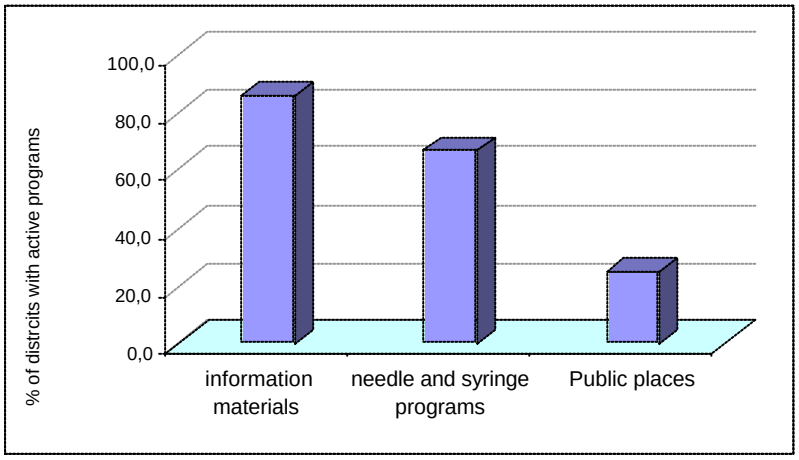
Graph 7.3 – Risk education/response training activities by setting



Based on CNR data

Principal activities include risk-protection educational efforts, syringe exchange programmes, distribution of informational materials on at-risk injection activities and on the risks of contracting drug-related infectious diseases, vaccination programmes (hepatitis B), distribution of condoms (drug use is often combined with unprotected sex).
In prevention programmes, distribution of informational materials and syringe exchanges are widespread throughout virtually the entire country. Of the facilities contacted, 85% state that there are active projects in their area aimed at providing accurate information on the prevention and transmission of HIV/AIDS or other infectious diseases through the distribution of flyers, multimedia materials, or local information campaigns, and 66% of the sample state that programmes for the distribution of syringes and sterile materials are carried out by the low-threshold facilities to discourage the habit among drug addicts of using syringes in common.
Finally, 25% of the sample responded that there are direct interventions in public places frequented by people injecting drugs.

Graph 7.4 – Distribution of information material, needle and syringe programs, street workers interventions



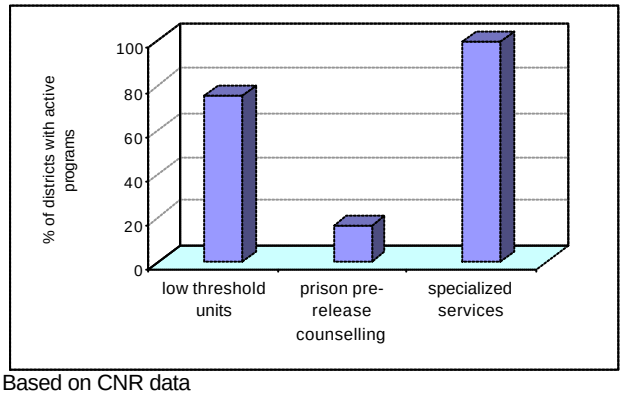
Based on CNR data

In recent years, also as part of infectious disease prevention, programmes have been put in place aimed at overcoming the mistrust of many drug addicts, especially non-E.U. foreigners, in regard to turning to the public health services, which often delays the diagnosis of HIV infection and any related pathologies.

7.2.2 Counselling

Among prevention efforts, individual counselling on protection from the risk of contracting infectious diseases associated with substance use are generally included among the services offered by the specialised services (Ser. T., therapeutic communities) and integrated into treatment. They are important for many reasons: they provide specific information and medical, psychological and social support; they offer the possibility of scheduling exams; they are effective in influencing behavioural change and in reducing the frequency of at-risk behaviours associated with the use of drugs and at-risk sexual behaviours; and they increase the frequency with which people show up at the facilities, and the effectiveness of the interventions.
This counselling is generally provided by health workers and by professional educators who provide specific responses based on personal requests and situations. Counselling is also provided by street units (75%) and before release from prison (16%). In these cases, counselling is performed by professional educators and health workers, social educators and aides.
In all of the regional specialised facilities in the survey, counselling is ensured for users of the facilities both before and after any findings relating to infectious diseases.

Graph 7.5 – Prevention of drug related infections: counselling settings



Based on CNR data

7. 3 Interventions related to psychiatric comorbidity

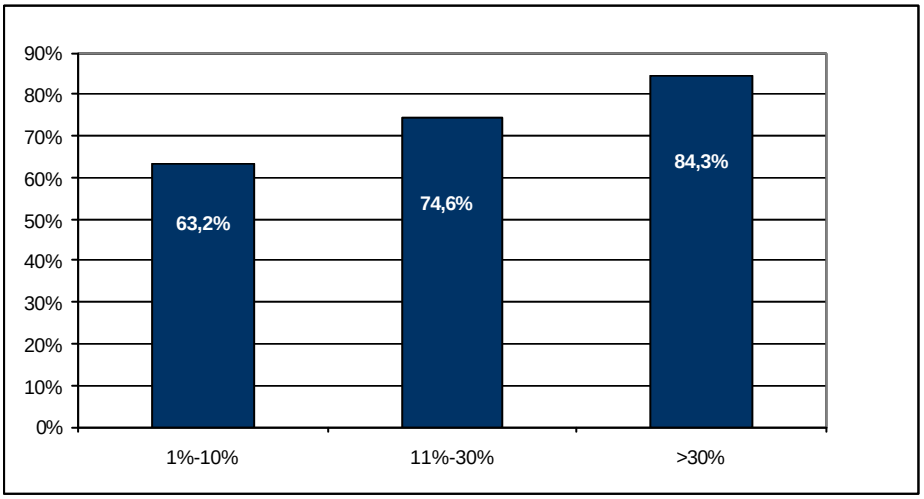
Planning and scheduling treatment for subjects presenting a disturbance deriving from the use/abuse of psychoactive substances necessarily involve an assessment of the concomitant presence of other psychiatric pathologies that influence the process and outcome of the interventions themselves.
The impossibility of separating the psychopathological disturbance from the addiction of subjects presenting psychiatric comorbidity requires a different organisation and additional specialisation on the part of the services agencies involved.
This study, carried out through a nationwide sampling survey, seeks to provide a framework that takes into account not only the presence of treatment users with dual diagnoses but also the responses provided to them through the application of the in-house resources of drug-addiction services, such as the presence of specialised physicians involved in the diagnosis and treatment of comorbid patients, as well as formal or informal cooperation with mental health agencies.
The interviews were given to the directors of the Ser.T. and, where possible, to agency managers, for a total of 292 agencies out of 541 surveyed in 2004 by the Health Ministry, thus reaching 54% of the total and covering at least 35% of the agencies for every region. The sample is therefore representative.
Specifically, the interview surveyed four areas of interest: first, the presence of specialised staff involved in diagnosing and treating those patients presenting comorbidities; second, with regard to dual diagnoses, it asked for an estimate of the percentage of comorbidity users with major

psychiatric disturbances being handled by the agency, the existence of a specific section on the clinical chart showing this diagnosis, and in what percentage this was indicated; third, an assessment of the existence of formal or informal cooperation between the Ser.T and the Mental Health agencies. Finally, an attempt was made to inquire as to the local presence of residential facilities specifically for dual-diagnosis patients, and how many were accredited.
Specialised staff involved in psychiatric diagnosis and treatment were present in 72% of the Ser. T. In 64%, there were permanently organised staff, with an additional 11.6% of contract staff working an average of 11 hours weekly, varying from a minimum of 6 to a maximum of 36.
The results of the responses provided on the percentage of subjects in treatment at the Ser.T presenting an associated major psychiatric diagnosis can be grouped into three categories:

- *Estimate of dual-diagnosis patients included between 1% and 10%:* 34% of the Ser. T fall into this category.
- *Estimate of dual-diagnosis patients included between 11% and 30%:* this is the largest category, accounting for 48% of the agencies.
- *Estimate of dual-diagnosis patients over 30%:* 18% of the Ser. T

As shown in Graph 7.6, as we go from an estimated presence of comborbidity patients in treatment of less than 10% to more than 30%, we note a larger presence of specialised staff. This might depend not so much on the different types of users for those agencies as on their greater capacity to detect concomitant psychiatric disturbances.

Graph 7.6: Percentage distribution of staff specialising in the diagnosis and treatment of psychiatric pathologies based on the estimated presence of patients with dual diagnosis in the Ser.T.

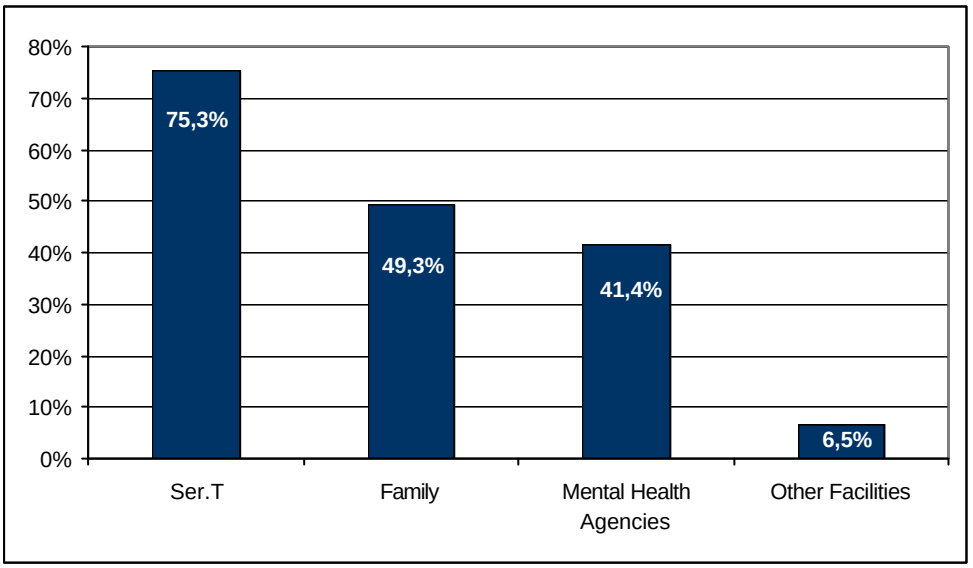


Based on IFC-CNR data (PISA)

Collaboration with the mental health agencies is formal in 57.7% of the Ser.T and informal in 19.2%. In addition, 3.1% of the agencies are awaiting formalisation, whereas 20% of the Ser.T do not engage in any kind of cooperative activity with the mental health agencies, and in some cases the relationship with the latter is problematic. Overall, cooperation, whether formal or informal, between the services and the mental health agencies varies from less than 62% for those Ser.T that do not have specialised staff to almost 87% for those who state that it is formal or under contract.
In all, about 46% of the Ser.T indicated just one site for psychiatric therapy, some 33% two, and just over 21% reported three.
In this case as well, an indication of multiple sites for administering psychotherapy is more frequent for those services that have established formal or informal cooperation with the mental health agencies compared with those that have not, with percentages ranging from almost 58% for the former to almost 48% for the latter.

The sites indicated for pharmacological therapy, needed in comorbid cases but often made difficult by low compliance by patients, are outpatient facilities, hospitals or residential facilities, and the homes of the users.
The site most frequently indicated for therapy is the Ser.T itself (75.3%l). Based on patient compliance, the services ask for the collaboration of family members for administering the pharmacological therapy, which may occur at home (49.3%); this percentage is followed by the percentage that indicates the mental health agency as the preferred administration site (41.4%). A low percentage of Ser. T (6.5%) indicate cooperation with other facilities, such as the psycho-social centre (CPS), the treating physician, and group homes (Graph 7.7).

Graph 7.7: Distribution of sites indicated for administering psychiatric therapy.



Based on IFC-CNR data (PISA)

Of the agencies interviewed, 40% have a local residential facility for patients with psychiatric comorbidity, and 87% of these are accredited. Interviews with Ser.T directors revealed that there are facilities in the various regions which, while not being residential and specifically for dual diagnoses, nonetheless take in subjects afflicted with psychiatric comorbidity.

7.4 Interventions related to other health correlates and consequences

A substantial number of public drug-addiction agencies in Italy have set up forms of assistance for organic pathologies related to the use of illegal psychoactive substances. In this regard, most of the Ser.T, especially in some regions, are equipped with a general-medicine outpatient clinic and a site for taking blood samples for blood chemical tests, and they work closely with radiology and nuclear-medicine institutes in order to be able to conduct the necessary exams.
For these patients, the fact that there is an opportunity for clinical follow-ups of an internal or specialised nature at the same site where addictions are treated is an essential aspect of therapeutic and rehabilitation strategies. It is very difficult for a heroin-addicted patient to take care of himself, and the cocaine addict experiences denial and shame with regard to the health consequences that derive from consuming that substance. For this reason, an offer of health services, both general and specialised medicine, in well-organised integration with the network of Ser.T and the private social centres, has been tried in many areas in Italy and is becoming important in the development of addiction departments.
The general-medicine outpatient clinic has to handle hepatopathies, including non-viral ones, their development into chronic form, forms of malnutrition and metabolic illnesses that often accompany chronic drug-taking, immunological problems including HIV infection, endocrinopathies, cardiopathies, pulmonary and renal diseases caused by drugs.

Various public facilities provide dental assistance for Ser.T. patients; this is very important in psycho-social terms, because it indicates the start of a process of rehabilitation and personal care.
Similarly, other Ser. T make use of a gynaecologist who offers specialist visits for drug addicts, with a continuity that would not be possible in normal specialised outpatient clinics, and assistance with pregnancy from the earliest stages. In this context, the services take care of patients who prostitute themselves, protecting them not only from the risk of sexually transmitted diseases but also from other complications which may more generally compromise the health of at-risk subjects.
In an emergency setting, intervention in health and in diseases associated with substance use must take into consideration the seriously irregular habits caused by the use of psycho-stimulants, hypothermia caused by amphetamine derivatives, cases of myocardial infarction or cerebral ictus induced by cocaine, the acute blood and neural diseases caused by intoxication from drugs and pharmaceuticals, and clinical diagnoses with convulsions, trisma and dyskinesia: in Italy, the facilities of the addiction departments frequently make agreements with emergency medicine departments in order to diagnose and treat these problems quickly and appropriately.
When surgeries are performed, good collaboration between the health system of the Ser.T and the anaesthesiology services may make possible adequate preparation of the addicted patient for taking anaesthesia.
Protection for pregnancies in female addicts is handled according to protocols that are well defined in various addiction services: under optimal conditions, at the first signs of a pregnancy this is reported to the municipal social services, not for repressive purposes directed at placing the child under foster care, but rather for organising true social and psychological support and assistance with economic problems, and protection against violence and degradation.
In addition to the municipal social assistance, a nurse or educator is responsible for following the patient according to established protocols at the OB-GYN service. If the patient freely decides not to interrupt the pregnancy, periodic visits, ultrasound scans and blood chemistry tests are provided with support from the Ser.T staff.
The mother's and unborn child's toxicological problems are discussed by the joint Ser.T, OB-GYN and neonatal team. Very extended treatments with decreasing doses of methadone are often used, or the patient is sent, when possible, for drug-free treatment in a residential setting (therapeutic community).
If the patient is abusing substances at the time of delivery, or is still being treated with agonist opioids, the Ser.T's collaboration is essential in providing information crucial to the treatment of withdrawal in the newborn. In this regard, a project recently concluded that was specifically intended to make available experimental models and valid tools for assessment and intake in specialised therapeutic and rehabilitational facilities;

identifying the specialised services needed to effectively meet the unique needs of the target users; improving the quality of the services by facilitating regional and inter-regional communication and liaison; supporting the services in sharing standards, procedures and criteria for assessing and checking results and quality; introducing and maintaining an assessment ethic in the pathological addiction services. The Mosaic inter-regional project, assigned by the Health Ministry and conducted by the Lombardia (head region), Emilia-Romagna, Tuscany, Marche, Umbria, Abruzzo and Basilicata regions, is aimed at strengthening specialised interventions among those drug addicts who are particularly marginalised and psycho-socially vulnerable, such as drug addicts with psycho-pathological or psychiatric complications, drug-addicted pregnant women or those with minor children (and any partner), marginal drug addicts and immigrants. The results of this work were presented on July 7-8, 2005, in Reggio Emilia.

Therapeutic communities for mothers with children, or for couples with children, often host the patients or families beginning with the final months of the pregnancy, offering a reassuring shelter and health and nutritional protection that represent important safeguards for health at least until the abuse of drugs, alcohol and benzodiazepines is interrupted. Prevention strategies to protect the unborn child against birth defects, and more generally against behavioural defects, imply the least possible exposure to drugs and alcohol during pregnancy, along with stress reduction and removal of the pregnant addict from traumatic conditions, poverty and loneliness.

These communities for addicted mothers and their children in Italy (e.g., Bologna: La Rupe; Imola: Il Sorriso; Cividate: Bessimo Co-op; Turin: Abele Group; Ascoli Piceno: Ama-Aquilone Co-op) usually work in close collaboration with the juvenile courts, the Ser. T and social services. The mother-child unit is offered the chance to have space for rebuilding a sufficiently calm relationship. In particular, the mother is given space to redevelop her own personal identity as a woman and mother. The most delicate moment of this process comes when she leaves the community; in the re-integration phase, housing that is independent but still connected to the community project is used. During this phase the women are able to measure their independence skills both economically and in managing their children (schedules, times, access to services like day care and so on).

It also needs to be noted that social interventions organised by Ser.T and local agencies play a crucial role as well in protecting health: the economic subsidies, distribution of food packages, payment of home heating costs and rent have a significant impact on the quality of life and consequently on clinical conditions. For example, the reappearance of tuberculosis, a widespread disease among drug addicts for some years now, may not have become a true epidemic precisely because of social protection for these at-risk subgroups of the population. In fact, tuberculosis and other respiratory diseases are especially dangerous when they strike individuals suffering from poor nutrition and living in precarious conditions.

Finally, it is important to recall that many of these interventions must be made in a low-threshold setting, in patients who refuse to get involved in therapeutic programmes and who are even less willing to turn to the services. For these patients, we require home interventions, street interventions and the ability to establish relationships with the homeless population and immigrants. Various street units of the Ser.T also provide health assistance in the ways possible and ensure survival standards that avoid an increase in drug-related diseases. These street units are very active throughout Italy. For example, in Rome, several private social agencies (e.g., Magliana '80, Villa Maraini Community, and others) operate street units with a physician, a psychologist and a social worker. The purpose of these street units is to make contact with drug addicts in their habitual meeting places, guide them, and send them to the services capable of providing a specific response to their needs. In addition, the street units also distribute and exchange syringes, prophylactics, distilled water, and informational brochures; they offer counselling and information on drugs and HIV as well as overdose first aid.

8. SOCIAL CORRELATES AND CONSEQUENCES

Overview

This chapter, besides data relating to the crimes envisaged by drug legislation (crimes of producing, selling and trafficking drugs, and of criminal association for those purposes), includes data relating to crimes committed by drug-dependant prisoners or those who received alternative sentences, with specific reference to crimes committed by under-age drug addicts or drug users, who have passed through the juvenile justice services.

8.1 Social exclusion

Some 89% of subjects seeking treatment in 2004 had a fixed abode, whilst 3% had no fixed address. The remaining 8% were housed at public facilities or at therapeutic communities or detained in prison.
Most subjects in treatment had an elementary-school education (13%), or a middle-school diploma (61%). The prevalence of subjects with an elementary-school education (2.4%) and those with a middle-school diploma (23%) is considerably lower than in the general population.
Consistent with the distribution in the general population, the percentage of subjects with low educational levels in the group of subjects in treatment also increases with age. In the 15-24 age group, about 50% of subjects have only a middle-school diploma; in the >45 age group, 70% do.
Thirty percent of subjects undergoing treatment are unemployed, almost double the rate in the general population (15%). The age group most exposed to unemployment in terms of users of services is the 15-24 group, with a frequency 2.5 times higher than for the general population in the same age bracket.

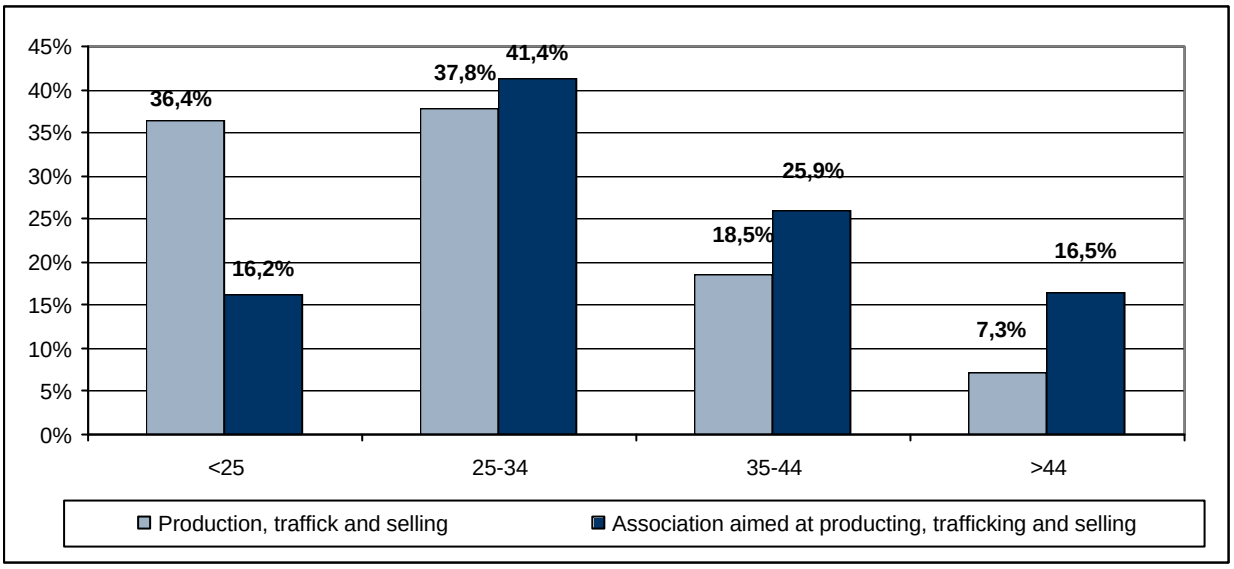
8.2 Drug-related crime

The following is an analysis of data relating to crimes under narcotics laws and crimes committed by addicts.
In the first case, the analysis is based on charges of crimes of producing, selling and trafficking in narcotics, and association for those purposes (arts. 73 and 74), and on those sentenced and held for those crimes.
In the second case, data will be presented relating to crimes committed by addicts incarcerated or who received alternative sentences.

8.2.1 Crimes under narcotics laws

Charges
As part of enforcement operations carried out in 2004, there were 31,261 charges filed for the crimes of producing, trafficking in and selling narcotics (art. 73), which in 10% of the cases (3,135) were associated with charges for association for the purpose of trafficking in illegal psychoactive substances (art. 74).
Charges continue to involve primarily subjects who are Italian citizens (about 72%), with an average age of almost 30, which varies minimally based on nationality (about 29 for foreigners and 30 for Italians) and which is more obvious in relation to the type of crime (Graph 1). We find a positive relationship between age and seriousness of the charge: while among the young (under 25) the share of those charged for association for the purpose of trafficking in narcotic substances (art. 74) is lower than for art. 73 (production, trafficking and sale of narcotic substances), from age 25 on the percentage of those charged for association for the purpose of narcotics trafficking (art. 74) exceeds that for crimes under art. 73.
Specifically, the average age shifts from about 29 for the less serious crimes (art. 73) to 34 for the more serious (art.74).

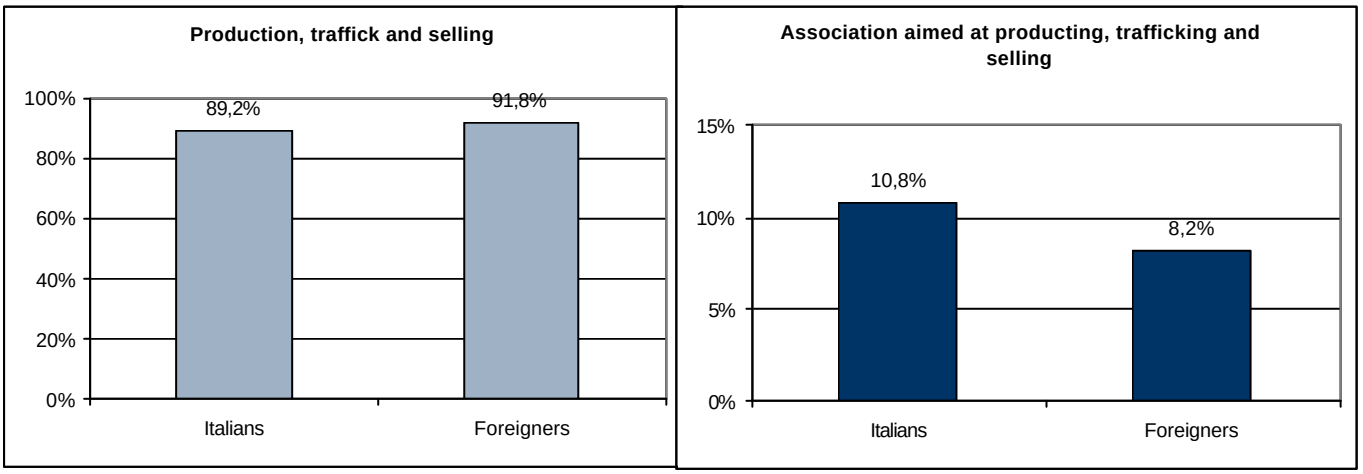
Graph 8.1 – Percentage distribution of crime type by age group



Based on data from the Central Anti-drug Services Office (D.C.S.A.)

We also find differences between charge and nationality (Graph 8.2). Charges for crimes of association for the purpose of producing, trafficking in and selling narcotics (art. 74) involve Italians significantly more than foreigners, who conversely are more frequently involved in crimes of production and sale of narcotics (art. 73).

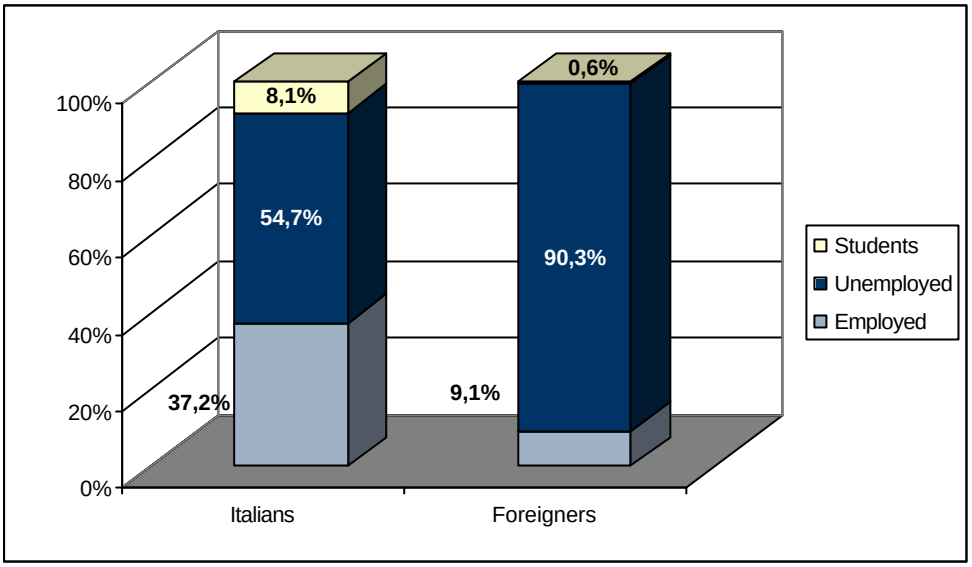
Graph 8.2 – Percentage distribution of crime type: differences based on nationality



Based on data from the Central Anti-drug Services Office (D.C.S.A.)S.A.)

In more than half the cases, charges involved subjects who are unemployed or employed only temporarily (of the 13,441 cases on which information is available, approximately 62% were unemployed and less than 1% had occasional employment or were housewives); this rises to 90% among foreigners as against slightly less than 55% for Italians (Graph 8.3).

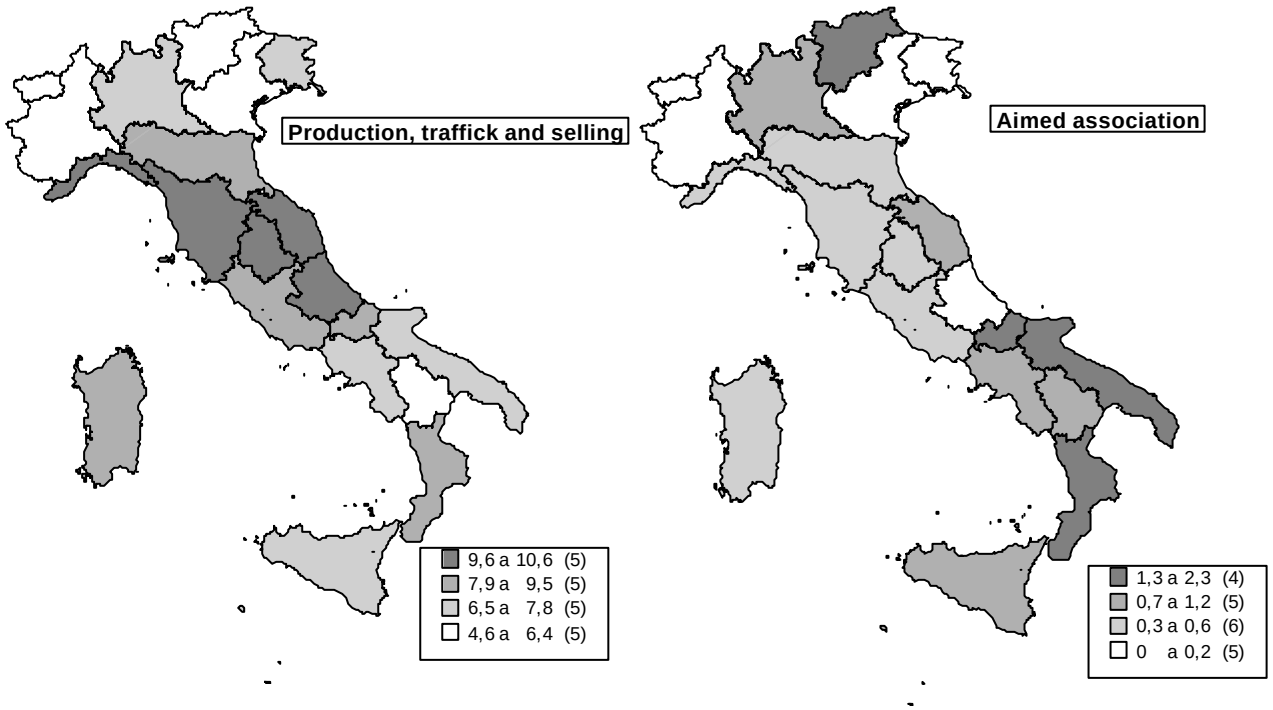
Graph 8.3 – Percentage distribution based on employment level of those charged, broken down by nationality



Based on data from the Central Anti-drug Services Office (D.C.S.A.)

Finally, with regard to the geographic distribution of charges by type of crime, the greatest presence of persons charged with association for purposes of producing, trafficking in and selling illegal substances is in the South, especially in the area adjacent to the Adriatic coast and in Calabria, whereas charges under art. 73 tend to be concentrated in the Centre and in Liguria.

Graph 8.4 – Distribution of charges divided into the production, trafficking and sale of narcotics and association for the purpose of producing, trafficking and selling of narcotics, in relation to number of residents (x10,000)



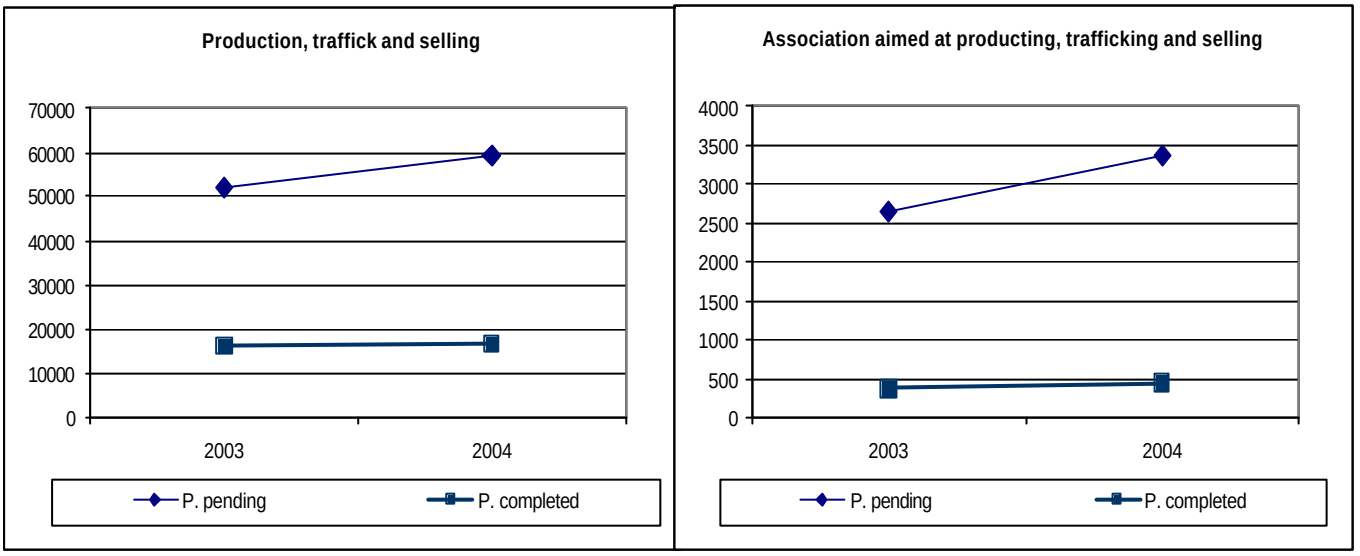
Based on data from the Central Anti-drug Services Office (D.C.S.A.)

Prosecutions

Moving on to an analysis of the data provided by the Criminal Justice Office relating to the number of prosecutions for crimes under Presidential Decree 309/90, in 2004 there was an increase in the overall number of pending prosecutions, which contrasts with a substantial stability in the number of those concluded during the year (Graph 8.5).

These factors indicate a substantial backlog of cases over time, which does not vary significantly in size from year to year (from 2003 to 2004, pending cases went from 51,769 to 59,649 for crimes under art. 73, production, trafficking and sale of narcotics, and from 2,648 to 3,381 for crimes under art. 74, association for the purpose of producing, trafficking and sale; during the same period, the number of prosecutions completed with at least one conviction becoming final went from 16,485 to 16,935 for art. 73 and from 387 to 453 for art. 74).

Graph 8.5 – Number of prosecutions pending and completed per crime (2003-2004)



Based on data from the Justice Ministry. Department for Justice Affairs – Legislative and International Affairs

With the exception of prosecutions pending for the crime of producing, trafficking in and selling narcotics, an overall analysis of the distribution of prosecutions nationwide finds higher values in the coastal areas, primarily the Tyrrhenian coast, especially with regard to association for purposes of trafficking in illegal substances.

Convictions

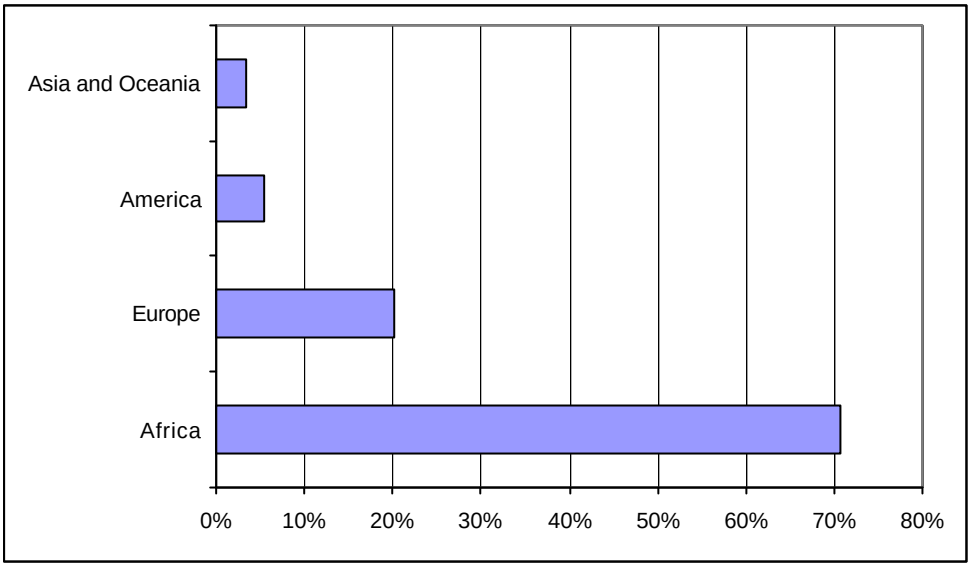
With regard to convictions for crimes under Pres. Decree 309/90, the data provided by the Criminal Records and Pardons Office of the Criminal Justice Office involve a sample of 9,539 subjects who were convicted at least once in 2004 for these crimes (approximately 45% of total convictions for such crimes during the year).

In this case as well, with no difference compared to 2003, the crime of association for the purpose of producing, trafficking in and selling narcotic substances (art. 74) involves fewer than 2% of convictions in 2004, showing higher concentrations in the South.

In almost 64% of cases involving Italian citizens, those convicted had an average age of approximately 32 years, older (almost 36) for those subjects prosecuted for the crime of association for the purpose of trafficking and sale, compared to those convicted for producing and trafficking in narcotic substances (art. 73) (almost 31).

As found in the previous year, among the foreigners convicted in 2004 we find mainly Africans (about 7%), who in almost all cases came from the Maghreb countries; the Europeans, who comprise about 20% of the total sample, were instead from Eastern Europe (graph 8.6).

Graph 8.6 - Distribution based on geographic origin of those convicted for producing, trafficking in and selling narcotic substances and association for the purpose of producing and trafficking.



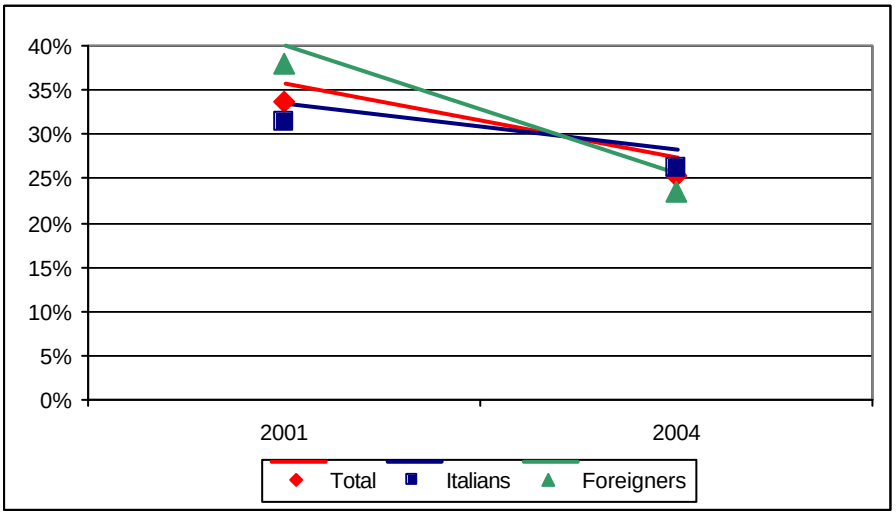
Based on data from the Justice Ministry. Department for Justice Affairs - Legislative and International Affairs

About 19% of those sentenced were repeat offenders; this percentage is slightly higher (about 20%) in the case of Italians and lower (16%) for foreigners.

Prisoners

Based on the flow of data provided by the Penitentiary Administration Department (Justice Ministry), the percentage of subjects entering the Penitentiary Administration's facilities in 2004 (Graph 8.7) for crimes committed in violation of the narcotics laws dropped significantly during the four-year period (2001-2004). This percentage, which in 2001 was 33% of the entire prison population, dropped to 26% in 2004 (equal to 21,439 subjects); this reduction is more evident especially among foreigners.

Graph 8.7 – Subjects held for crimes relating to producing, trafficking in and selling narcotic substances and association for the purpose of producing and trafficking: 2001-2004



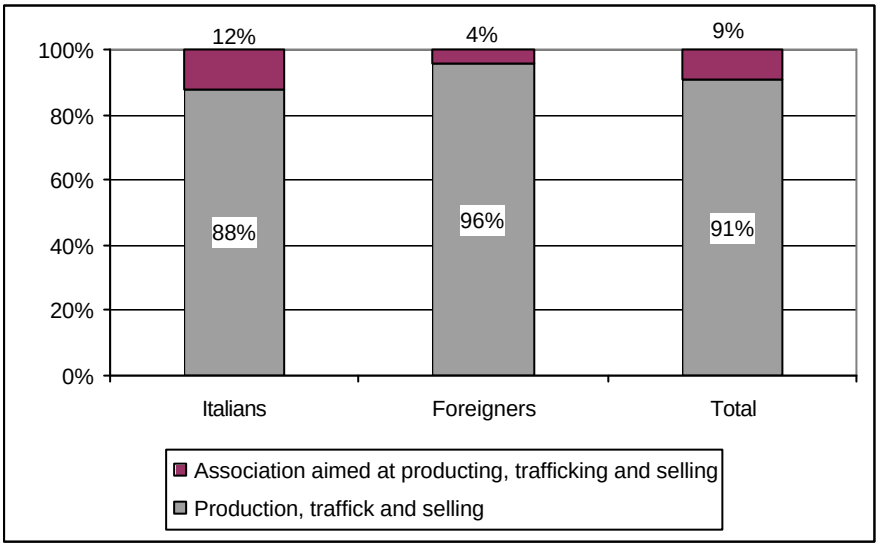
Based on data from the Justice Ministry. Penitentiary Administration Department

Of those entering the system in 2004 for these crimes, almost 40% were foreigners.

More specifically, with regard to the type of crime, it can be noted that about 91% were involved in crimes of production, trafficking and sale of narcotic substances (art. 73), and for the remaining 9% in more serious crimes involving association for the purpose of producing, trafficking in and selling narcotic substances.

This distribution changes when we consider Italians and foreigners separately (Graph 8.8); while foreigners held for crimes of producing, trafficking in and selling narcotics (art. 73) represent a significantly greater percentage than Italians, the latter are more frequently held for more serious crimes (art 74) involving association for the purpose of producing, trafficking in and selling narcotics.

Graph 8.8—Distribution of subjects held for crimes relating to producing, trafficking in and selling narcotic substances and for association for the purpose of producing and trafficking; by article of law and nationality.



Based on data from the Justice Ministry. Penitentiary Administration Department

What we find instead from the data provided by the Juvenile Justice Department (Justice Ministry), crimes committed by minors[7] in violation of Pres. Decree 309/90, which in almost all cases involve production, trafficking and sale of narcotics (art. 73), account for 13% of all crimes committed by those held at juvenile penal institutions.

8.2.2 Other drug-related crime

With regard to crimes committed by addicts or consumers of narcotics, information was taken into consideration relating to prisoners who are addicted to or consumers of narcotics (these data were provided by the Penitentiary Administration Department of the Justice Ministry, and by the Juvenile Justice Department[7]) and to those who, because of their status as addicts, received sentences alternative to detention (these data were provided by the Pardons and Criminal Records Office).

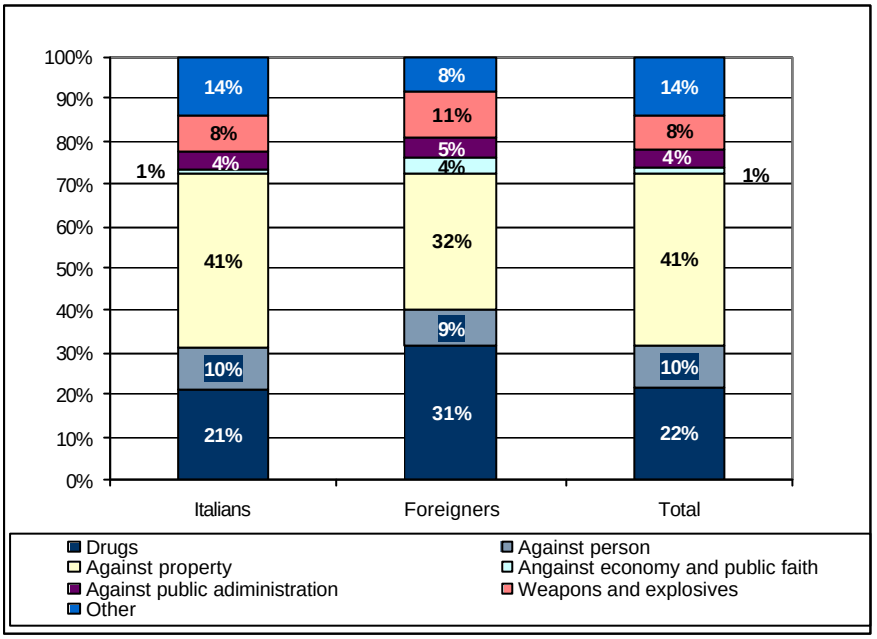
[7] With regard to juveniles, the information is provided not only in relation to prisoners but also to those who have passed through the various Juvenile Justice services. Note that this flow also includes juveniles older than 18 (even if only 8%), i.e., people who committed the crime when juveniles and who are monitored by juvenile services until they are 21.

Addicts and alternative measures

Of the 1,465 addicts who received an alternative sentence based on the provisions of Pres. Decree 309/90, about 95% are Italian citizens.
The average age is 36 but drops to about 34 among foreigners.

An analysis of the distribution of crimes[8] committed by subjects who received sentences alternative to detention because of their status as addicts (Graph 8.9) shows that about 41% of the crimes were against property (theft, robbery, etc.); crimes under the narcotics laws (trafficking, sale, etc.) follow at a decidedly lower level (less than 22%).

Graph 8.9 – Types of drug-related crime: distribution based on nationality of those convicted who received, or had revoked, an alternative measure.



Based on data from the Justice Ministry. Department for Justice Affairs - Legislative and International Affairs

A more detailed analysis shows varying distribution according to nationality. While crimes against property prevail in the case of Italians (about 41%) , whereas in the case offoreigners are 32% the last ones are prevalent for the crimes committed in violation of the law on narcotics (about 31% against the 21% in the case of Italians).

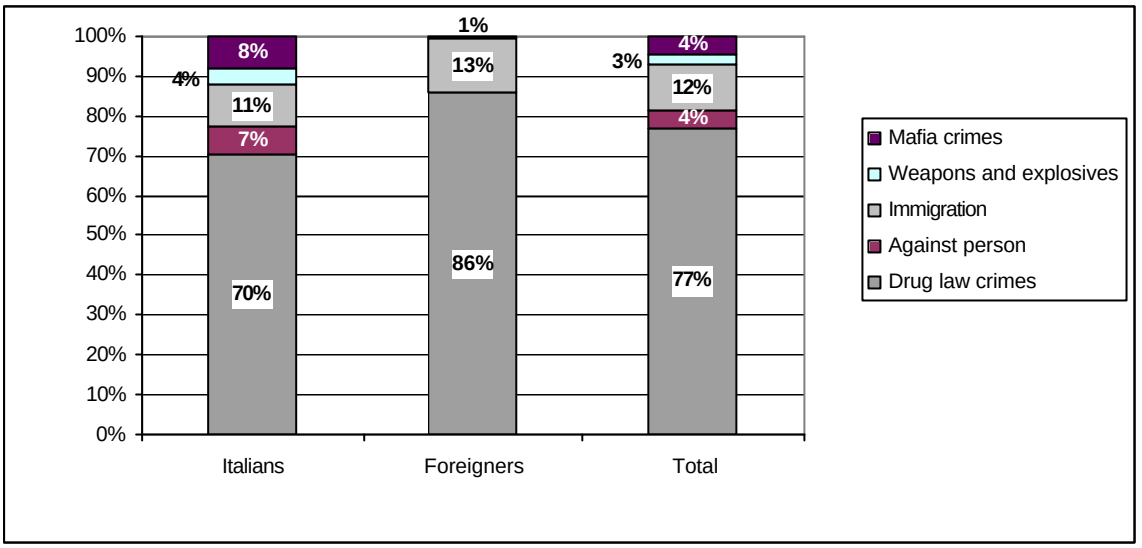
Addicts in prison

With no significant changes from the preceding three-year period, addicts incarcerated in 2004 represent about 29% of all those imprisoned, and of these, some 26% are of foreign nationality.
An analysis of the data by individual[9] shows an average age of about 33, which is significantly lower among foreigners than among Italians (about 30 as against 34, respectively).

In terms of these data, we find (Graph 8.10) that in this case reference is made to addicts "actually incarcerated"; they constitute a type of population different from that described in the preceding paragraph (prisoners who received sentences alternative to detention). The percentage of crimes committed by this group in terms of violation of the narcotics law (production, trafficking and sale of narcotics, art. 73; and association for the purpose of producing, trafficking in and sale of narcotics, art. 74) in this case accounts for 77% of all crimes. This value changes when we consider nationality separately; the percentage of crimes committed in violation of Pres. Decree 309/90 by foreigners (about 86%) which is significantly greater (chi2 (4) 184.77 p=0.000) than for Italians (about 70%).

[8] For greater clarity, the most representative categories of crimes were considered.
[9] Relating to 2004 and gathered non-randomly, the data refer to a sample of 22,962 subjects, including 2,802 addicts.

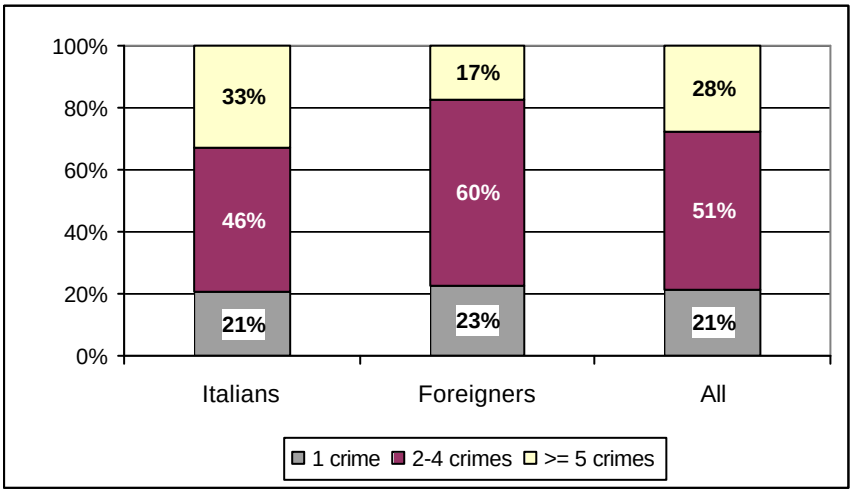
Graph 8.10 – Types of crimes committed by addict convicts: 2004



Based on data from the Justice Ministry. Penitentiary Administration Department

Significant differences (chi2(2) = 77,7085 P=0.000) between Italians and foreigners can also be found in the number of crimes committed by each subject; while for both the highest percentages involve convicts who committed between two and four crimes (among foreigners, this percentage is decidedly higher than for Italians), when we look at those with more than four crimes, the percentage among Italians is higher than that for foreigners (about 33% as against 17%, respectively).

Graph 8.11 – Number of subjects who have committed one or more crimes: distribution by nationality



Based on data from the Justice Ministry. Penitentiary Administration Department

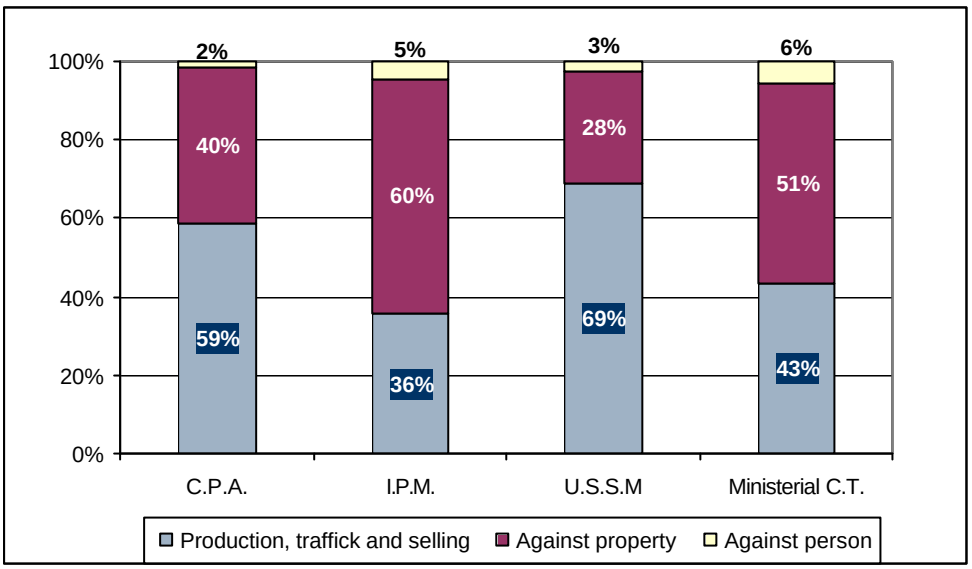
Narcotic-consuming juvenile prisoners: crimes committed

Juveniles who are addicted to or make use of narcotics passing through the various services of Juvenile Justice represent about 14%, 2%, 18% and 20% of the total entries occurring at the primary reception centres, the juvenile social services offices, the ministerial communities, and the juvenile penal institutions, respectively (these figures do not include transfers between criminal institutions).

We find that those who have committed crimes in violation of Pres. Decree 309/90 (in almost all cases this group consists of crimes relating to “production, trafficking in and sale of narcotics”) tend

to serve out their sentence mainly at the primary reception centres (C.P.A.), the juvenile social services offices (U.S.S.M.) or the therapeutic communities (Ministerial C.T.) for juveniles, rather than at the penal institutions (Graph 8.12).

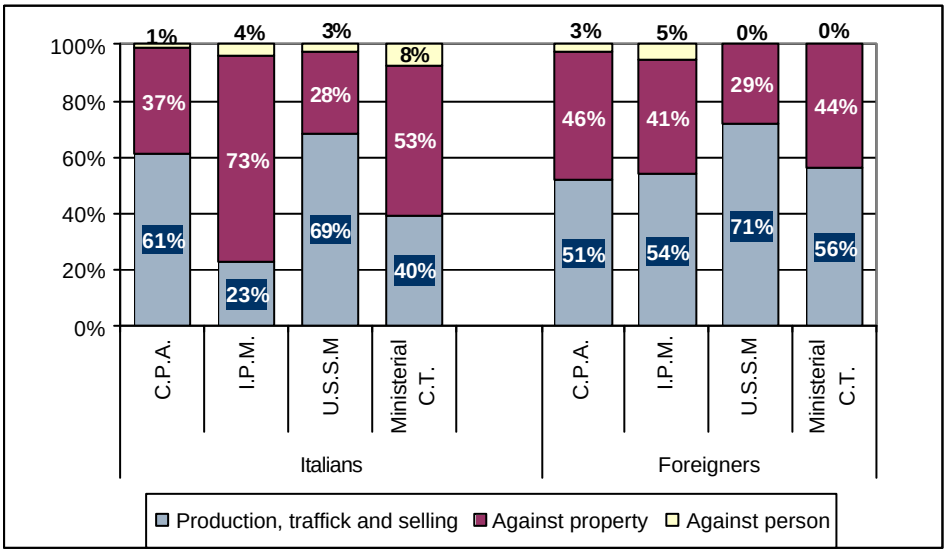
Graph 8.12 – Crimes committed by addicts or subjects who use narcotics passing through the various juvenile justice institutions



Based on data from the Justice Ministry – Juvenile Justice Department

This changes when we consider Italians and foreigners separately (Graph 8.13); especially significant is the difference found within the penal institutions, where the percentage of Italians having committed crimes in violation of Pres. Decree 309/90 is about 23%, as against 54% for foreigners.

Graph 8.13 – Crimes committed by addicts or subjects who use narcotics passing through the various juvenile justice institutions



Based on data from the Justice Ministry – Juvenile Justice Department

8.3 Drug use in prison

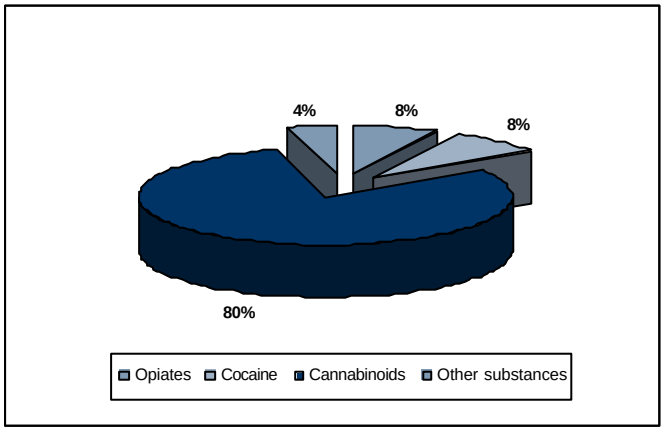
The information given below refers to juveniles passing through the juvenile justice services (primary reception centres, juvenile penal institutions, juvenile social services offices and communities)[10] testing positive for the use of narcotics based on monitoring conducted by the Juvenile Justice Department.

Juveniles coming into contact with the various juvenile justice services and testing positive during 2004 numbered 1,032; considering the difficulty of diagnosing the state of addiction or previous forms of use and abuse of substances other than heroin which are normally more common among juveniles, and also keeping in mind possible denial regarding the use of drugs by the juveniles themselves and their families, the percentage of subjects presenting ailments from substance use prior to incarceration could be considerably higher than that actually found.

Some 27% are foreigners and slightly less than 82% are between the ages of 14 and 17 (these data remain basically stable for the 2000-2004 five-year period, with no significant differences over the years). In almost all cases (about 96%), the foreigners come from non-E.U. countries, especially from the Maghreb (about 65%).

The main substance used (Graph 8.14) remains cannabis once again this year; it is consumed before incarceration by almost 80% of the juveniles tested; cocaine (about 9%) and heroin (about 8%), follow at decidedly lower percentages. Use of multiple types of drugs can be found in about 21% of the cases and in almost all these cases involve combining cannabinoids and cocaine.

Graph 8.14 – Percentage distribution of juveniles (who take narcotics) passing through the juvenile justice services, by substance used (2004)

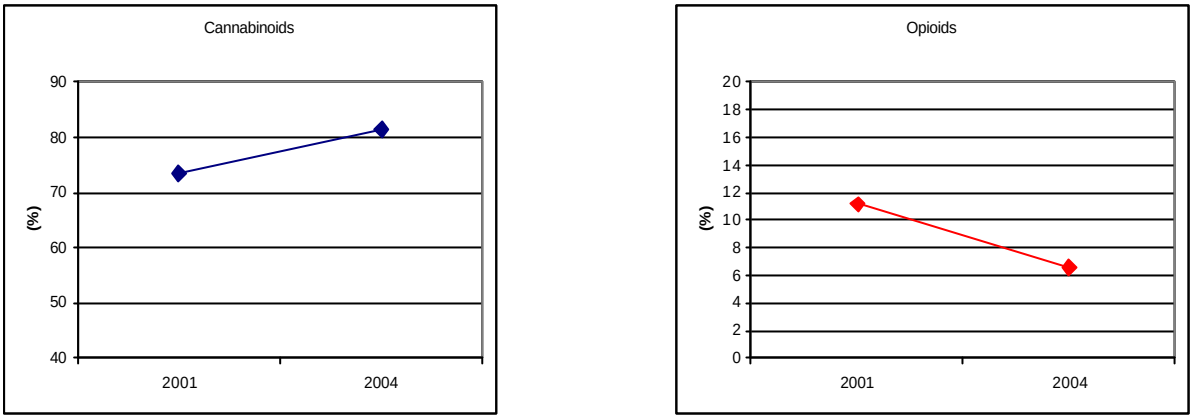


Based on data from the Justice Ministry – Juvenile Justice Department

A comparison between use of the various substances (Graph 8.15) found during the preceding years (2001-2004) shows a significant downward trend for “heroin and the other opiates” (p.>0.037) and an increase in the case of the “cannabinoids” (p>0.041).

[10] The analysis involves individual “subjects”: it should be recalled that during the legal process the juvenile may come in contact with more than one Juvenile Justice service, and so it is important to consider that just one time, regardless of the number of entries made into the various services during the period. Although in a smaller percentage, this flow also includes not just juveniles but also young people over age 18, who in 2004 represented slightly more than 8% of the total number of narcotics-taking prisoners; these are people who committed the crime when a juvenile but who are monitored by the juvenile services until they are 21.

Graph 8.15 – Use of heroin and cannabinoids among juveniles passing through the juvenile justice services: 2001-2004



Based on data from the Justice Ministry – Juvenile Justice Department

Heroin is consumed on a "daily" basis in most of the situations (about 62%) whereas "cocaine" and the cannabinoids are distributed quite evenly between an "occasional" use, "several times a week" and "every day." "Solitary use" of substances mainly involves heroin (about 65% use it by themselves, 31% in groups) and to a lesser extent cocaine (55% alone, 45% in groups); for the cannabinoids, we find mainly group use (about 57%).
As is well known from the scientific literature, a close association has been found between disturbed behaviour in the child and pre-adolescent, or antisocial personality in the adolescent, and the propensity to use alcohol and drugs and to develop addiction. Of those adolescents involved in judicial matters leading to detention, a majority have consumed illegal substances and abused alcohol. Their aggressive, impulsive and at times violent behaviour is aggravated and complicated by substances of abuse, but in a high percentage of cases this behaviour existed before they took drugs. It is especially difficult to identify the forms of use, abuse and addiction in our sample; this would require a more in-depth assessment within the juvenile justice system. Under-evaluation of the problem of psychoactive substances in these young people during rehabilitation programmes risks undermining all the social and relational efforts made, and causing the motivational-type therapies to fail.

8. 4 Social costs

No information available

9. RESPONSES TO THE SOCIAL CORRELATES AND CONSEQUENCES

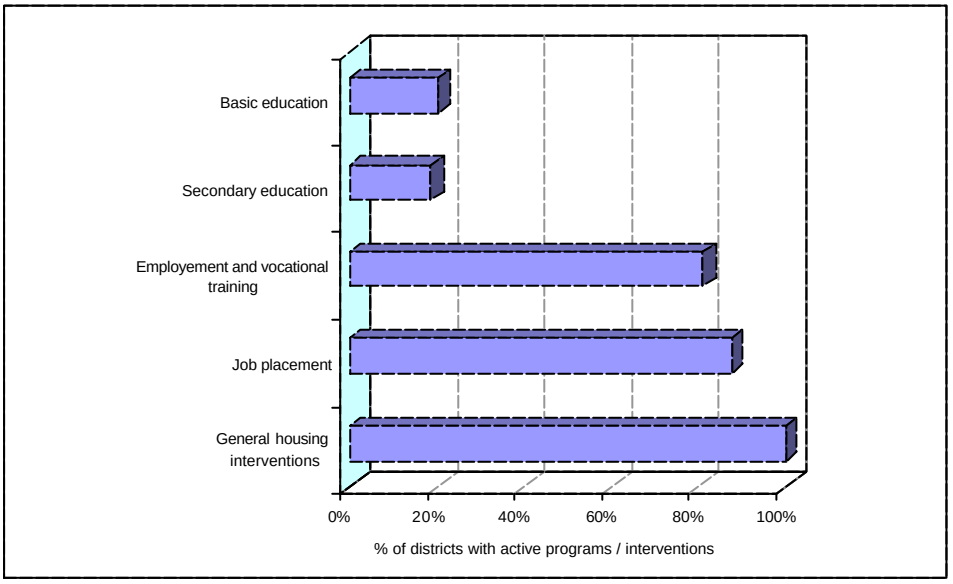
Overview

Data relating to the social implications and consequences of the use and abuse of illegal drugs are taken from the survey carried out on a representative sample of the public drug addiction services and which was promoted by the Monitoring Office of the National Anti-drug Policies Department.
As regards, on the other hand, the prevention of drug-related crimes, this chapter covers the initiatives to tackle both the social causes of drug addiction and the risks of involvement in criminal activity by drug addicts.

9.1 Social reintegration

The concluding moment of the therapeutic process of recovery from addiction is social reintegration, which promotes the subject's reintegration into the social context.
The information gathered on social reintegration projects and policies for substance users and ex-users refer to measures which on the one hand have a social objective (in particular involving housing, education, career training and employment) and on the other are closely involved in therapy and rehabilitation. Acquiring a good education and cognitive and cultural tools, forming a career identity and becoming aware of one's own skills contribute to structuring that set of personal resources that can combat the addictive illness and strengthen control over impulses. In this regard, it is clear that the tools for social reintegration must be considered an integral part of therapy. Ensuring the conditions for dignified survival, including those involving housing, is a decisive factor in programmes that combine psychosocial intervention and the use of pharmaceuticals: indeed, it is almost impossible to stabilise a patient abstaining from using illegal substances if that subject is allowed to continue living on the street. In addition, as might be guessed, in the wake of clinical treatment social reintegration can become an essential co-factor in relapse-prevention strategies.
The survey conducted shows that, while coverage of these measures is ensured throughout the country, we find great differences based on the type of measure: all of the projects provide for the possibility of being hosted at first-reception or residential facilities and housing assistance; job reintegration, with payment of subsidies and vocational training, are included in about 80% of the country, whereas completion of education is far less frequently found, especially in terms of secondary education.

Graph 9.1: Tools used to promote social integration by services, in percentages



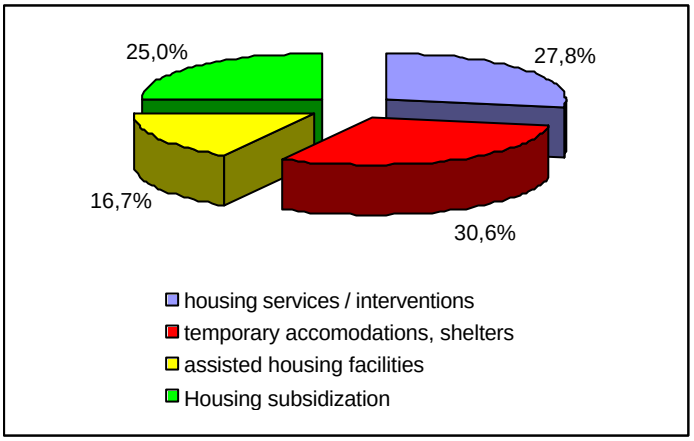
Based on CNR data

Housing

As part of the "housing measures" category, making primary reception facilities available covers 30.6% of measures and corresponds to strict necessity or to emergency conditions that require getting the patient off the street. Included in these facilities are crisis centres, low-threshold reception centres, and dormitories run in some cases by street units. Support less linked to emergency situations promotes the possibility of finding stable housing, through a close relationship with the social services of local agencies, economic support to deal with rental costs, assistance with paying utility bills, and support in the bureaucratic processes. .

The main categories of intervention called for by legislation and by social policy involve home intervention, residential facilities, primary reception facilities, and housing subsidies. Survey data show that primary reception facilities and home intervention are present in 30.6% and 27.8% of the services sample, respectively.

Graph 9.2: types of housing measures for (ex-) drug users.



Based on CNR data

Employment

Measures in the area of employment are aimed at enabling the subject to achieve social independence through integration into the job market for (ex-) substance users.
Job integration often occurs in a protected setting that calls for strong integration with various professionals such as social workers, teachers, and psychologists, to guide the processes of awareness, identity and relationships.

With regard to employment, the survey found that reintegration measures were available and accessible, both with subsidy payments and through support in seeking stable employment. Job reintegration measures that call for professional activities in a protected environment and with economic support paid out directly by the social services are part of a clinical and therapeutic approach and are aimed at acquiring the skills and resources mentioned above. More than 80% of the experts in our survey sample stated that measures are present in their own areas that call for job integration of patients who have successfully concluded a therapeutic and rehabilitation programme. In addition, we find career training projects and measures aimed at addicts in almost 80% of the sample.

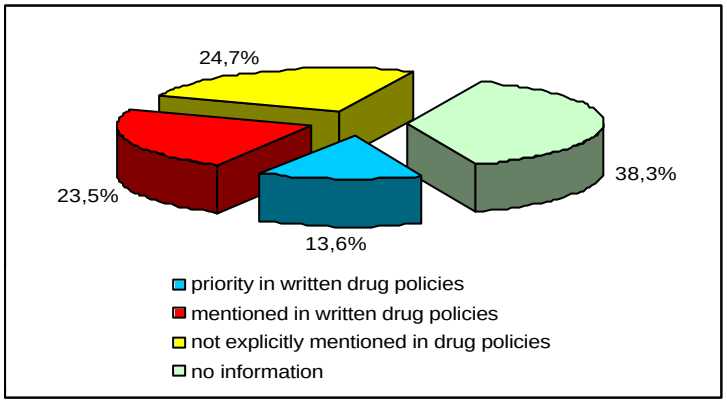
9.2 – Prevention of drug–related crime

Prevention of drug.-related crime is a complex topic, both in terms of the many types of crimes and of its multiple facets and social implications.
We will not deal here with the programmes adopted both nationally and internationally in the area of drug trafficking, organised crime and money laundering, or the fight against so-called chemical precursors, even though a reduced offer favours reduction in demand and, hence, contributes to fighting the phenomenon of drug-related crime.

Priority activities in preventing crime must be aimed at getting rid of critical situations, such as, for example, urban decay, multiple forms of poverty, social marginalisation, difficulties in integrating increasingly broad segments of the population (foreign immigrants, people fired from their jobs, female victims of violence). Robbery and aggravated extortion are among those crimes most commonly committed by addicts.
Preventing the social causes of drug addiction and the risks of involvement in criminal activities for drug-addicted subjects requires effort to strengthen the presence nationwide of those working in

the area of social prevention, social workers, and other skilled social operators integrated with the appropriate services, and, therefore, capable of intervening promptly. It is also important to back these people up with other measures for social reintegration and growth in personal and group relationships for the addicted user, prisoners and ex-convicts.
In terms of prevention, we should recall the importance of programmes aimed at rehabilitating prisoners convicted of crimes associated with narcotics trafficking, dealing and possession. In this context, there are primary reception agencies for those released from prison; they serve as a bridge between imprisonment, release, and re-integration of the ex-convict, with particular attention on addicted subjects.
The topic of prevention inside prison has been dealt with in part in Chapter 7. With regard to juvenile offenders or those having problems with the law, selective prevention is a priority or at least officially mentioned in health and social policies in only 37.1% of the cases in our sample (priority in 13.6%, officially mentioned in 23.5%).

Graph 9.3: Prevention among the juvenile population having problems with the law: degree of importance attributed to this topic in regional and local policies.



Based on CNR data

Finally, in the area of drug–related crime prevention, it is worthwhile recalling that Pres. Decree 309/1990, modified after the 1993 referendum, rescinded criminal sanctions against narcotics consumers with an eye towards prevention and recovery. Therefore, in the wake of depenalisation of the personal use of narcotic substances, the action carried out at local level by prefects through the Addiction Operations Groups (N.O.T.), in collaboration with the Ser.T, appears as both selective prevention for high-risk subjects who are offered an active recovery approach, and as prevention of drug-related crime.

10. DRUG MARKETS

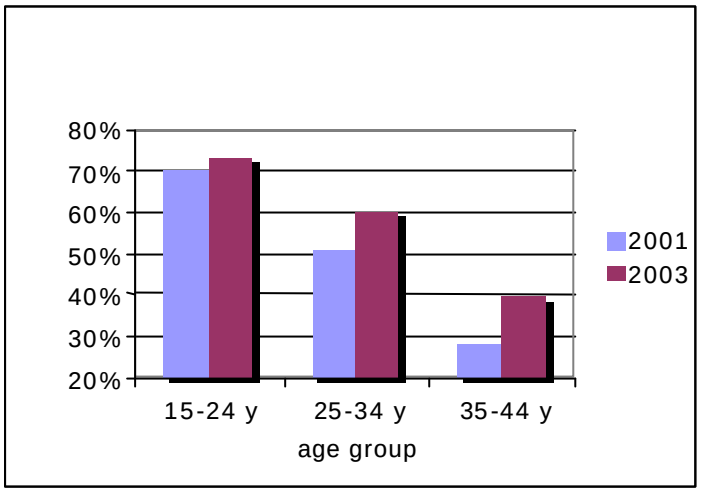
Overview

As for the availability of drugs, an analysis was undertaken of the replies from subjects who were interviewed by means of the sample surveys IPSAD®Italia2001 and IPSAD®Italia2003 (representative of the 15-44 age range in Italy), and who reported that they knew soemone using illegal drugs. From the data reported it is possible to see an increase, between 2001 and 2003, in people who reported contacts in the drug world; in particular, the willingness to seek out illegal drugs seems to have increased for the youngest age groups.
As for drug raids, even if the overall number of operations carried out in Italy in 2004 was lower than the figure for 2001, this fall did not concern all drugs, nor did it automatically lead to a fall in the quantities intercepted.
Besides the seizure of illegal drugs and substances, it also includes data relating to seizures (which the police are currently engaged in) of the chemical precursors which are essential for the synthesis of illegal psychotropic drugs.

10.1 Availability and supply

Slightly fewer than half of the subjects interviewed in the IPSAD®Italia2001 and IPSAD®Italia2003 sample surveys (representing the Italian population between the ages of 15 and 44) state that they know someone who uses illegal substances.

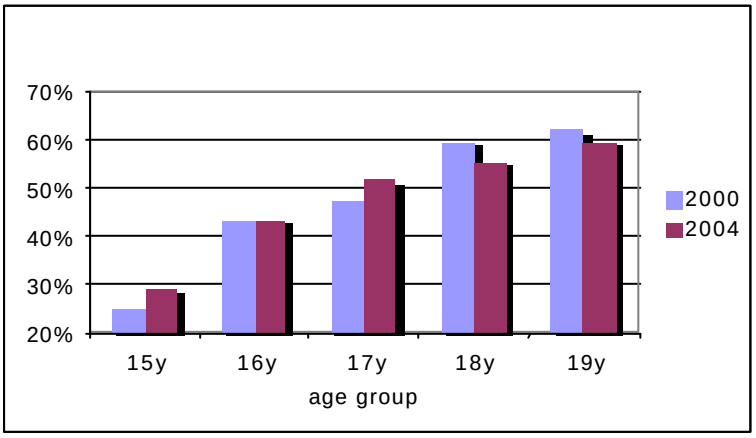
Graph 10.1 – IPSAD: distribution by age group of subjects who know consumers of illegal drugs, 2001-2003 compared



Based on IPSAD®Italia2001 and IPSAD®Italia2003 data

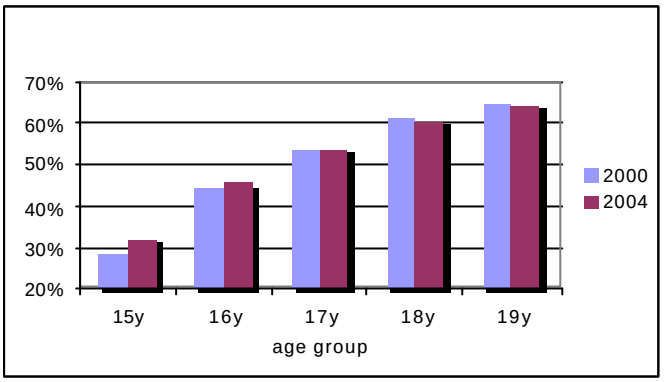
Young people have more contacts with consumers; in particular, the 15-24 age bracket shows greater exposure, with a 70% prevalence of subjects who know users. From 2001 to 2003 we also note an increase in the number of subjects who say they know someone in the drug world (with the most substantial increase in the 35-44 age group). The distribution of kids with consuming friends increases with age to peak at 19 (about 60% of those interviewed); we also find a slight increase in the phenomenon in the four-year period, especially with regard to students aged 15 to 17.

Graph 10.2 – ESPAD: Distribution by age group of subjects with friends who use illegal drugs, 2000-2004 compared



Based on ESPAD®Italia2000 and ESPAD®Italia2004 data

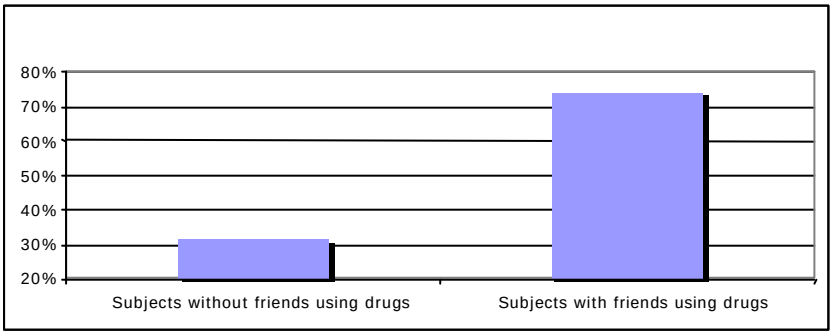
Graph 10.3 – ESPAD: Distribution by age group of subjects who state that they are able to find drugs easily, 2000-2004 compared



Based on ESPAD®Italia2000 and ESPAD®Italia2004 data

The availability of narcotic drugs seems to have increased from 2000 to 2004 with regard to the younger age groups. About 30% of 15-year-olds had no difficulty in locating illegal substances, and this availability increases proportionally with age; at 19, 60% state that they can easily find drugs.

Graph 10.4 – ESPAD: Distribution of subjects who know consumers of illegal substances in relation to the ease of finding drugs: 2004



Based on IPSAD®Italia2004 data

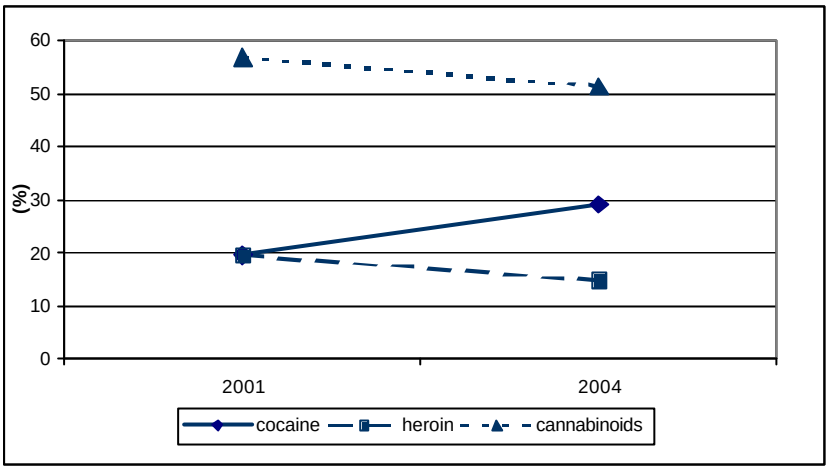
Finally, we note a strong correlation between ease of finding illegal substances and having friends who use them. For students with consuming friends, it is twice as easy to find illegal drugs.

10.2 Seizures

Although the total number of operations carried out in Italy in 2004 was lower than in 2001 (18,653; a decrease of about 14%), this drop did not involve all substances, nor did it automatically lead to a reduction in the quantities intercepted (Graph 10.5).
If in fact we pause to analyse the operations aimed at individual substances,[11] against a downward trend (2001-2004) recorded in the case of the cannabinoids and heroin, we find a significant increase for cocaine and substantial stability in the data relating to the amphetamine derivatives.

[11] Operations in which more than one substance was seized or found were considered multiple times, one for each substance.

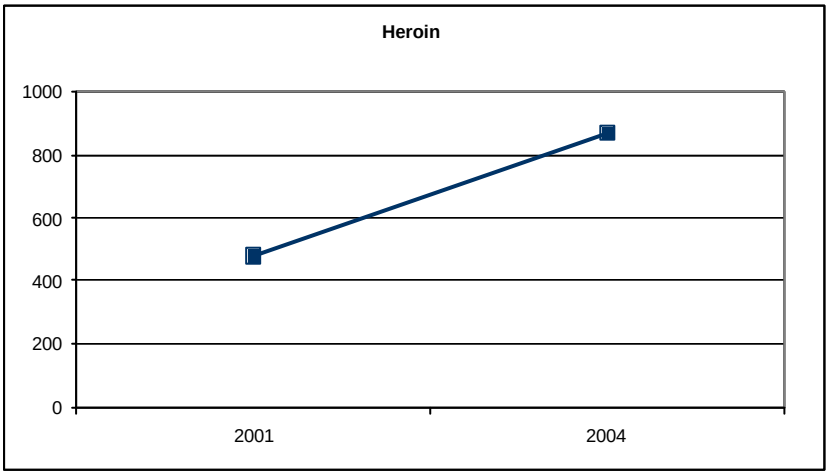
Graph 10.5 – Operations conducted against various substances: 2001-2004



Based on data from the Interior Ministry - D.C.S.A.

In terms of average quantities of substances seized (Graph 10.6), we find significant differences only in the case of heroin, for which the values double between 2001 and 2004, going from just over 400 grams per individual operation to about 800 grams.

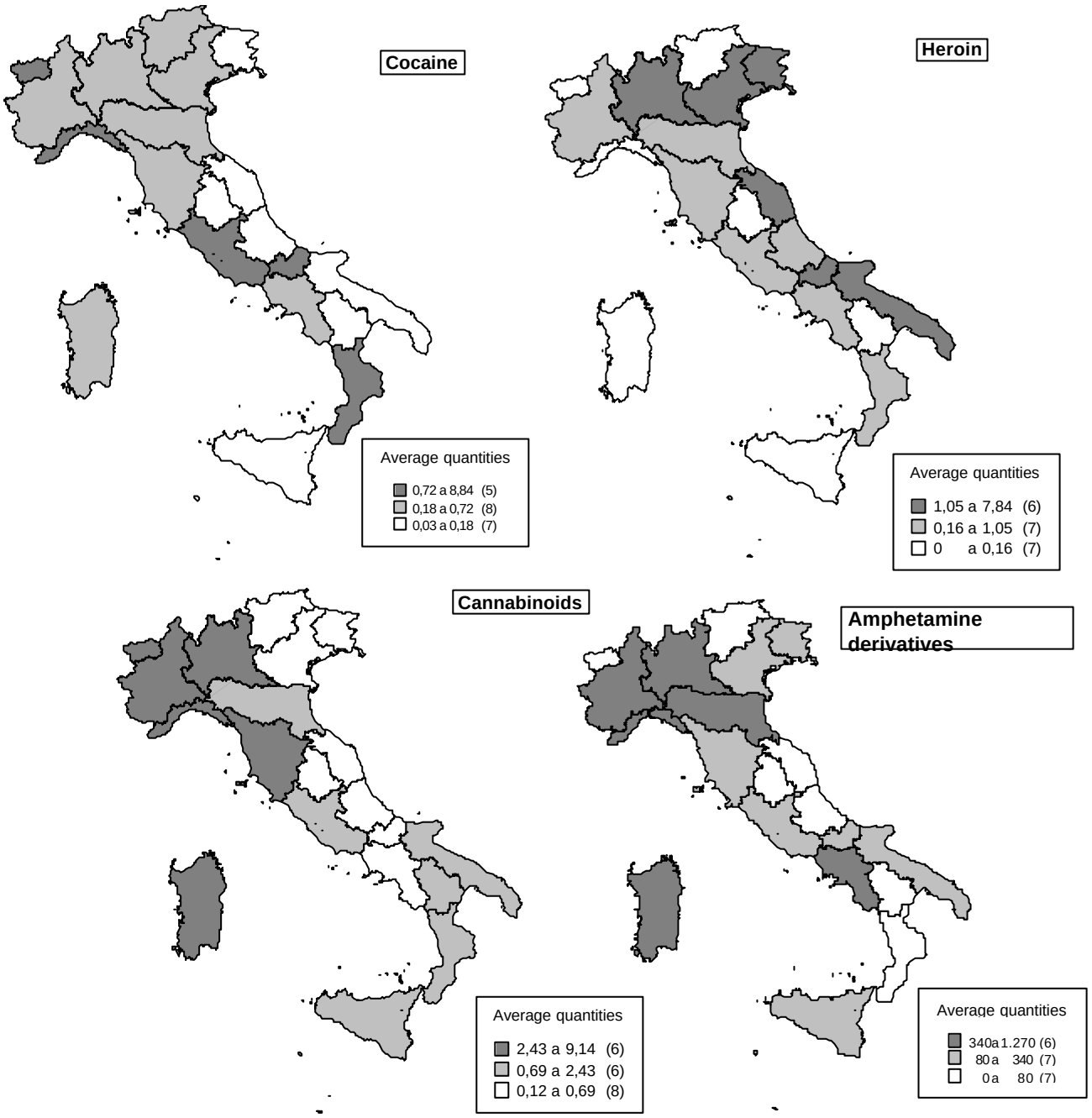
Graph 10.6 – Average quantity of heroin seized: 2001-2004



Based on data from the Interior Ministry – D.C.S.A.

As in the previous four-year period, however, the quantities of narcotics intercepted during the year vary nationwide with notable swings, even within the same regions, obviously the result not only of the quantities seized or found but also the number of operations directed against them (Graph 10.7).
We should note here the high value found in Calabria for cocaine (an average quantity of almost 9 kilograms in 88 operations, including one of 320.5 kg), or for heroin in Friuli Venezia Giulia (an average quantity of 8 kg in just 46 operations, including one of 148.5 kg). Overall, the regions where the highest average quantities for cocaine are reported are Valle d'Aosta, Liguria, Lazio, Molise and Calabria
In the northwest, Tuscany and Sardinia, the highest average quantities for cannabinoids are recorded, whereas in Lombardy and along much of the Adriatic Coast, with the exception of Emilia Romagna and Abruzzo, we find the highest levels for heroin.
In the northwest (with the exception of Valle d'Aosta), Emilia Romagna, Sardinia and Campania the highest average levels of amphetamine derivatives are recorded.

Graph 10.7 – Regional distribution of average quantities of seized substances in 2004



Based on data from the Interior Ministry – D.C.S.A.

Seizures of precursors

In addition to seizures of illegal narcotic and psychoactive substances used as a substance of abuse, law enforcement agencies are committed to fighting the trafficking in the main chemical precursors needed for synthesizing psychoactive substances. This activity is especially difficult inasmuch as these substances are imported and marketed for legitimate purposes as well, as part of normal industrial production. As can be imagined, it is especially easy for traffickers to avoid controls and to find ways of diverting the chemicals used in synthesising drugs. In this regard, the traffic in acetic anhydride, potassium permanganate, ephedrine, and safrole derivatives is especially important. Acetic anhydride is used in the acetilation of morphine to lead to a synthesis

of heroin; potassium permanganate makes it possible to transform the paste taken from coca leaves into cocaine. Amphetamines are produced by using ephedrine as a base, and safrole is used as a base to produce ecstasy. In 2003, 414.5 kg of ephedrine were seized, and in 2004, 191 tablets of the same substance were seized. In 2003, 33.1 kg of potassium permanganate were seized, as well as 7 litres of acetic anhydride. We have to go back as far as 2001 to find a seizure of 16,297 litres of acetic anhydride. From the data in our possession, it can be imagined that even in Italy, albeit at a far lower level than in other countries, criminal organisations may be forming that are capable of synthesizing substances for abuse or performing the chemical transformations described.

10.3 Price and purity

Based on the data found by the DCSA (Central Anti-drug Services Department), updated to September 14, 2004, and relating to the levels of narcotic substances found on September 1, 2004,[12] we find a variation in average prices, depending on the purity and origin of the drugs, depending on the sales channel: trafficking or dealing (Table 1). While in marijuana trafficking the average price variation is between Euro 950 and 1,500 per kilo, in dealing the average price per gram varies between Euro 5 and 6; hashish on average has higher prices than does marijuana, both in trafficking and in dealing: between Euro 1,500 and 2,300 per kilo for the former, and between Euro 7 and 8 per gram for dealing.
There are also average-price differences between black and white heroin: for the former, between Euro 23,500 and 28,500 per kilo in trafficking, and between Euro 50 and 60 per gram for dealing; white heroin costs between Euro 37,500 and 44,500 per kilo, while for dealing it costs between Euro 75 and 90 per gram.
Cocaine is the costliest drug of all: in trafficking, it costs between Euro 38,000 and 46,000 per kilo, and in dealing between Euro 80 and 98 per gram. The average price of 1,000 ecstasy tabs varies between Euro 4,800 and 5,200 in trafficking channels, while in dealing an individual tab costs between Euro 19 and 24.
Finally, 1,000 doses of amphetamine are worth between Euro 7,250 and 7,500 in trafficking, whereas a dose costs between Euro 19 and 21 from a dealer; 1,000 doses of LSD cost an average of Euro 8,750 in trafficking, while a dose costs between Euro 25 and 26 from a dealer.

Table 1 – Trafficking and dealing prices of narcotic substances

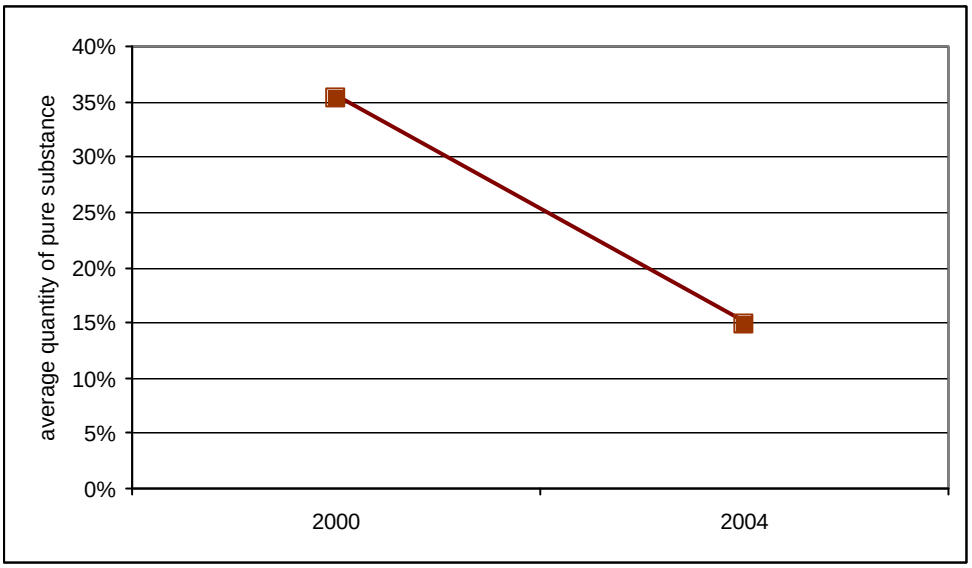
Substance	Traffic Euro per kilo or per 1000 doses)		Dealing Euro per gram or per dose)	
	Min	Max	Min	Max
Marijuana	950	1.500	5	6
Hashish	1.500	2.300	7	8
Black Heroin	23.500	28.500	50	60
White Heroin	37.500	44.500	75	90
Cocaine	38.000	46.000	80	98
Ecstasy	4.800 (1,000 doses)	5.200	19 (single dose)	24
Amphetamines	7.250 (1,000 doses)	7.500	19 (single dose)	21
LSD	8.750 (1,000 doses)		25 (single dose)	26

Based on data from the Interior Ministry – D.C.S.A.

With regard to the purity of the substances seized, from 2004 to 2004 (updated at January 31, 2005) we find a significant reduction in the average quantity of pure substance found in seized heroin, dropping from 35% to 15% (Graph 10.8), whereas for the other substances no significant variations were recorded in the average level of purity found (Table 2) over these years, given the major annual variations in the period in question.

[12] Prices formulated based on average prices recorded in the cities of Palermo, Reggio Calabria, Naples, Rome, Florence, Bologna, Verona, Venice, Trieste, Turin, Milan and Genoa.

Graph 10.8 - Average quantity of pure substance (%) found in heroin seized: 2000-2004



Based on data from the Interior Ministry – D.C.S.A.

Table 2 - Average quantity of pure substance (%) found – 2000-2004

DRUG	2000	2001	2002	2003	2004
Cannabis resin	7,05	7,62	8,29	7,61	8,22
Cannabis leaves	4,35	14,43	4,89	7,85	5,78
Black Heroin	35,29	28,94	15,55	12,75	14,81
Cocaine	63,02	64,83	58,89	63,58	54,74
Amphetamines	32,06	27,89	24,04	27,2	35,37

Based on data from the Interior Ministry – D.C.S.A.

Other studies at the local level

A study by the Forensic Medicine Institute of the Universities of Modena and Reggio Emilia (Licata, Verri, Bedushi) (being published in the Annals of the Higher Institute of Health) provides data and information on changes in the percentage of delta 9 tetrahydrocannabinole (δ9 THC) in 5,227 samples taken from cannabis seized during the 1997-2004 (first four months) in the Modena area and analysed at the request of the courts by the Forensic Toxicology Lab of the Modena Forensic Medicine Department.

The samples were classified as marijuana and hashish and divided into subgroups:

- "loose marijuana": samples not compressed, chopped, or indefinable from a morphological standpoint:
- "Kilobricks": compressed cannabis samples consisting of leaves, buds, stems and seeds;
- "Buds": samples consisting of buds;
- "Domestic marijuana," i.e., cannabis preparations that were definitely produced locally;
- samples consisting of hashish broken into thin bars;
- samples consisting of hashish in tablets or loaves (thickness varying from 0.8 to 2.5 cm).

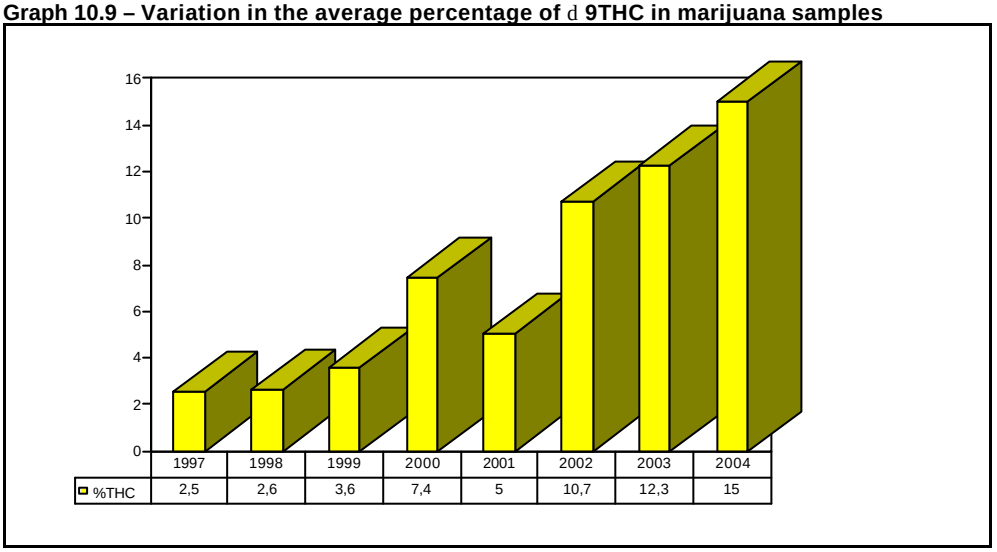
A gas-chromatography analysis was done on the samples extracted from marijuana and hashish. For the 1997-2004 (first four months) period, 508 seizures containing hashish and 111 containing marijuana were observed. Table 3 shows the quantities seized annually in the Modena area:

Table 3 – Quantities of hashish and marijuana seized in the Modena area: 1997-2004

Year	marijuana	Hashish (Kg)
1997	8,97	1,46
1998	97,15	8,77
1999	159,89	2,88
2000	2,36	37,27
2001	46,43	40,53
2002	55,75	14,98
2003	0,657	227,30
2004	1,062	14,12

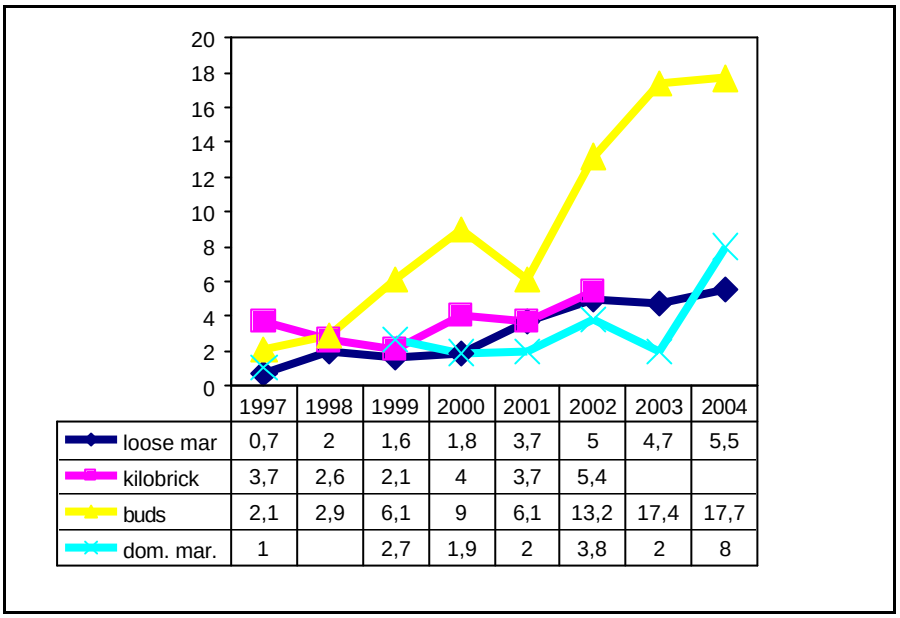
Monitoring of the δ9 THC in the marijuana sample seized yielded the information contained in Graph 1, showing the average percentage increase in THC from 2.5% in 1997 to 15% in 2004.

Graph 10.9 – Variation in the average percentage of d 9THC in marijuana samples



Since 2002 there has been a clear prevalence of selected buds with a high percentage of active principle, and the appearance of domestic marijuana, also selected. Also significant is the disappearance from the Modenese clandestine market of dealing in kilobricks, i.e., compressed marijuana, which was significantly present in previous years (Graph 10.10).

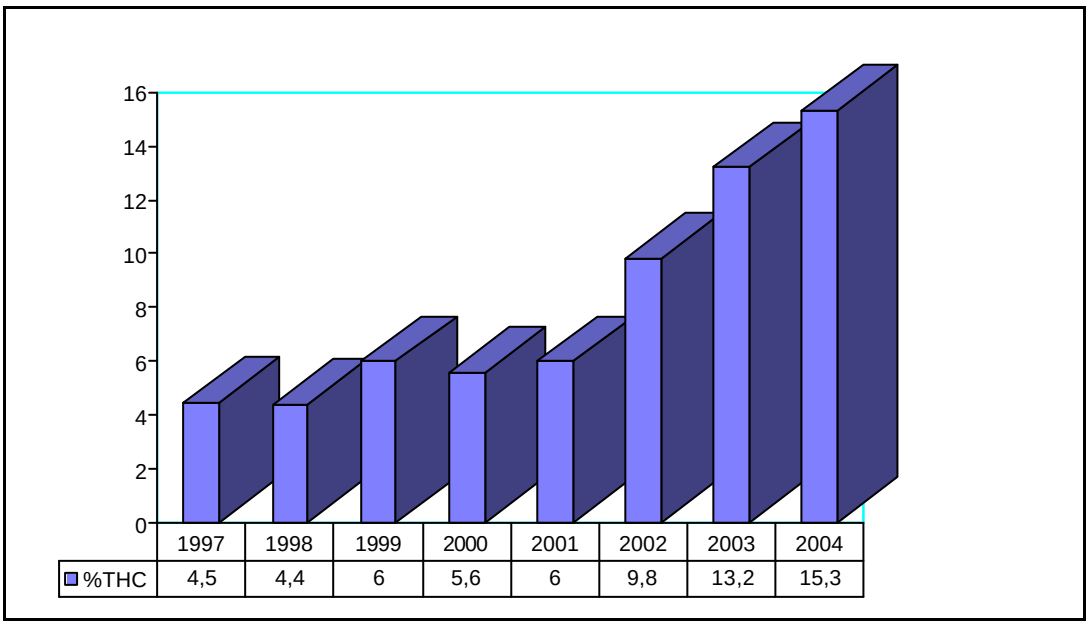
Graph 10.10 - Variation in the average percentage of d 9 in marijuana samples broken down by type



	1997	1998	1999	2000	2001	2002	2003	2004
loose mar	0,7	2	1,6	1,8	3,7	5	4,7	5,5
kilobrick	3,7	2,6	2,1	4	3,7	5,4		
buds	2,1	2,9	6,1	9	6,1	13,2	17,4	17,7
dom. mar.	1		2,7	1,9	2	3,8	2	8

Graph 10.11 shows the variation in the average percentage of THC in hashish samples: we find a gradual increase over the period analysed; in fact, while in 1997 the average percentage was 4.5%, it was 15.3% in 2004.

Graph 10.11 - Variation in the average percentage of d 9THC in hashish samples



	1997	1998	1999	2000	2001	2002	2003	2004
%THC	4,5	4,4	6	5,6	6	9,8	13,2	15,3

Since 2002, we have seen the appearance of more potent samples (13-20% δ 9THC), reaching 12-20% in 44% of the samples by 2004.
In conclusion, assessments relating to cannabis samples for the years 1997-2004 show a slight fluctuation in the potency of hashish (from 4.5% δ 9THC to 6%) and an increase in marijuana (from 2.5% δ 9THC to 7%). The trend for the years 2002-2004 points to a significant increase in potency, with average δ 9THC values going from 10.7% to 15% (marijuana) to 15.3% (hashish).

The significant number of samples analysed annually, together with the small size of the goods seized, further support the conclusions reached, i.e., an upward trend in cannabis potency, which is grounds for alarm with regard to its use and abuse.
It is impossible to know for certain whether the findings from the Modena area are to be attributed to samples representing only the local situation, or whether they represent a more widespread trend involving an increased concentration of active principle in cannabis derivatives.

PART B SELECTED ISSUES

11. GENDER DIFFERENCES

Overview

Despite continuing differences between men and women in the use of illegal drugs, there is a greater increase in the use of drugs (in particular cannabis and cocaine) among women compared to men of the same age, above all in the young age group.
In relation to gender differences in the request for treatment, in line with findings in previous years, most of those in care at drug treatment services are men, at 87% of patients overall.
As for infections, while there is confirmation, both among new patients and those already in care at the drug addiction services, that the main problem for women concerns HIV, while in relation to hepatic infections, the analysis of patients shows a broad balance between the sexes for both hepatitis B and C.
The analysis carried out on the basis of sex, in relation to drug-related crimes, highlights the scarce presence of women among those reported and those condemned for crimes connected to drug legislation (a trend that is also confirmed for “minors” who have passed through the juvenile justice services).

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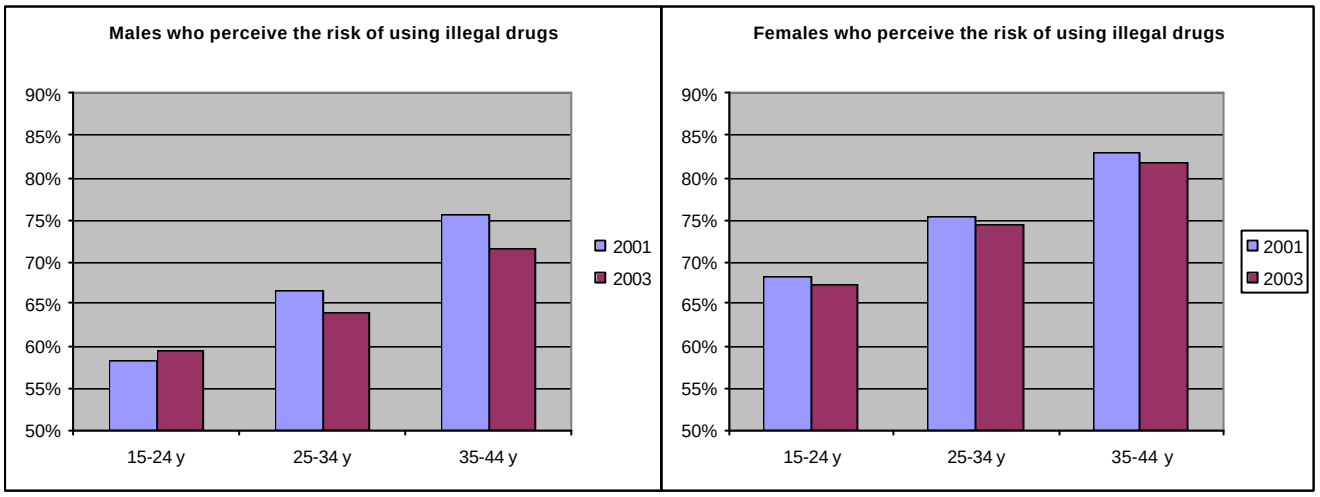
11.1 Drug use in the general and school populations

Drug use in the general population

Analysis of the data emerging from the studies done on the general population reveal that female subjects are more likely to perceive the risk of taking illegal psychoactive substances (about 10% more than their male peers), and the older age groups report greater concern over the phenomenon (about 10% more than the young). Although not significantly, in all age groups (except for 15-to-24-year-olds) we find a slight decrease with respect to 2001 that is more apparent among males.

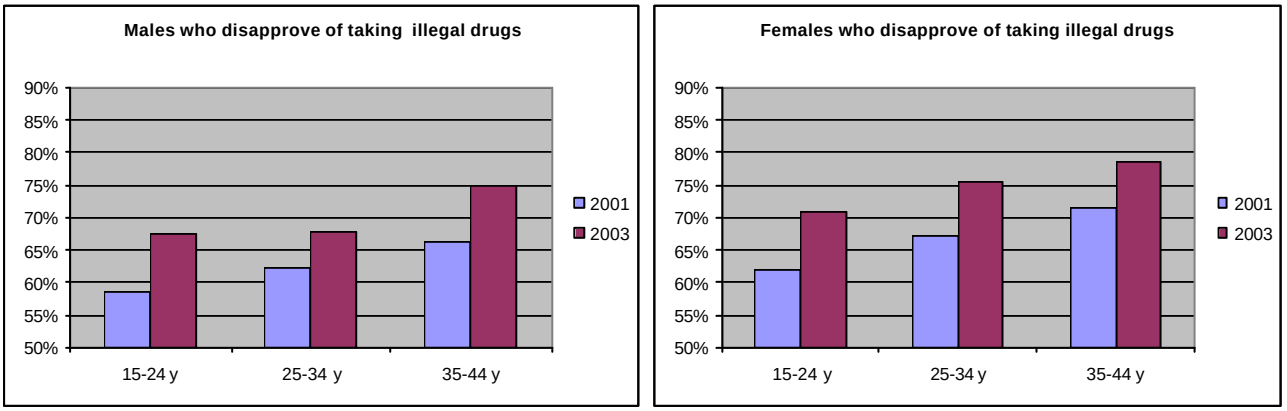
Graph 11.1: Perception of risk for personal health in relation to the use of illegal substances, by gender and by age group (2002-2003)



Based on IPSAD®Italia2001 and IPSAD®Italia2003 data

In both years, consistent with the risk perception analysis, the percentage of women who disapprove of using psychoactive substances is greater than among men.

Graph 11.2: Disapproval of use of illegal substances by gender and by age group (2001-2003)

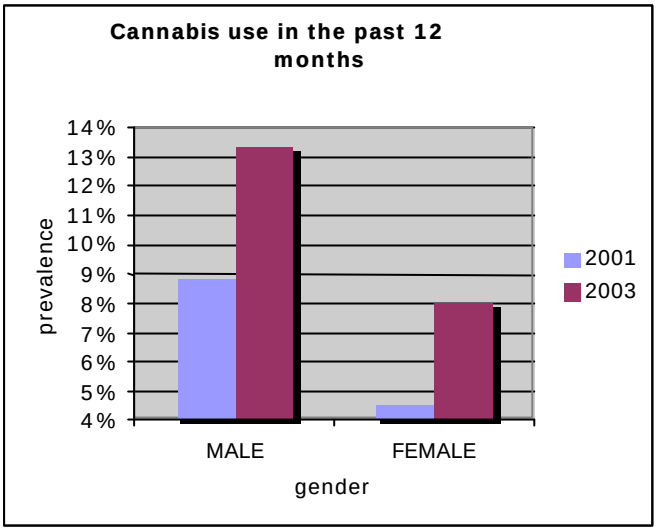


Based on IPSAD®Italia2001 and IPSAD®Italia2003 data

Graph 11.4 shows the strong increase in experience in cannabis use in the previous 12 months in both sexes between 2001 and 2003. A more in-depth analysis within the individual age groups reveals that among youngsters the increase in use by females is double that observed among male subjects.

This fact seems to coincide with what was found by Maxwell's 2001 survey in the United States, which showed that the prevalence of young female consumers is reaching that of their male peers.

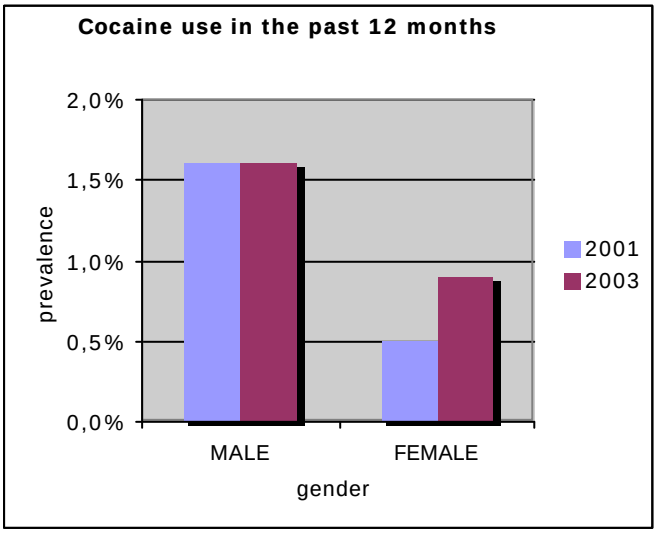
Graph 11.3: Cannabis use (one or more times in the past 12 months): by gender (2001-2003)



Based on IPSAD®Italia2001 and IPSAD®Italia2003 data

The increase in cannabis use among females seems not to be correlated with lack of risk perception, which, as stated above, is high among females. More complex socio-cultural factors probably underlie this increase in the use of cannabis derivatives by females, with the disappearance of protective factors which had previously seemed solid.
With regard to cocaine as well, the increase in use among females is very high; from 2001 to 2003 the number of females reporting having used it one or more times in the previous 12 months virtually doubled.

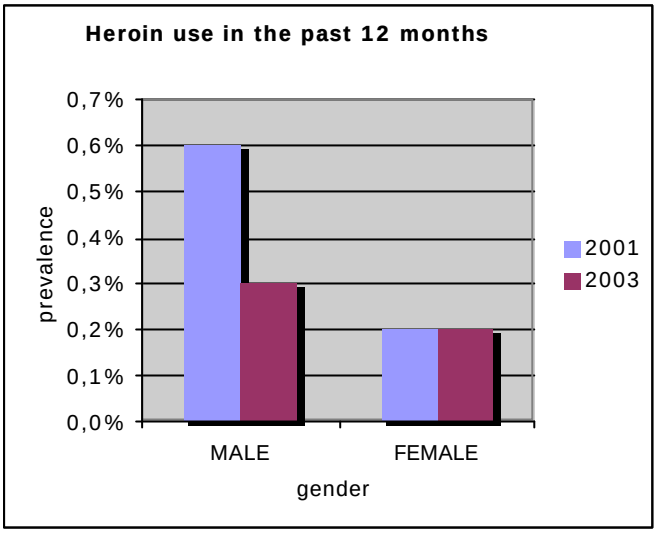
Graph 11.4: Cocaine use (one or more time in the past 12 months): by gender 2001-2003)



Based on IPSAD®Italia2001 and IPSAD®Italia2003 data

With regard to opiates, female subjects reporting use are one-third the number of males, in a proportion that remains consistent both in age groups and in the three-year survey period.

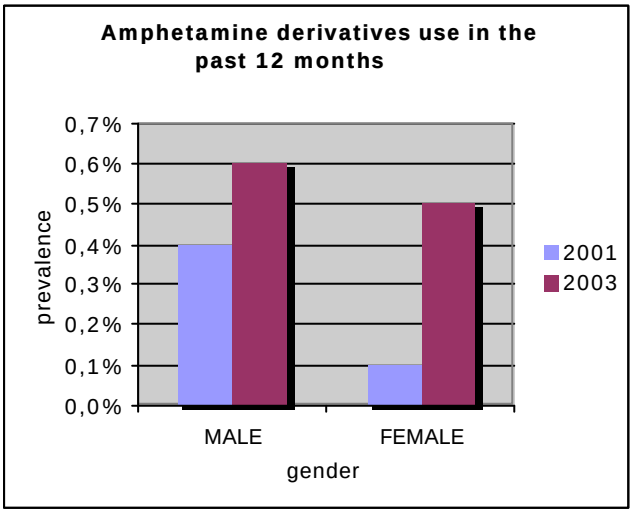
Graph 11.5: Heroin use (one or more time s in the past 12 months): by gender (2001-2003 compared)



Based on IPSAD®Italia2001 and IPSAD®Italia2003 data

The increase in exposure to the amphetamine derivatives involves both males and, to a significantly greater extent, females, who in 2003 were four times more numerous than in 2001, reaching the level of use of their male peers that year.

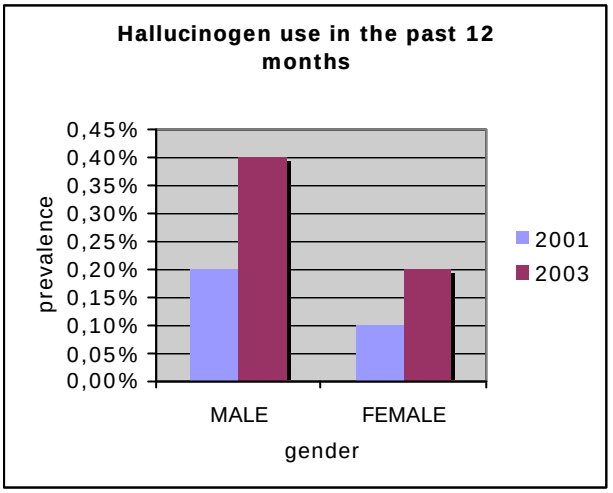
Graph 11.6: Amphetamine derivatives use (one or more times in the past 12 months): by gender (2001-2003 compared)



Based on IPSAD®Italia2001 and IPSAD®Italia2003 data

Males show double the use of hallucinogens compared to females, with no particular gender differences in the increase in hallucinogen use.

Graph 11.7: Hallucinogen use (one or more times in the past 12 months): by gender. (2001-2003 compared)

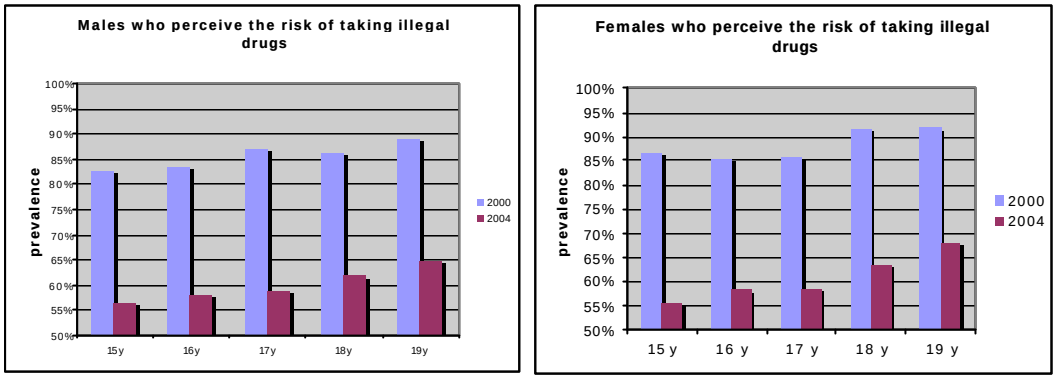


Based on IPSAD®Italia2001 and IPSAD®Italia2003 data

Drug use in school population

Surveys done on the school population also show a greater perception of the health dangers associated with drug taking among girls.
Compared with 2000, however, among students of both sexes we find an appreciable reduction in risk perception even though, as age increases and especially among females, awareness of the dangers increases

Graph 11.8: Perception of risk for personal health among students in relation to the use of illegal substances, by gender and by age group (2002-2003)

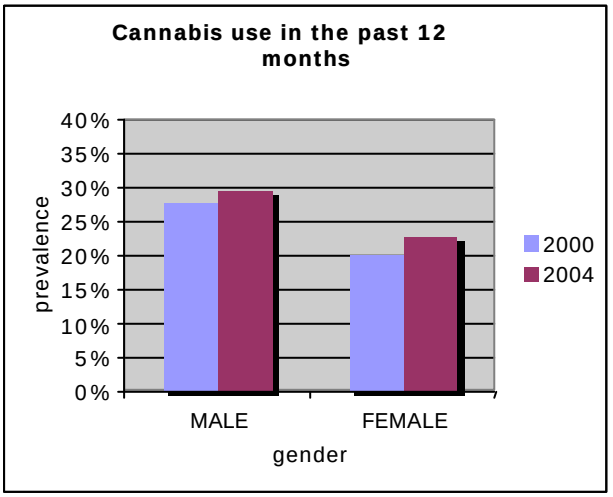


Based on ESPAD®Italia2000 and ESPAD®Italia2004 data

I

n the school population, make students report greater contact with cannabis, with a risk of using it that is approximately one and a half times greater than among their female peers.

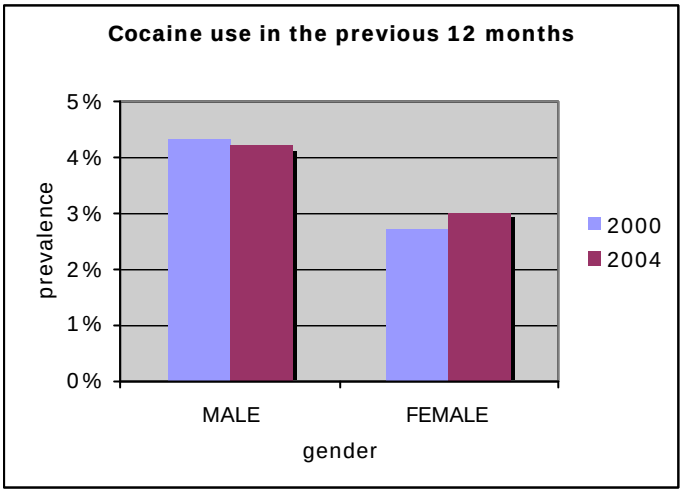
Graph 11.9: Cannabis use (one or more times in the past 12 months): (2000-2004 compared)



Based on ESPAD®Italia2000 and ESPAD®Italia2004 data

Although cocaine use among secondary school students for the most part involves males, girls show an increase in cocaine use between 2000 and 2004.

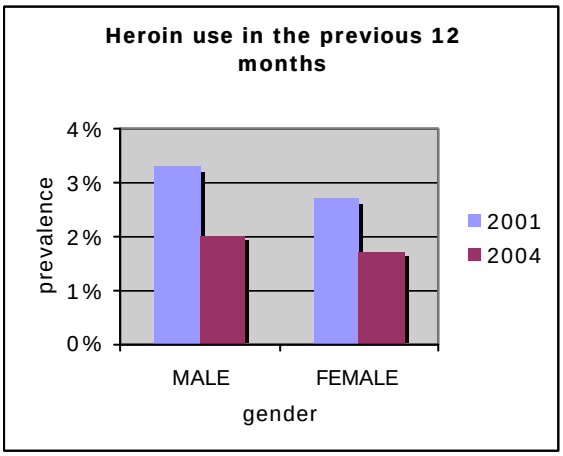
Graph 11.10: Cocaine use (one or more times in previous 12 months) by gender. (2000-2004 compared



Based on ESPAD®Italia2000 and ESPA D®Italia2004 data

With regard to heroin, however, we find no significant differences due to gender during the period in question.

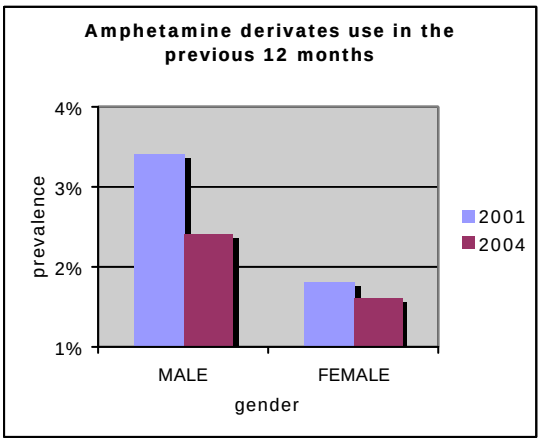
Graph 11.11: Heroin use (one or more times in previous 12 months) by gender. (2000-2004 compared)



Based on ESPAD®Italia2000 and ESPAD®Italia2004 data

Use of amphetamine derivatives is primarily male, and students contribute the most to the reduced use between 2000 and 2004.

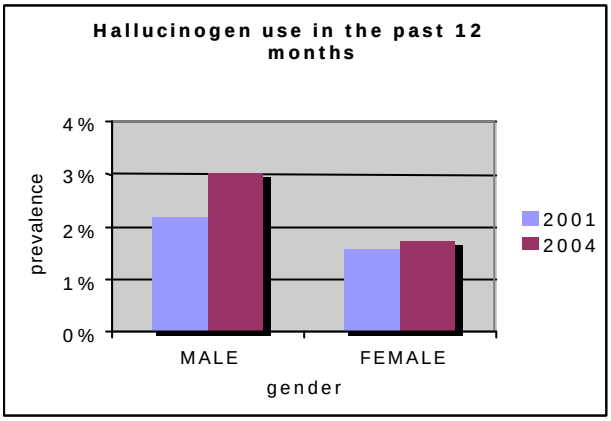
Graph 11.12: Amphetamine use (one or more times in the previous 12 months) by gender. (2000-2004 compared)



Based on ESPAD®Italia2000 and ESPAD®Italia2004 data

With regard to hallucinogens, males report use that is approximately double that for their female peers.

Graph 11.13: Hallucinogen use (one or more times in the past 12 months) by gender (2000-2004 compared)

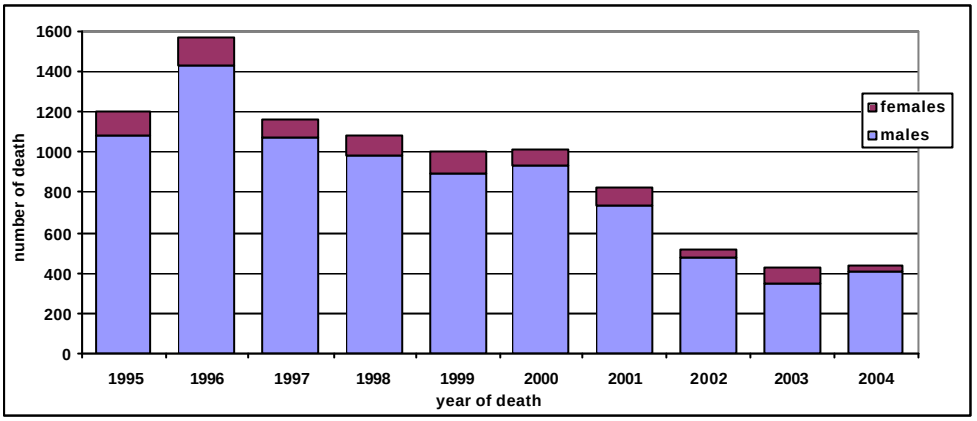


Based on ESPAD®Italia2000 and ESPAD®Italia2004 data

11.2 Drug-related deaths

As found in the data supplied by the DCSA relating to cases presumably attributable to death by acute intoxication (as deduced from circumstantial evidence), of the 441 deaths from overdose recorded in 2004, 7% were females; the greater involvement of males is thus confirmed, despite the episodic increase in the number of females who died in 2003 (Graph 11.14).

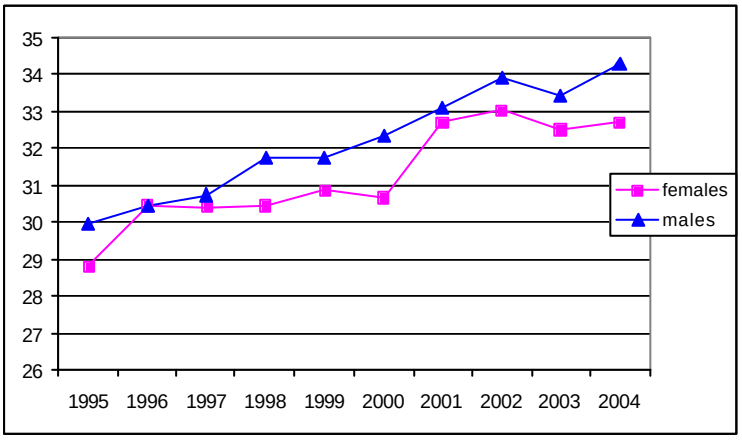
Graph 11.14: Distribution of drug-related deaths by gender and year of death



Based on data from the Interior Ministry – D.C.S.A.

In 2004, females died at a younger age than males: the average age at death for females was about 33, as compared to slightly more than 34 for males.
This gap in the average age of those who died based on gender is a characteristic that has been noted for some years now, in which the males are on average older than females; for both, since 1995 the average age at death increased by about four years, going from 30 to 34 years for males and from 29 to 33 for females (Graph 11.15).

Graph 11.15: Distribution of average age at death by gender and year of death



Based on data from the Interior Ministry – D.C.S.A.

Finally, with regard to nationality, of the 31 females who died in 2004, four are foreigners, as against 6.3% foreigners among the males who died.

11.3 Treatment demand (Sert-Multicentrica-PSA data)

In line with the results of past surveys, the population being treated at the Ser.T. is for the most part male, accounting for 87% of all users, which is equivalent to seven males for every female; this holds steady for the entire four-year period considered. These proportions between the sexes can also be found in the distinction between “new” and “old” users.

In 2004, users being treated at the Ser.T. had an average age of about 33, but with significant differences within the distinction between patients entering treatment for the first, whose average age was about 29, and those already being treated in previous years, somewhat older (slightly under 34).

Graph 11.16: Average age of new users and of those already treated in previous years, by gender - 2004

Based on data from the Justice Ministry

However, based on an analysis by gender and age, we find some differences between the two subgroups: whereas among those already treated in previous years the average age among males and females is more or less similar (in 2004, the average age for males was 32.8, and for females 32.4), among females and males never previously treated we find a lower average age, with an approximate one-year difference (females subjects average 29, whereas males averaged about 30); in the absence of data on age at first use of the substance, this does not mean that females start using substances before males do but rather than females tend to seek treatment one year earlier than do male addicts (graph 11.16).

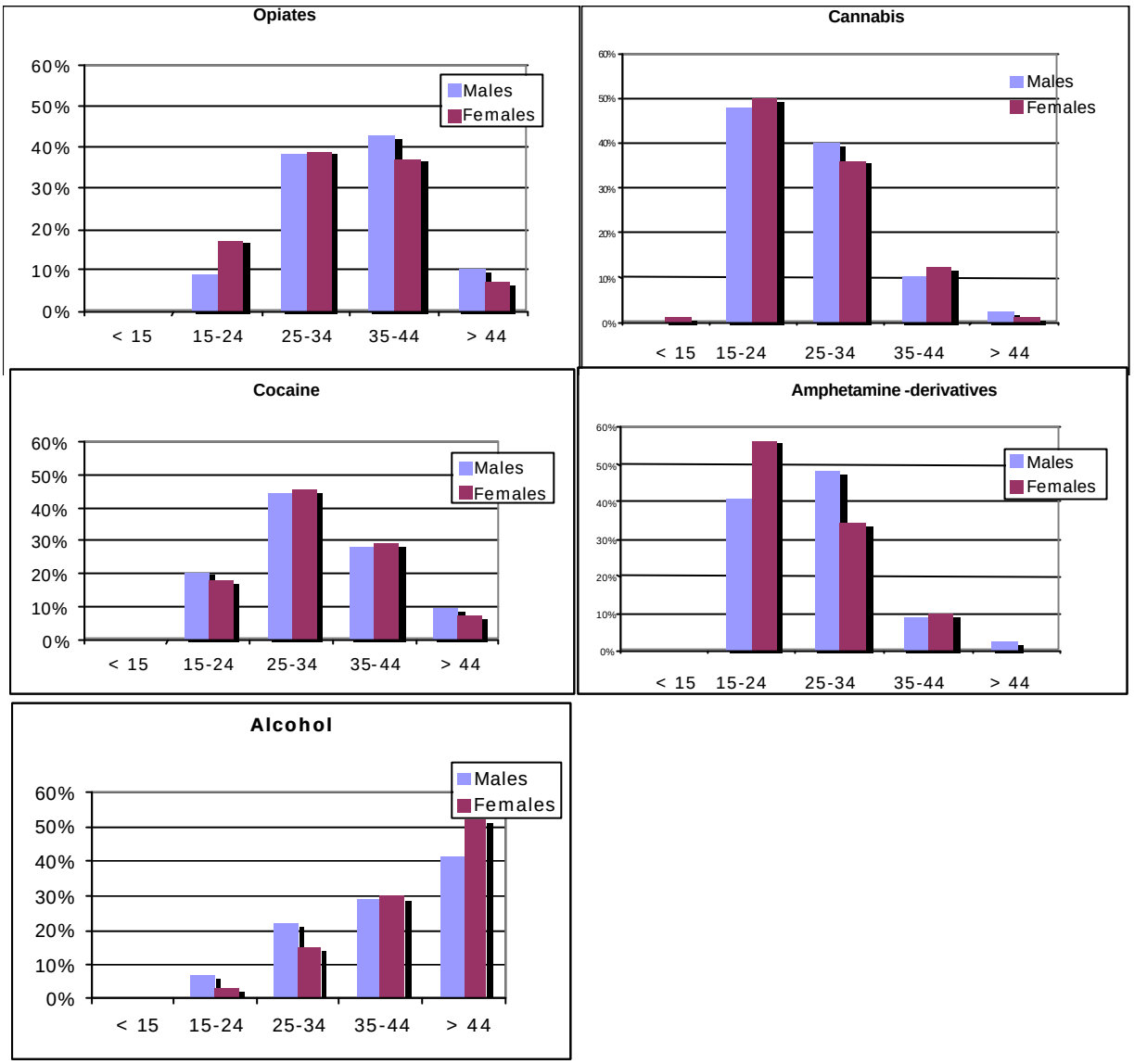
The following presents the findings of an analysis of the data obtained according to the standard survey protocol on demand for treatment proposed by the European Monitoring office on subjects being treated in 2004. The data refer to the sample of public treatment facilities cited previously.

For all substances, males come in more frequently (at an interval ranging from 92.6% of cases for opiate addicts to 79.3% of cases for those treated primarily for alcohol abuse).

age distribution differs according to the substance for which treatment is begun. Comparing genders (Graph 11.17) among those subjects primarily abusing opiates, younger females and older males are most frequent. we find exactly the opposite when the abuse substance is alcohol. For other abuse substances, we find no differences due to gender in the various age groups. The most numerous age groups are those ranging from 25 to 44.

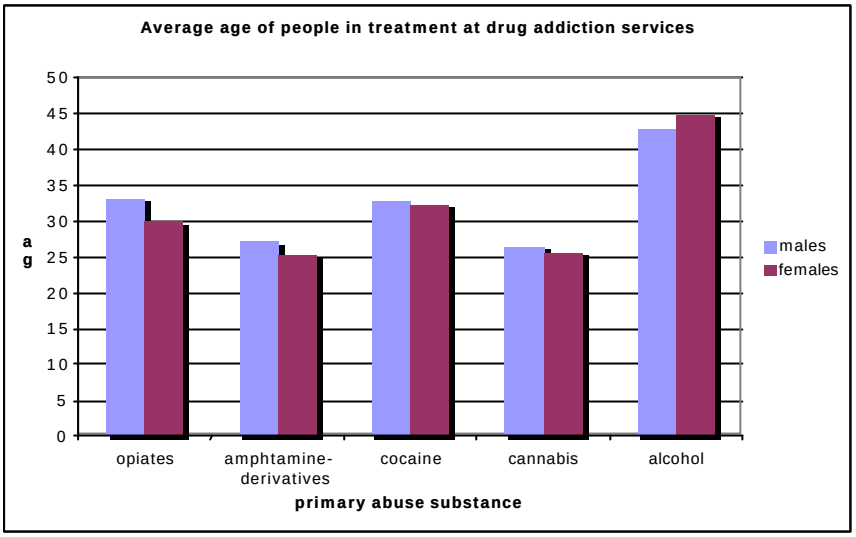
For those addicted to cannabinoids and amphetamines, distribution tends to be slanted towards the young, in this case from ages 15 to 34. Alcohol appears as the primary substance of abuse among older users.

Graph 11.17: Percentage distribution of users treated at the Ser.T. base don gender, age and the substance for which treatment is given (2004).



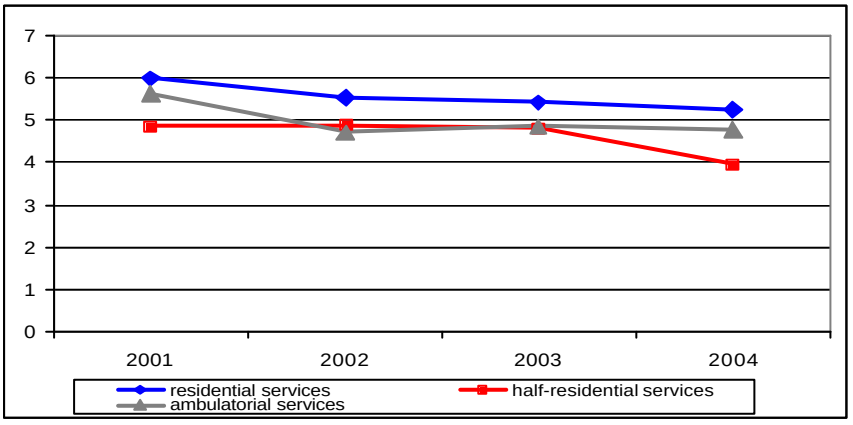
Graph 11.18 shows the average age of users for each of the primary abuse substances considered; note that users addicted to cannabis or amphetamines averages 6 to 8 years younger than users addicted to opiates/cocaine. In fact, subjects whose primary abuse substance is cannabis or amphetamine derivatives show an average age (about 26) that is lower than those coming in for primary cocaine abuse (about 32) or for primary opiate abuse (about 35). Those coming in to the Ser.T. for primary alcohol abuse seem to be a separate population (approximate age 43).
Significant differences between the average ages of the sexes can be seen for opiate users (33 for males and about 30 for females) and for alcoholics (about 42 for males compared with about 45 for females).

Graph 11.18: Percentage distribution of users treated at the Ser.T. based on gender, age and the substance for which treatment is given (2004).



Data from accredited private agencies show (Graph 11.19) that the ratio between the genders in these agencies went from about six males for every female in 2001 to 5/1 in the following three-year period; in 2004 this figure dropped slightly in semi-residential facilities (4/1, but as early as 2001 it was five males for e very female).

Graph 11.19: Ratio between genders in the various types of accredited private facilities – 2001-2004



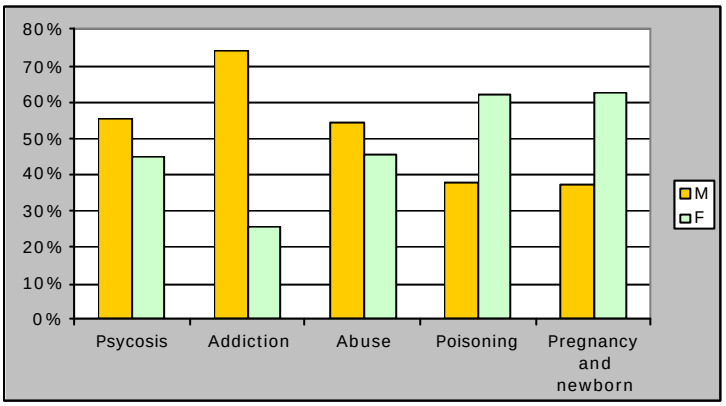
Based on data from the Interior Ministry - DCDS.

Demand for treatment at facilities not specifically for addictions

Analysis of drug-related admissions

Analysis of drug-related admissions in Italy for the 2001-2003 three-year period, done based on gender, shows that the ratio between discharge forms for males and those for females is 1.4, hence with a prevalence of males. There is an interesting difference, found in all the reference years, between the average age of the females and that of the males, which is generally 5.5 years.
The diagnosis that applies to the greatest number of male subjects is the one that we have seen is the most frequent of all: "drug addiction," which shows a M/F ratio of 2.8 (for each admission of a female, we find 2.8 males admitted). But the diagnosis "poisoning by psychoactive substance" is more frequent on the forms for female patients (M/F ratio of 0.61), evidently in relation to the greater frequency of suicide attempts.
Admissions of males and females are distributed differently based on the type of drug-related diagnosis. Admissions of males included in the diagnostic group called "drug addiction during pregnancy and injury from drugs to the foetus or newborn" obviously refer to the newborn.

Graph 11.20: Percentage distribution by gender and type of drug-related diagnosis (principal or associated)



Based on data from the Health Ministry.

In terms of distribution by gender, we may note a very high share of cases relating to the male population in the following units: infectious diseases (78.1%), recovery and functional rehabilitation (70.9%), psychiatry (66.7%) and toxicology (57.1%). For females, we see a high number of admissions in the following units: neurology (61.6%), intensive care (59%), casualty (57.3%), paediatrics (51.7%), general medicine (47.6%), and toxicology (42.9%).

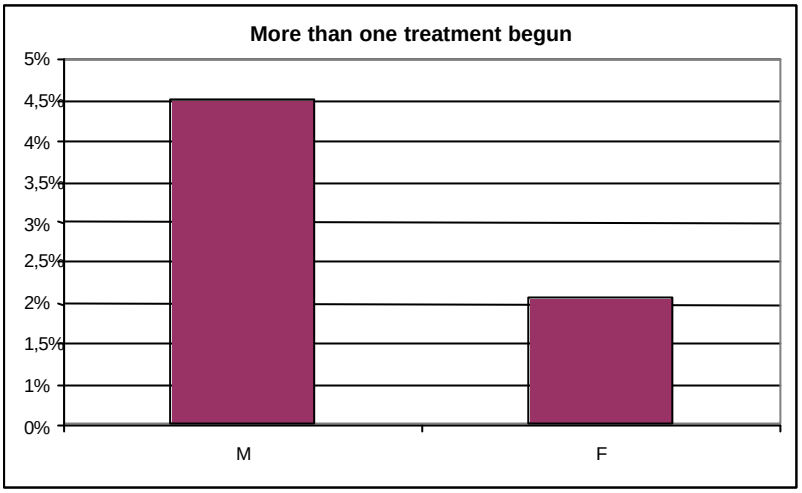
Subjects reported by the Prefectures for possession of illegal substances

These reports are greatly gender-influenced, with 183,094 males, or 94% of all reported cases, in the 2000-2004 period.
The percentage of females arrested for possession of amphetamines ranges from 10% to 15% over the five-year period in question, whereas for heroin it remains steady at around 10%.

Subjects reported by the Prefectures sent to a therapeutic programme

Of the 195,136 subjects reported to the prefectures over the 2000-2004 five-year period, a sample of 7,476 subjects (about 4% of the total) was examined, for whom a therapeutic programme was initiated in collaboration with the specific local assistance facilities.
For 4% of these subjects, more than one programme was begun during the 2000-2004 period (averaging two for each subject).
Graph 11.21 shows an association between gender and the number of programmes begun (males tend to repeat more than females).

Graph 11.21: Percentage distribution of the number of treatments begun for each subject. Compared by gender



Based on data from the Central Anti-drug Services Office (D.C.D.S.)

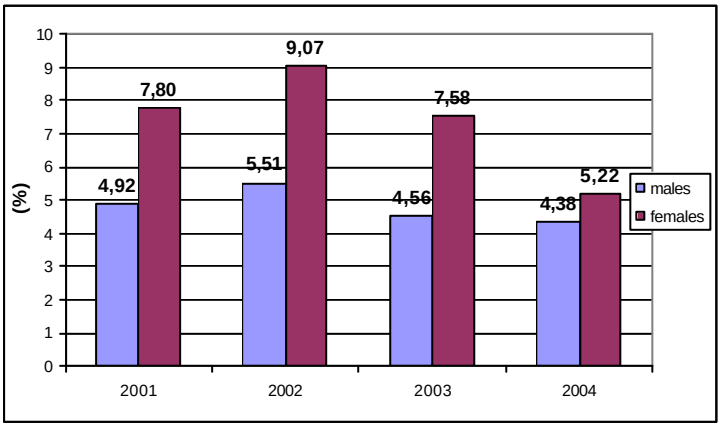
More than 95% of the subjects considered are still in treatment.
Using survival analysis methods, it has been estimated that treatment lasts two years on average (estimate by Kaplan-Meier). No differences were found between average duration of treatment for males and females.

11.4 Infections

HIV

Analysis based on the gender of users subjected to HIV testing in the addiction centres shows the persistence among new cases (Graph 11.22) of a trend noted in years past; in 2004, of the 1,652 addicted females tested, the percentage of positive tests was higher than among the 10,353 males (5.2% for females as against 4.4% for males), with a M/F ratio of 1.18.

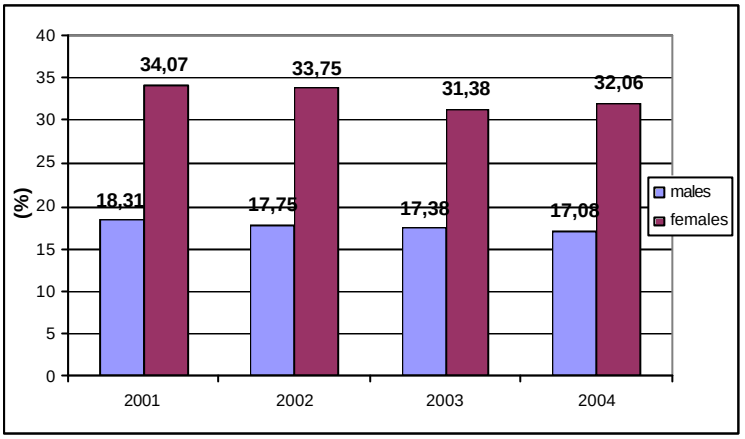
Graph 11.22: Percentage distribution by gender of positive results from the HIV test among new users in treatment at Ser.T., 2001-2004



Based on data from the Health Ministry.

This difference is also confirmed among users already in treatment, with a percentage of positives in 2004 of more than 32% among females, as compared with 17% among males, with a F/M ratio of 1.9 (Graph 11.23).

Graph 11.23: Percentage distribution by gender of positive results from the HIV test among users already in treatment at the Ser.T., 2001-2004



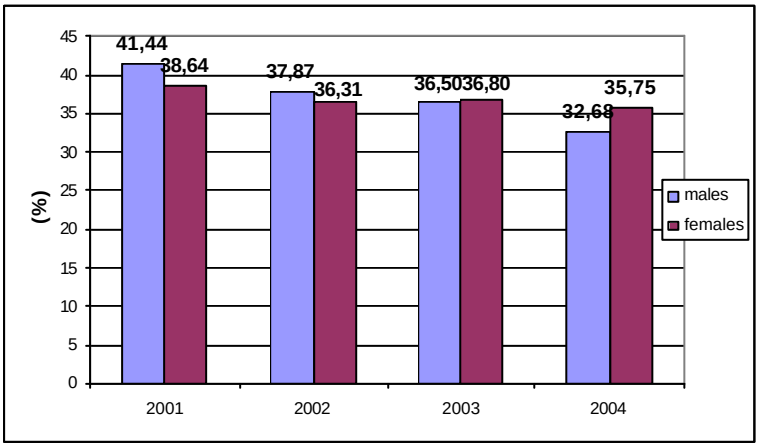
Based on data from the Health Ministry.

We thus find confirmed the greater problems of females, among those users already in treatment, with regard to the HIV virus: this should be viewed in the light of the fact that females, who are subject to the risk of passing the virus on to their children as well, are more frequently tested than males. In 2004, of new users of the addiction services, slightly more than 37% of the females were tested, as compared with 33% of the males, which figures are lower if we consider those (addicts and otherwise) who passed through penal institutions, among whom slightly more than 32% of the females and 28% of the males were tested.
As confirmation of the information coming from the addiction services, of the 708 prisoners tested,[13] those testing positive and substance abusers were 93% male, with no significant difference between genders (the rate of those infected is about 11% in females and 12% in males).

Hepatitis B and C

With regard to hepatitis infection, analysis of users both new and already in treatment at the addiction services shows substantial balance between the sexes, for both hepatitis B and C. With regard to the latter infection, however, during the four-year period in question we find a decrease in the level of positives (from 41.4% to 32.7%) which is not the case for females, in whom substantial stability was recorded (Graph 11.24).

Graph 11.24: Percentage distribution by gender of positive results from the epatitis C test among new clients at the Ser.T., 2001-2004



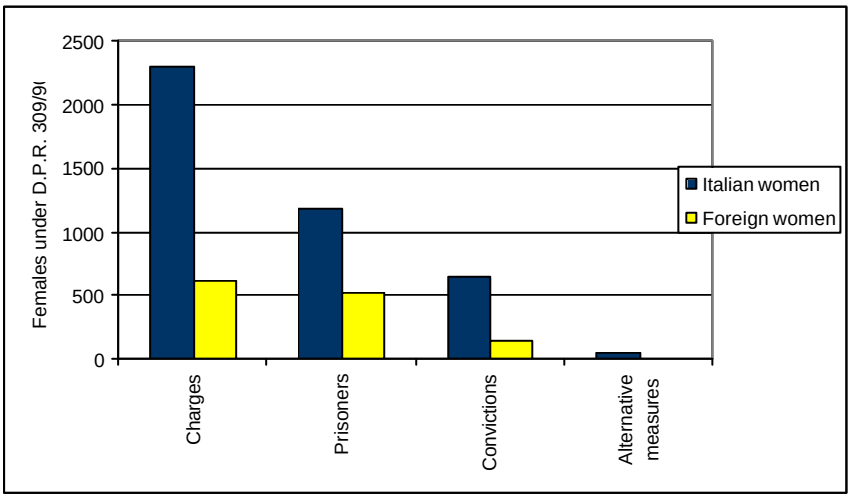
Based on data from the Health Ministry.

[13] The data obtained for 2004 were gathered non-randomly.

11.5 Drug-related crime

Analysis of the 31,261 reports filed in 2004 for the production, trafficking and sale of narcotics and for association for the purpose of same shows that, regardless of the type of crime committed, females (who account for slightly more than 9% of all reports filed, and about 6% in the case of minors) are less likely to be subjected to restrictive measures than males: in this specific case, the rates of 73% and 78% for females and males, respectively, drop to about 57% and 67% among minors.
If we consider the nationality of those involved, however, we find that among Italians the lower likelihood of measures against females holds true for production, trafficking and sale of psychoactive substances (for art. 73, about 69% of females as compared with 74% of males), whereas this difference is not significant in the case of art. 74 (for association for the purpose of production, trafficking and sale of narcotics, with 76% and 78%, respectively).
Among foreigners, however, females are less often subjected to restrictive measures than are males for both charges (about 83% as against 88% for the crime of production, trafficking and sale of narcotics, slightly less than 77% and 89% for association for the purpose of).
In addition to those arrested, the sharp preponderance of males is also found among those sentenced for crimes associated with the narcotics laws (about 91%), among those entering prisons for such crimes (about 92%), and among those who, after being convicted for such crimes, received alternative sentences because of their addiction (about 91%; percentages calculated on 31,261 arrests, 9,539 convictions, 21,439 prisoners and 625 addicts, respectively).
Despite the low presence of females in these crimes, in all the situations analysed, with the exception of those under age 19, their presence is significantly lower among foreigners than among Italians (for foreigners under age 19, females account for 4%, as compared with 7% among Italians), and they are virtually absent (just 1 case out of 51 foreigners) in the case of female addicts receiving alternative sentences (Graph 11.25).

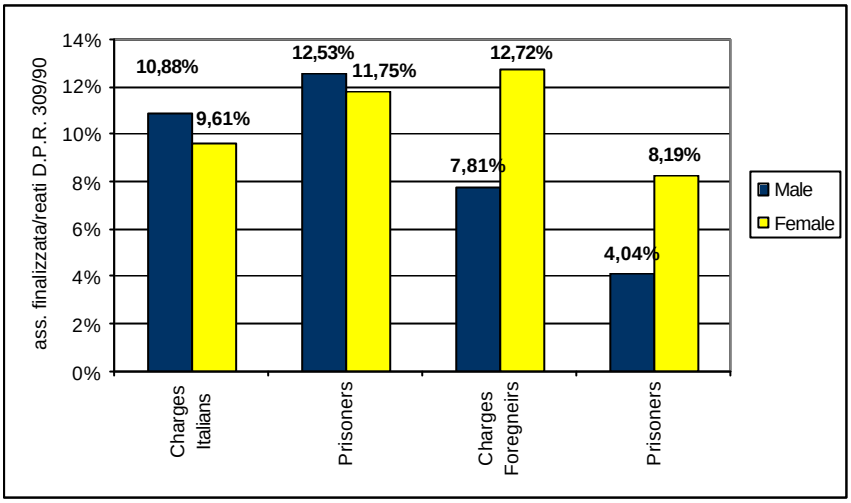
Graph 11.25: Distribution of female addicts who received alternative sentences among those charged, sentenced and imprisoned who committed crimes under D.P.R. 309/90 (by nationality)



Based on data from the Interior and Justice Ministries.

Unlike the situation with Italians, for whom analysis of the type of crime committed reveals no significant gender differences (Graph 11.26), among foreigners females are significantly more involved in serious crime (association for the purpose of producing, trafficking and sale) compared with their co-nationals (almost 13% compared with less than 8% of those charged and about 8% compared with 4% in the case of those imprisoned).

Graph 11.26: Percentage distribution of those charged and imprisoned who committed the crime of association for the purpose of producing, trafficking and selling narcotics (by sex and by nationality)

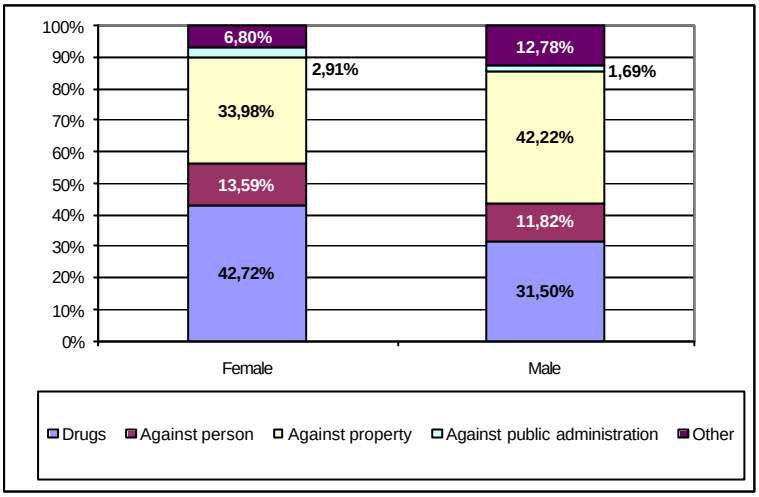


Based on data from the Central Anti-drug Services Office (D.C.S.A.) of the Interior Ministry and the Penitentiary administration of the Justice Ministry.

Among those imprisoned, foreign females are in any case more represented even if we consider them independently of the type of crime. In this case, the presence of females among foreigners is higher than among Italians, with rates exceeding 11% as against 7% for Italians.
This fact allows the hypothesis that, when involved in criminal activities, Italian females commit crimes associated with narcotics laws more than do foreign females (among those imprisoned, the level of Italian females with crimes associated with the narcotics laws is about 34%, as against 14% for foreign females.
Although they are less present than the other sex, it is worthwhile to note that if we consider crimes committed by those who, because of their status as addicts, received alternative sentences[14] (figures calculated on 1,465 addicts), females are in any case more frequently involved in crimes under the narcotics laws than is the other sex (about 43% and 31%, respectively), whereas for all other crimes there are no significant differences (Graph 11.27).

[14] For greater clarity, the most representative crime categories were considered, and, in the case of multiple crime by the same person, put in order of seriousness. Except for crimes associated with the narcotics laws, then, we considerd, in decreasing order, crimes against persons, against property, against the econopmy and public trust, against the government, and those associated with immigration law.

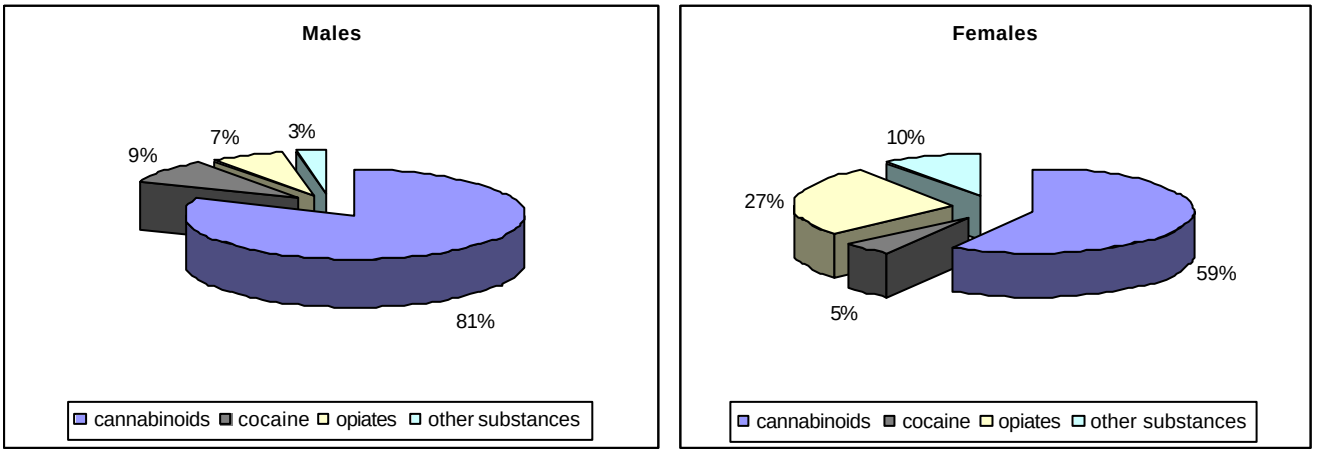
Graph 11.27: Crimes committed by addicts receiving alternative sentences and not sentenced for crimes under D.P.R. 309/90 (by sex, type of crime and nationality)



Based on data from the Justice Ministry. Department for Justice Affairs - Legislative and International Affairs

Overall, the percentage of females convicted of multiple crimes of more or less the same category, and for multiple crimes, is sharply lower than for the other sex (about 71% compared with almost 78%, respectively) among both Italians and foreigners.
Addicts entering adult penitentiaries in 2004 represent about 30% of prisoners. If we consider minors as well, this figure does not exceed 20% (about 14% in first-reception centres, 20% in penitentiaries for minors,[15] 2% Social Service Offices, and 18% in ministerial communities). The analysis done based on gender also shows that in the case of minors the low female presence, with a percentage barely reaching 4% of the total number of those found positive for narcotics and coming into contact with the various juvenile justice agencies (this figure remains basically stable throughout the 2000-2004 four-year period, with no significant differences over the years). The main substance used is cannabis, taken by about 81% of minor males and 59% of the females (Graph 11.28); opiate abuse is decidedly more evident among females (about 27%) than among males (almost 7%), who instead consume cocaine in higher percentages than do females (about 9% and 5%, respectively).

Graph 11.28 – Percentage distribution of juveniles (who take narcotics) passing through the juvenile justice services, by substance used and b y gender (2004)



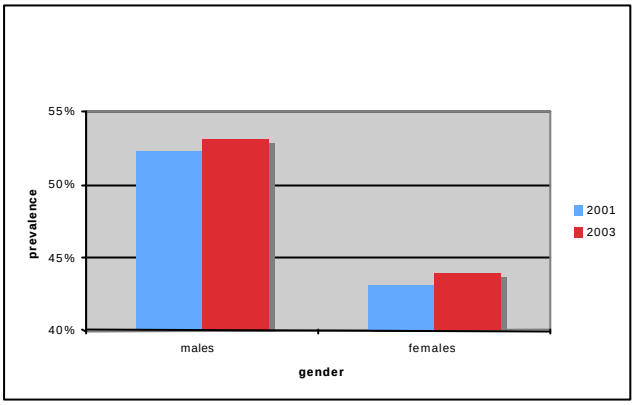
Based on data from the Justice Ministry – Juvenile Justice Department

[15] It should be recalled that the number of entries does not correspond to the number of subjects, therefore a double count is possible.

11.6 Availability and supply of illegal psychoactive substances

Of the subjects interviewed in the IPSAD®Italia2001 and IPSAD®Italia2003 sample surveys who state that they know someone who uses illegal substances, over 50% are males.

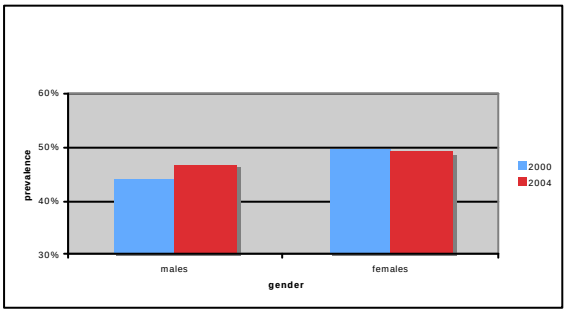
Graph 11.29 IPSAD: distribution by gender of subjects who know users of illegal drugs, 2001-2003 compared



Based on IPSAD®Italia2001 and IPSAD®Italia2003 data

We find a distribution similar to that found in the general population studies in the surveys relating to the school-age population as well, ESPAD®Italia 2000 and ESPAD®Italia 2004: about 50% of the students interviewed report having friends who use illegal substances, with a slightly higher presence in the female group.

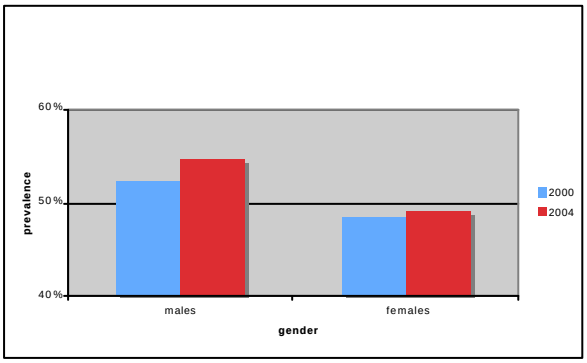
Graph 11.30 ESPAD: Distribution by gender of subjects who know users of illegal drugs, 2000-2004 compared



Based on ESPAD®Italia2000 and ESPAD®Italia2004 data

Finding illegal drugs appears to be a simple matter for a majority of those interviewed, more than 50% of males and slightly less for females.

Graph 11.31 ESPAD: Distribution by gender of subjects who state that they are able to find drugs easily, 2000-2004 compared



Based on ESPAD®Italia2000 and ESPAD®Italia2004 data

12. EUROPEAN DRUG POLICIES: EXTENDED BEYOND ILLICIT DRUGS?

The reason behind an expansive approach to addiction and the inappropriateness of prevention and treatment efforts limited solely to illegal psychoactive drugs are well recognized in Italy for a series of reasons involving various disciplines and sectors.

First, it is clear that a common neuro-pharmacological mechanism is behind the link that develops between the individual and all types of addictive substances: in this regard, the involvement of the system of gratification and dopaminergic behaviours and the onset of persistent changes to the main neurotransmitters are the result of protracted exposure to nicotine and alcohol and to illegal substances. It must not be forgotten that even among prescription substances drugs like benzodiazepine, the barbiturates and some antidepressants risk creating addiction and are subject to various forms of abuse. Despite the fact that the cultural framework, the social and environmental context and the setting in which the various drugs are taken change appreciably according to the substance, the existence of a common addictive mechanism, and, probably, of common forms of vulnerability mean that the various forms of relationship with substances, the forms of compulsion and various impacts on behavioural dysfunctions reappear in a way that is reproducible for all forms of addictions. If the problem is considered from the viewpoint of the evolution of the addictive disorder and the succession of substances consumed in the individual's clinical history, it can be shown, as it is by the data in our report this year, that smoking tobacco during adolescence and abusing alcohol are the primary antecedent for susceptibility to the taking of illegal substances and to the development of addictions. In most cases, the first approach to psychoactive substances and to experimentation with their psychoactive effects occurs through an encounter with prescription drugs, with the use of alcohol and smoking tobacco. Prescription drugs and legal substances generally accompany, in a very high percentage of cases, the onset of addictions: it is difficult to imagine cocaine addiction not accompanied by heavy alcohol use and forms of self-medication with benzodiazepine; the association between heroin and benzodiazepine, and between heroin and alcohol, is very commonly observed. as part of primary prevention, risk factors such as impulsiveness, a novelty-seeking temperament, social anxiety, a weak sense of belonging to family and to social institutions, and problems with humour are common ground for addictions to both legal and illegal substances. The same personality characteristics and the same psychological problems in many cases also underlie non-pharmacological addictions and forms of compulsion directed at objects and behaviours. It is no accident that we find the incidence of eating disorders, pathological gambling, a propensity towards risk-taking or abuse of the computer or Internet among consumers of substances, or that in conjunction with drug addictions we find very substantial percentages of comorbidity.

Therefore, an approach to the problem that tends to fragment both preventive measures and therapeutic and rehabilitational responses runs the risk of not being fully effective, as it ignores essential parts of these behavioural problems and their common matrix. The risk that this approach carries with it may include an underassessment of the specific aspects involving single forms of addiction, with regard to prevention, and an excessive standardisation of the clinical settings and approaches with regard to treatment measures.

It is quite clear that Italy needs to train professionals capable of dealing with addictive disorders in general, in reference to those common behavioural and psycho-biological mechanisms alluded to above, and equally obvious that it is important to put these professional skills into differentiated settings, with distinct phases in the clinical approaches and specialised operational units.

A comparison with classic psychiatry opens up a discussion involving a unified vision of addictive disorders understood as disease categories unto themselves, and various forms of yielding to legal or illegal substances as expressions symptomatic of underlying psychopathologies. From this point of view as well, addictions to legal and prescription substances cannot be ignored, as they very frequently appear in conjunction with major psychiatric disorders and personality disorders.

Dealing with addictions to legal and/or prescription substances by setting up therapeutic programmes for nicotine, alcoholism and addiction to benzodiazepine, or providing therapeutic responses for non-pharmacological addictions, may serve to change the image of the addiction

services in public opinion and vis-à-vis the institutional agencies. Although treatment sites and therapeutic and rehabilitational methods must be kept distinct, the fact that a single institution handles all forms of addiction and not just those which, in the collective imagination, are connected with social marginalisation and deviance carries with it a reduction in the stigma for the institution itself and. consequently, reduces the level of prejudice against those who are chronically addicted to illegal drugs. In the same way, dealing with various types of addictions opens up new educational and design perspectives within the agencies and allows professionals to look to themselves, rediscovering long unused skills and resources.

For these reasons, many Italian regions have formulated an expansive approach to addictions as part of integrated public-private systems of a departmental nature. The addiction departments (or programmes) call for broad attention to addictions to legal and illegal substances and to non-pharmacological addictions: it is for this reason that they are not called "drug addition departments" but rather "addiction departments" in general, or "pathological addiction departments."

Most of these pathological addiction departments or programmes include alcoholism services set up in agreement with general physicians, hospitals and private associations (Alcoholics Anonymous, self-help clubs for alcoholics in treatment). In a majority of cases in Italy, the alcoholism department's team takes on its own identity distinct from the other professionals who deal with drug addiction, and the service has ad hoc facilities for treating alcoholism.

Some departments – still not very many – have set up therapeutic and rehabilitational programmes for tobacco smokers: nicotine addiction is dealt with here through group therapy, psychotherapy and pharmacological therapy. Some of these anti-smoking centres collaborate with the pneumological services and provide rigorous screening for respiratory indicators and oncological risk factors; others collaborate with the Cancer League, a private association involved in preventing neoplastic diseases.

Little attention is paid to benzodiazepine addictions, even when they accompany illegal drug taking. Few departments have set up strategies for addictions to prescription drugs.

Considering the context of non-pharmacological addictions, several addiction departments in Italy have developed therapeutic and rehabilitational strategies for bulimia and anorexia, which have aroused little interest in the mental health services. Eating disorders are treated by specific operating units, located outside the drug addiction services, through psychotherapy, group therapy and pharmacological measures.

The experience acquired by professionals in treating drug addictions seems especially useful for a subtype of bulimics in whom the concomitance of eating dsorders and substance and alcohol abuse is found very frequently.

Finally, some pathological addiction departments have developed therapeutic and rehabilitational programmes for gamblers, in whom it is very common to find nicotine addiction and willingness to abuse alcohol and take psycho-stimulants (cocaine).

If we consider the legislative measures of some Italian regions in the area of organisation of addiction services, it is easy to find specific references to the need to expand the offer of therapeutic and rehabilitational interventions to addictions to legal psychoactive substances and to non-pharmacological addictions: in particular, by a decision of April 2003 the Lombardia region approved the regional "addictions" project, which expressly calls for "specialised treatment services for those addicted to alcohol and multiple substances" within the specialised treatment services; it also states that "the basic objectives of the treatment of subjects with problems of addiction to illegal and legal substances and their families are to prevent the spread of the abuse of legal and illegal substances and to intervene in favour of the psycho-physical health of people who abuse legal and illegal drugs and are addicted to them"; similarly, the Tuscany region, where there are 27 anti-smoking centres within the regional Health Plan (specifically, among the strategic development guidelines), sets the objective of "raising awareness in local communities of policies promoting psycho-physical health and wellbeing, in particular among young people, and especially in relation to proper lifestyles with regard to alcohol, tobacco and narcotics, and in particular towards the so-called "new drugs," and "combating the spread of multiple forms of abuse and addiction among young people, at school, and at work." Other regions as well, like Campania and Sicily, as part of

their approval of guidelines for organising these departments, have underscored the need to provide measures for alcoholics and for “new addictions to gambling” (Campania Region – decision of 10 October 2003 on guidelines for organising addiction departments) and to “guarantee the maximum level of opposition to the spread of pathological addictions (including those caused by alcohol and tobacco)” (Sicily Region: Decree of the Health Director of December 2001 for approval of guidelines on the pathological addictions department).

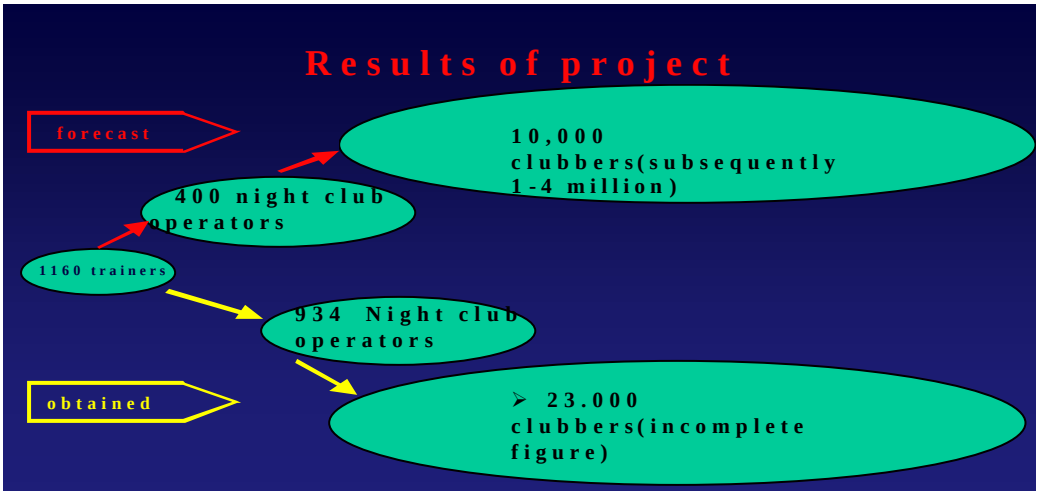
13. DEVELOPMENTS IN DRUG USE WITHIN RECREATIONAL SETTINGS

The use of psychoactive drugs (including alcohol) by young people is increasingly common and often associated with going out. A significant trend is seen, however, in a move of the main place of use from places of entertainment to other social settings such as gardens, the street, video arcades, pubs, parties and, finally, the home. There are some surprising results from research studies, including those undertaken by the Regions in cooperation with the National Health Institute (ISS), according to which some consumers prefer to take, at home and alone, so-called "social" drugs which are bought illegally for "relationship" purposes. Note should be taken that such drugs are taking on a significance which is no longer purely recreational and their use is seen as the "norm" regardless of the specific context. Finally, consideration is given to drug use aimed as self-medication for depression and anxiety which are gradually becoming more common among users of "recreational" drugs.

Having a good time is an important element in the quality of life, especially for the young; consequently it is essential to ensure that risk-taking behaviour does not compromise the positive effects. The promotion of lifestyles that are more in tune with health and safety was the aim of the "National Project for the training of night club personnel to prevent the use of psychotropic drugs among young people". This project, financed with the national drug prevention and fighting fund and which ended in 2004, was conducted by the National Health Institute(ISS) in cooperation with: Ministry of Health, Ministry of Labour and Social Policies, the Italian night club association (SILB), the Regions (members of the public and private care services), and the Interregional Technical Group for Synthetic Drugs. The aim was to provide specific training for workers in nightclubs so that they would be able to take action for their young clients by promoting health protection in places of entertainment. The other objective was to test within popular meeting places intervention strategies aimed at discouraging the use of psychotropic drugs and reducing health and driving risks.

It was planned to provide staggered training, centrally of 160 trainers, and then local training of 400 nightclub personnel in order to reach, in the test stage, 10,000 young people. The goals set were achieved and, as can be seen in figure 1, bettered. The groundwork was done for the construction of more targeted and appropriate health protection and safety initiatives; a permanent local network was established among personnel who work in various guises in the field of prevention; operating principles were established with the central structures, the Regions and the SILB in order to enable subsequent specific initiatives throughout Italy that were in harmony and coherent with one another.

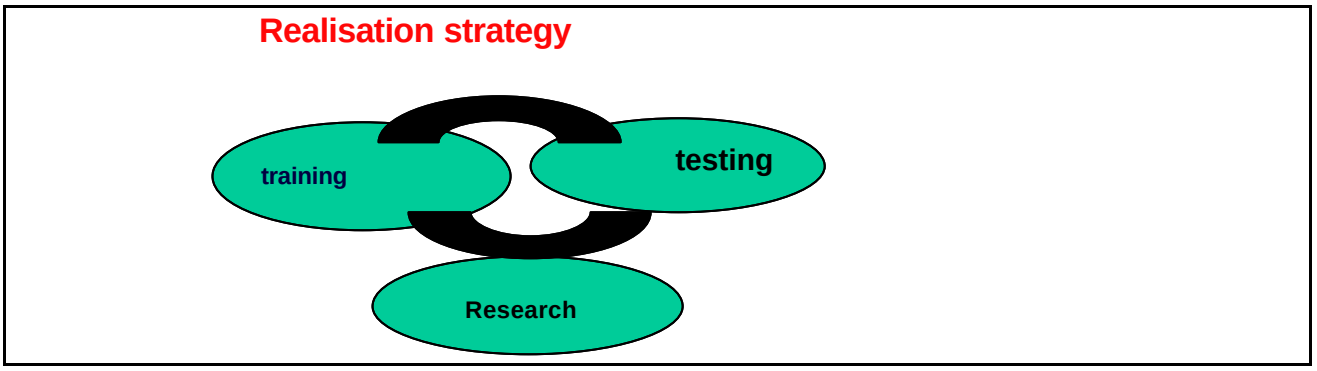
Figure 1.



The operational success resulting from this model applied nationally has led to development of the model and to the highlighting of some particularly interesting aspects. The National Department for

Anti-Drug Policies, taking account of the data published in the Report to Parliament which revealed an increase in risk-taking behaviour (a tendency to associate having a good time with *thoughtless and risky behaviour, a* common approach to the *use of alcohol and drugs, an i*ncrease in drug use in various *meeting points, a lack of awareness and serious consideration of the consequences* despite information campaigns, a *lowering of the average age* of the first experimentation with drugs, a continuing *high level of road accidents* only in the youngest age groups in the population), commissioned the ISS to undertake a national study, which is currently underway and called "Cariddi", in order to look more closely at some issues with a fully developed approach (fig.2). In particular: road safety, use patterns (in relation to the nomadic nature of free time and night-time entertainment), work with groups of youngsters, features of entertainment venues (not just night clubs, with attention paid to target, gender and setting), use, problems and consequences in the labour market, and effective communication to promote responsible behaviour.

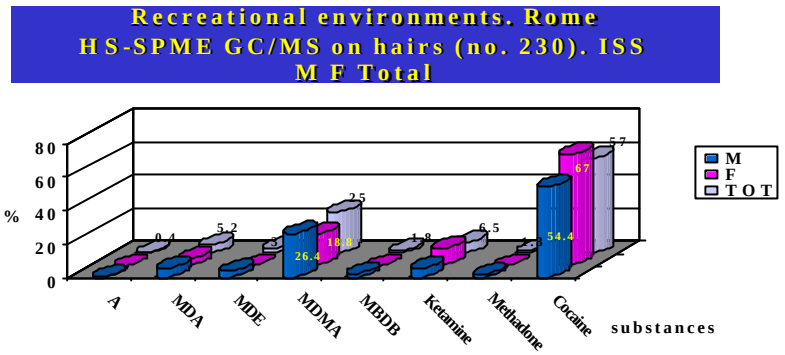
Figure 2. Cariddi study, approach to issues agreed with the Regions



The features of the phenomenon being observed and the related settings highlight the problems revolving around drugs used in places of recreation and the extent of their use remains difficult to assess in quantitative terms. It is, however, worth stressing the growing spread of the use of cocaine which seems to be starting to replace ecstasy. Cocaine cuts across all the social strata of the population and clearly involves increasingly younger people and reduces gender differences which were a feature of opiates, for example.

The study of use in recreational settings is very difficult to pursue for a variety of factors, including methodological ones; the tools used in classical epidemiology are barely adequate. In the last two years the ISS, in cooperation with associations from the private care sector, has explored an "analytical" approach through searching for psychoactive drugs in hair and in saliva to confirm or refute self reporting, a basic tool in most studies. With this aim an exploratory study was carried out on over 300 people in recreational situations. The variability in the drugs potentially taken, the lack of screening tests for many new molecules, the low concentration expected of individual drugs in the biological samples of those who mix their drugs (over 60%), the features of the matrices to be analysed, these all required the finalisation of an analytical method, suitable in terms of specific application and accuracy, with sufficient execution speed in order to be able to be applied in the epidemiological field and capable of recording at the same time a high number of molecules by using a minimum quantity of a biological sample. The technique perfected for this purpose uses headspace solid phase microextraction and gaschromatography coupled with mass spectrometry. Figure 3 shows the pilot study carried out in the area of Rome in 2003.

Figure 3. Positive results found by substance and by gender in the hair of young people and young adults

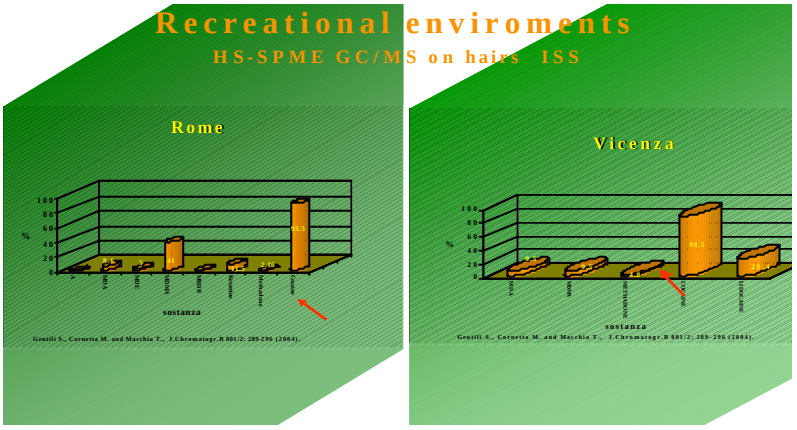


Source: Gentili S., Cornetta M. and Macchia T., J. Chromatogr. B, 801/2: 289-296 (2004).

As can be seen, among the positive results found the share represented by cocaine is significant in percentage terms; this is even more evident for women.

On the basis of the idea of local features, two areas considered dissimilar in terms of drug taking habits were compared with the same methodology. The results described in figure 4 support, however, a similar situation in terms of preferences for cocaine.

Figure 4. Positive results found through analysis of hair in the samples taken in Rome and Vicenza.

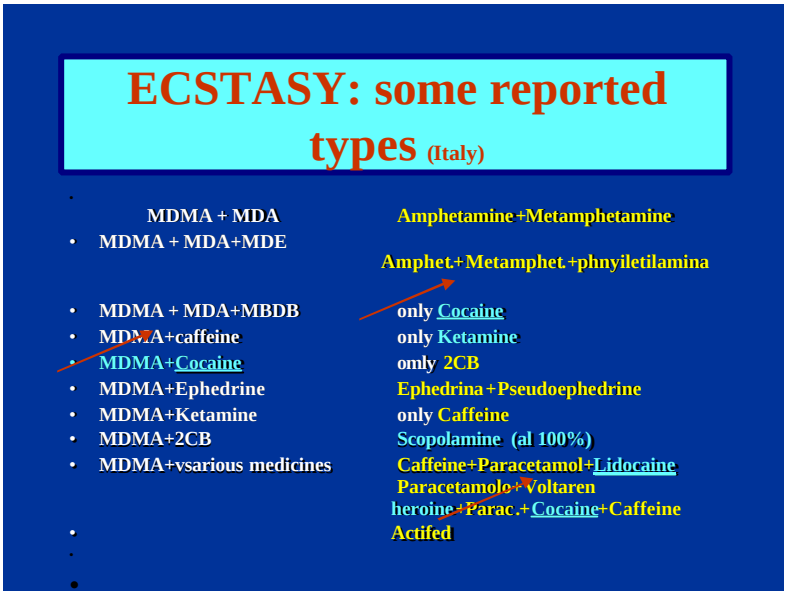


It is interesting to note that the positive results found in the HS-SPME GC/MS reflected what had been declared in the self-reporting only in 82 % of cases.

In the remaining (appreciable) positive cases (18%), cocaine was not among the substances referred to. These people declared use of mushrooms, mescaline or ketamine, and, in half the cases, use of ecstasy. Therefore, it was possible to imagine involuntary use.

This idea would seem in some way sustainable in light of the composition (fig. 5) of pills circulating on the Italian black market such as ecstasy and recorded between 1999 and 2000.

Figure 5. Composition of ecstasy pills analysed in Italy.



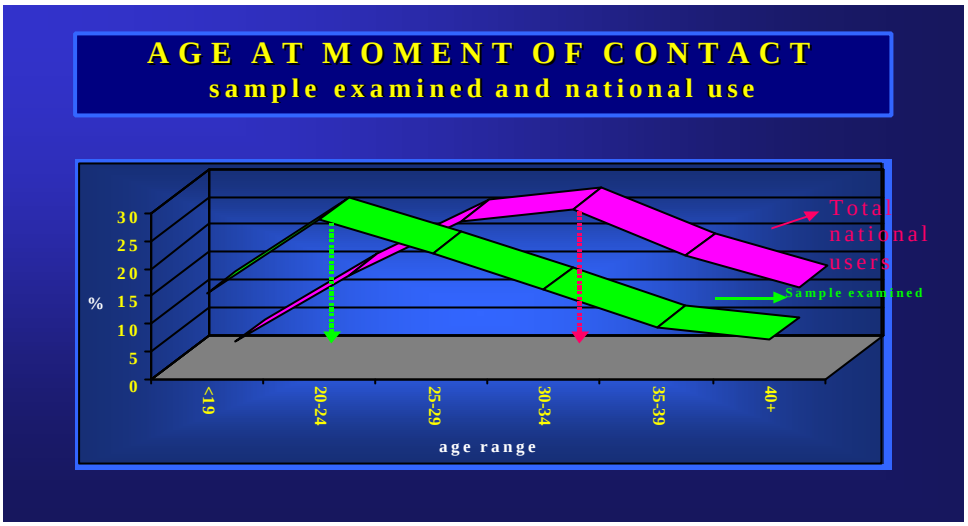
It is, therefore, not unusual for cocaine, either alone or together with other drugs, to be found in the composition of pills labelled as ecstasy, which could explain, at least in part, involuntary use.

The increase in the use of cocaine is seen in various recreational environments, it was recorded among rave-goers in the Bologna area by interviewing 327 people present at the Bologna rave parade in 2004 about their drug use habits (Metropolitan Epidemiologic Monitoring Centre on Pathological Addictions, Bologna). In the last year, cocaine was the most commonly used drug (46.4%) after cannabis (92.6%) and the average age for first use was the lowest (age of 18.9) after cannabis (15.5), LSD (17.6) and poppers (17.4). In addition, among drugs taken at any time of life, cocaine was in second place with 65.6% after cannabis with over 95%.

From a study conducted by the ISS in cooperation with 85% of the Regions on 220 local drug addiction services (40% of the total number of such services), published in 2004, it is clear that the so-called “recreational” drugs have little to do with recreation except in name. In fact in this type of user, addiction (42%) and problem use (32%) levels are such that start to lead these people to the public services for specific treatment. There also emerges an attempted suicide rate that is 36 times the level observed in the general population as recorded by ISTAT and 1,247 times higher in people who also had psychiatric problems. We should remember that, according to the WHO 2005 report, in Europe suicide (at a rate of 17.5 per 100,000 inhabitants) is the second cause of death, after road accidents, in the 15-35 age range. Finally, we should remember that, according to a study carried out on twins in the United Sates and published in the Archives of General Psychiatry of 2004, men and women who start to use cannabis before 17 have a risk of attempted suicide which is 3.5 times higher than for those who start after 17.

From the ISS study there is clear evidence of the younger age of users with “recreational” problems at specialist services compared to other users (fig. 6).

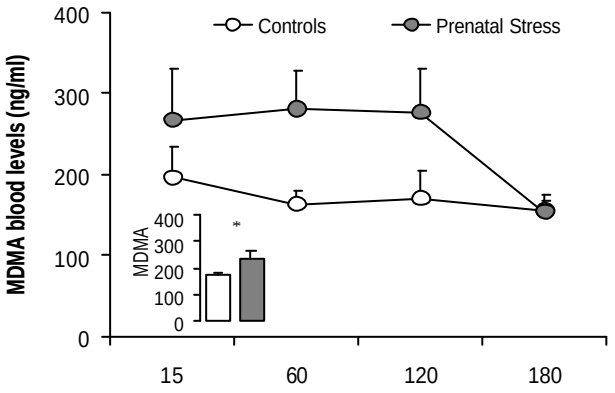
Figure 6. Age of users with "recreational" drug problems compared to other users



As can be seen, in the first case, around 40% are under 24 compared to 17% of other users. Finally, a peculiarity of this type of user, women are more common in the first two age ranges.

Also in the light of these figures and the spread in the use of so-called "recreational" drugs, especially cocaine, amphetamines and hallucinogens, we expect in the near future an increase in younger people (with specialist treatment needs) with healthcare problems, including mental, behavioural and social health. This increase may be assisted by "environmental" factors such as prenatal stress. The results produced by a study carried out on animals show (fig. 7) how rats subjected to prenatal stress are more sensitive to MDMA compared to unstressed rats of the same age.

Figure 7**. Blood levels of MDMA (ng/ml) in 30-day old adolescent rats, with prenatal stress and controls.**



Ogni punto rappresenta la media ± S.E.M di **sei** animali.
Fonte: S.Morley-Fletcher, M.Puopolo, S.Gentili, G.Gerra, T.Macchia, G.Laviola.
European Journal of Pharmacology 489 (2004) 89-92.

In the previous graphic every point represents the average ± S.E.M. of six animals
Source: S. Morley-Fletcher, M. Puopolo, S. Gentili, G. Gerra, I. Macchia, G. Laviola.

From the figure we can hypothesise that in subjects with prenatal stress the drug could accumulate in the body owing to the difficultly of metabolising and could cause acute toxicity even in moderate doses. If the model seen in animals should repeat itself in young people, if the stress stimuli,

including the use of “recreational” drugs, should continue to spread rapidly also among women and therefore involve directly or indirectly the period of pregnancy, we should prepare ourselves to face an increase in problems in the very young who would be even more sensitive to the effects and risks of drugs taken for recreational purposes.

Another study by Dr. Raimondo Maria Pavarin (raimondo.pavarin@ausl.bologna.it), head of the Metropolitan Epidemiological Observatory for Pathological Addictions of Bologna, makes it possible to deduce the relationships between the abuse of illegal substances and alcohol in recreational environments.. In particular, certain musical entertainment venues were selected (Bologna's Street Rave parade, which since 1996 has been the main anti-prohibition musical event targeting young Italians: the 2004 event was attended by more than 150,000 people – the Heineken Beer Festival in Imola, the Flipp Out Festival in Bologna, and Arezzo Wave - which since 1987 has been one of the main musical events for Italian youth and which, at the 2004 event, was attended by more than 200,000 people), where a majority of those who attended have similar lifestyles, use or have used narcotic substances more than their peers and anticipate innovative use trends and models.

This study paid special attention to identifying groups of subjects with potential behaviours involving alcohol abuse and use of narcotic substances, and combinations thereof, and the problems of various types that they reported. The questionnaire used for the interviews was developed by taking into account five indicators, with closed-answer predefined variables corresponding to them: social and personal data, narcotics use, alcohol use, at-risk behaviours, miscellaneous problems.

Social and personal data included the following: sex, age, place of habitation (an open field, not necessarily residence), nationality (Italian or foreign), housing situation (lives with family, with others, alone), work (yes, no), studies (yes, no), and the last level of schooling completed (middle-school, secondary school, university degree).

Use of narcotic substances is surveyed in regard to use over time (use ever, in the past year, and in the past month), age at first use, and, for those having consumed in the past month, to the primary means of use (intravenous, smoking, sniffing, eating).

The most commonly encountered substances were identified as Hashish, Marijuana, LSD, Ketamine, Hallucinogenic mushrooms, Salvia Divinorum, Amphetamines, Benzodiazepine, Opium, Heroin, Cocaine, Crack, Ecstasy, Poppers and Psychotropic drugs. The possibility of entering other substances was also provided.

With regard to alcohol use, subjects were asked when they normally consume alcohol (during the week or on weekends) and their frequency of use over the past year (daily, several times a week, once a week, once a month). For problematic alcohol use, the C.AG.E. (Cut, Annoyed Guilty, Eye-opener) test was used; it is an effective tool for assessing one's own risk level with respect to alcohol use. The test consists of four simple questions (Have you ever felt the need to cut down on drinking? Have you ever been bothered by criticisms of the way you drink? Have you ever felt discomfort or guilty because of the way you drink? Have you ever drunk alcohol just after waking up?) to which subjects reply Yes or No: one positive answer to this test indicates a "suspicion," two a "strong probability," at least three a "certainty" of the existence of an alcohol-related problem.

With regard to at-risk behaviours (ever, past year and past month), two items were included relating to simultaneous use of multiple narcotic substances (mix) and alcohol plus narcotics in the same evening. The subjects were also asked if they had ever driven after drinking.

As for problems encountered during the past year, the following were identified: hospitalisation, psychiatric problems, treatment with psychotropic drugs, contacts with law enforcement, addiction, detox, overdose, traffic accidents, significant economic problems, and psychological problems such as depression and mood swings, anxiety and panic attacks, paranoia and feelings of persecution, memory problems, sleep problems (insomnia, nightmares), physical and psychosomatic problems (headache, fainting spells, tachycardia, nausea, gastritis, hallucinations).

In order to estimate the "interviewer effect," the consistency of the subject's responses to two different interviewers was checked. Cohen's Kapa test was used to measure reproducibility.

The questionnaire is structured with preset answers for all items. A total of 35 researchers were used after they had been given special training. During the training, special emphasis was given to how to contact young people and how to ask questions relating to the presence of "problems." The interviews lasted an average of 10-15 minutes.

Statistical analyses – In order to describe the characteristics of the subjects interviewed, contingency tables were used and frequencies were analysed. In order to assess the relationship among the various types of problems and the other indicators used, a univaried analysis was done first, and then a multivaried analysis, which made it possible to assess probability of entire groups of variables.

A logical regression was done to calculate probability; the ODDS RATIO was calculated with relative confidence intervals at 95%. This method was used to calculate the at-risk profiles for the various types of problems.

STATA 8.0 was used to analyse the data.

Below are the results of the study:

Characteristics of those interviewed**:** In all, 2015 subjects were interviewed, with an average age of 25.1 – higher among males (25.5) than females (24.6); in particular, one out of five subjects were under age 20, one in two was between 20 and 29, and 5% were over 40.

Of those interviewed, 42% were females, 3.4% foreign, 66% live with their original family, 67% work, 42% go to school, 12% go to school and work, 27% graduated from lower middle school, 61% have a secondary school diploma, and 11% have a university degree.

The subjects interviewed came from 19 Italian regions: 36% from Tuscany, 27% Emilia Romagna, 8% from Lombardy, 5% from Lazio, 4% from Veneto. No differences were found in terms of sex: 39% of the females were residents of Tuscany, 27% of Emilia Romagna, 8% of Lombardy.

Socialising – In terms of the preferred events and places for gathering, we find concerts, pubs, cinemas, and beer halls followed by coffee shops, discothèques, social centres and disco-pubs. Parish youth clubs and game rooms were not popular.

Compared to the males, it appears that when females go out they prefer pubs, movies, and gyms, and less often to coffee shops, beer halls, wine bars, discos, social centres, rave parties and stadiums.

In terms of context, comparisons show that those interviewed at concerts prefer coffee shops, pubs, beer halls, discos, wine bars, concerts and gyms; those interviewed at the Street Rave prefer social centres; those interviewed at Arezzo Wave prefer movies, stadiums and private clubs.

Satisfaction – Overall, 63% are "not satisfied": 38% are very concerned about their own future, 31% are dissatisfied with their jobs; 28% with parents or school, 22% with their partners or friends.

In terms of gender differences, the females on average are less satisfied than the males and in all of the areas considered except their jobs.

Most important thing…. - The most important thing is "love" followed by "family," "learning new things," "friends," "travelling," and "having fun." For females, the most important thing is "love" followed by "family," whereas for males it is "learning new things" followed by "love."

For those interviewed at concerts, the most important thing is "love"; at the Street Rave, "learning new things"; at Arezzo, "family."

Traffic accidents: last accident/infraction – 74% of those who were in an accident were driving. Of the accidents occurring while the interviewee was driving, 40% occurred on the weekend, 28% went off the road, and 32% between 10 p.m. and 6:00 a.m.

Males had the higher percentages of accidents on weekends, going off the road, and between 10:00 p.m. and 6:00 a.m.

In all, 75% have a driver license, 6% had theirs suspended, 3% had theirs withdrawn, and 12% had points deducted.

Of the cases of points deducted, 35% involved speeding, 22% involved failure to use seatbelts/helmet.

Of the cases of licenses withdrawn, 22% involved driving under the influence of alcohol or drugs; 25% of the suspensions involved drunk driving and 18% speeding.

We find a higher percentage of males than females among subjects with a license, and with a license withdrawal, suspended, or with points deducted.

Traffic accidents appear correlated with at-risk behaviours: we find a greater likelihood of accidents among those who stated they had driven at least once in the past year after drinking alcohol or consuming various types of substances during the evening, and among those who answered affirmatively to at least two items on the C.AG.E. test..

Alcohol use – 85% of those interviewed regularly drink alcohol, 46% only on weekends. During the past year, 41% drank several times a week, 10% every day.

One in four believes he or she should reduce his/her drinking; 7% have been criticised for they way they drink; 15% have drunk at least once upon awakening; 13% have had feelings of guilt over their drinking. 41% answered affirmatively to one of the items on the C.AG.E. test, 19% to at least two, 7% to at least three, and 2% to all four.

Compared to females, males have a higher prevalence of alcohol use and positivity on the C.AG.E. test; females prefer to drink on weekends.

Table 1 shows the results of the multivaried analysis; those values that are 95% statistically significant are shown in bold. Foreign rather than Italian nationality, being unemployed, regular attendance at coffee shops, drinking alcohol frequently, driving after drinking, mixing alcohol with narcotics, and using several types of narcotics in the same evening are all variables associated with a greater probability of positive answers to at least two items on the C.AG.E. test. In terms of event, we find a greater likelihood among those interviewed at concerts and among those residing in Emilia Romagna.

We also find an effect from level of education, albeit not statistically significant: probability declines in relation to level of schooling.

Table 1 – Profile at risk for positive answers to 2 C.AG.E.A test items – Odds Ratio (the values shown in bold are 95% statistically significant).

	O.R.			O.R.			O.R.
concerts	**1**		**coffee shops**	1.5		**Emilia Romagna**	**1**
raves	0.6		**pubs**	**1.2**		**Tuscany**	0.6
Arezzo	**0.9**		**beer hall**	**1.1**		**Lombardy**	**0.8**
			discos	**0.9**		**Lazio**	**0.7**
males	**1.1**		**private clubs**	**1.0**		**Other**	**1.0**
age >=25	**0.9**		**social centre**	**1.1**			
foreigners	2.3		**disco-pubs**	**0.8**		**work**	0.8
			gaming halls	**1.4**		**school**	0.6
family	**1**		**wine bars**	**1.3**		**work/school**	2.3
with others	**1.1**		**raves**	**1.2**			
alone	**1.4**		**concerts**	**1.0**		**drug use ever**	**0.9**
			movies	**0.8**		**mix ever**	2.1
middle school	**1**		**stadiums**	**0.8**		**alc. mix ever**	2.5
secondary school	**0.7**		**parish centre**	**1.0**		**alcohol always**	1.8
university	**0.5**		**gym**	**0.8**		**driving after drinking**	1.8

At-risk behaviours – The prevalence of narcotics use and at-risk behaviours is higher among males than females and more widespread among the participants at Street Rave Parade followed by those interviewed at Arezzo Wave and at concerts. These are widespread behaviours that persist over time: more than half of those who have tried a substance continue to use it.

79% have used an illegal substance at least once ever, 64% in the past year, 54% in the past month.
69% of those who have tried an illegal substance at least once have also used it in the past month.
36% have used multiple narcotics in the same evening (mix), 26% in the past year, 16% in the past month. 45% of those who have tried at least one mix of narcotics have also done so in the past month.
65% have used alcohol and narcotics in the same evening at least once, 52% in the past year, 41% in the past month. 64% of those who have tried it at least once have also done so in the past month.
61% have driven at least once after having drunk alcohol, 48% in the past year, 36% in the past month.
59% of those who have done so at least once have engaged in the same behaviour during the last month as well.

Table 2 – Prevalence of substance use and at-risk behaviours – comparison by type of event and by gender

		Total	%	females	%	males	%
substance use	**ever**	**1581**	**78.5**	**602**	**71.4**	**979**	**83.5**
	year	**1296**	**64.3**	**481**	**57.1**	**815**	**69.5**
	month	**1093**	**54.2**	**390**	**46.3**	**703**	**60.0**
	month/ever	**69.1**		**64.8**		**71.8**	
mix	**ever**	**724**	**35.9**	**219**	**26.0**	**505**	**43.1**
	year	**532**	**26.4**	**168**	**19.9**	**364**	**31.1**
	month	**328**	**16.3**	**99**	**11.7**	**229**	**19.5**
	month/ever	**45.3**		**45.2**		**45.3**	
alc. mix	**ever**	**1303**	**64.7**	**483**	**57.3**	**820**	**70.0**
	year	**1053**	**52.3**	**379**	**45.0**	**674**	**57.5**
	month	**835**	**41.4**	**285**	**33.8**	**550**	**46.9**
	month/ever	**64.1**		**59.0**		**67.1**	
drink/drive	**ever**	**1229**	**61.0**	**412**	**48.9**	**817**	**69.7**
	year	**960**	**47.6**	**321**	**38.1**	**639**	**54.5**
	month	**719**	**35.7**	**232**	**27.5**	**487**	**41.6**
	month/ever	**58.5**		**56.3**		**59.6**	

Hence we find a high prevalence of at-risk behaviours in relation to the use of narcotics and alcohol, including combinations thereof, and to driving after drinking. These are persistent habits established over time, common to both males and females.
The use of narcotics is widespread and crosses through the various socialising venues: it is habitual not only among frequenters of social centres, raves and concerts but also discos, stadiums, gyms and parish youth clubs.
Half of those interviewed state they have used some drug in the past month: those who have tried substances continue to use them.
Of those having used a narcotic substance at least once ever, we find an overdose prevalence of 2%, higher among males, whereas among current consumers 3% inject, especially for heroin, cocaine and ketamine.
Also in the past month, one out of three people interviewed state that they have driven after drinking, one in six has used multiple substances in the same evening, and two out of five combine alcohol and narcotics: these are deeply rooted behaviours that continue over time.

Narcotic substances – Table 3 shows a breakdown of narcotic substances used ever, in the past year, and in the past month in terms of the total and by gender.
Those interviewed report a high use of varied substances, especially the cannabinoids, cocaine, poppers, hallucinogenic mushrooms, ecstasy, amphetamines and LSD. In terms of current use, at least one subject in two has used cannabinoids, one in ten cocaine, 8% ecstasy or amphetamines during the past month.
In terms of gender, males have a higher prevalence relative to each individual substance than do females. It should be noted that 40% of males and 30% of females have tried cocaine at least once ever and 15% and 9%, respectively, in the past month.

Table 3: Substances used ever/in past year/past month – percentage comparisons by gender

	males							females					
	ever	%	year	%	month	%		ever	%	year	%	month	%
Heroin	**137**	**11.7**	**67**	**5.7**	**42**	**3.6**		**45**	**5.3**	**23**	**2.7**	**14**	**1.7**
Benzodiazepine	**55**	**4.7**	**30**	**2.6**	**13**	**1.1**		**19**	**2.3**	**8**	**0.9**	**4**	**0.5**
Cocaine	**485**	**41.4**	**329**	**28.1**	**172**	**14.7**		**235**	**27.9**	**154**	**18.3**	**76**	**9.0**
Crack	**92**	**7.8**	**52**	**4.4**	**25**	**2.1**		**30**	**3.6**	**18**	**2.1**	**9**	**1.1**
Amphetamines	**307**	**26.2**	**191**	**16.3**	**115**	**9.8**		**129**	**15.3**	**72**	**8.5**	**42**	**5.0**
Hashish	**863**	**73.6**	**720**	**61.4**	**635**	**54.2**		**475**	**56.3**	**380**	**45.1**	**326**	**38.7**
Marijuana	**915**	**78.1**	**737**	**62.9**	**624**	**53.2**		**558**	**66.2**	**436**	**51.7**	**351**	**41.6**
LSD	**312**	**26.6**	**133**	**11.3**	**50**	**4.3**		**120**	**14.2**	**42**	**5.0**	**21**	**2.5**
Ketamine	**150**	**12.8**	**88**	**7.5**	**51**	**4.4**		**73**	**8.7**	**42**	**5.0**	**23**	**2.7**
Mushrooms	**345**	**29.4**	**182**	**15.5**	**50**	**4.3**		**144**	**17.1**	**80**	**9.5**	**22**	**2.6**
Salvia	**214**	**18.3**	**154**	**13.1**	**52**	**4.4**		**88**	**10.4**	**59**	**7.0**	**18**	**2.1**
Opium	**246**	**21.0**	**126**	**10.8**	**68**	**5.8**		**86**	**10.2**	**49**	**5.8**	**24**	**2.8**
Ecstasy	**318**	**27.1**	**190**	**16.2**	**117**	**10.0**		**143**	**17.0**	**80**	**9.5**	**37**	**4.4**
Poppers	**378**	**32.3**	**186**	**15.9**	**65**	**5.5**		**163**	**19.3**	**61**	**7.2**	**20**	**2.4**
Psychotropic drugs	**114**	**9.7**	**47**	**4.0**	**23**	**2.0**		**53**	**6.3**	**20**	**2.4**	**8**	**0.9**

Only 28 subjects have injected drugs: 2.6% among those having stated they used some substance in the month preceding the interview: 2% heroin, 4% cocaine, 0.5% ketamine, 0.4% opiates, one subject benzodiazepine. The prevalence is 3% among males and 1.8% among females.
Overdoses, which are discussed in the "problems" section, involve 2% of those who have tried a substance at least once ever, 2.5% among males and 1.2% among females.
The average age at first use is 16.3, and while it is lower among consumers of cannabinoids, it rises with the danger of the substance (heroin, crack) and is higher for substances appearing recently on the market (opium, salvia divinorum).

The females are slightly older at first use than males.
The average age of current consumers is 23.7; it is lower for substances appearing recently on the market (opium, salvia divinorum) and higher for "heavy" substances (heroin, crack). The females are on average younger than the males.

Table 4: Age at first use/current age for those using in the past month – percentage comparison by gender

	First use				**Use in past month**		
	F	M	TOT		F	M	TOT
Total	**16.5**	**16.2**	**16.3**		**22.3**	**24.5**	**23.7**
Heroin	**18.3**	**18.6**	**18.5**		**23.1**	**25.7**	**25.0**
Benzodiazepine	**19.6**	**18.8**	**19.0**		**21.3**	**24.3**	**23.6**
Cocaine	**19.0**	**18.9**	**18.9**		**23.0**	**24.9**	**24.3**
Crack	**18.5**	**20.0**	**19.6**		**23.0**	**25.5**	**24.9**
Amphetamines	**17.9**	**18.5**	**18.4**		**22.2**	**23.9**	**23.5**
Hashish	**16.1**	**16.0**	**16.0**		**22.6**	**24.5**	**23.8**
Marijuana	**16.3**	**16.1**	**16.2**		**22.5**	**24.3**	**23.7**
LSD	**17.6**	**18.0**	**17.9**		**21.8**	**23.9**	**23.3**
Ketamine	**18.5**	**20.1**	**19.6**		**20.4**	**23.3**	**22.4**
Hallucinogenic mushrooms	**19.1**	**19.8**	**19.6**		**20.2**	**23.9**	**22.8**
Salvia divinorum	**19.7**	**20.4**	**20.2**		**20.1**	**22.4**	**21.8**
Opium	**18.4**	**19.8**	**19.4**		**22.2**	**22.2**	**22.2**
Ecstasy	**18.6**	**19.2**	**19.0**		**20.8**	**23.8**	**23.1**
Poppers	**17.6**	**18.3**	**18.1**		**21.3**	**23.0**	**22.6**
Psychotropic drugs	**17.5**	**18.4**	**18.1**		**21.5**	**24.5**	**23.7**

In terms of subjects stating they have used narcotic substances in the past month, 1.1% tried for the first time in the past month, 3.8% in the past year, and 60% have been using for more than five years.

Among males, 0.7% tried for the first time in the past month, 3.4% in the past year, and 64% have been using for more than five years. Among females, 1.8% tried for the first time in the past month, 4.6% in the past year, and 51% have been using for more than five years.

Table 6, regarding subjects stating they used narcotics in the past month, shows the time elapsed since the first use for each individual substance.
In the past month, 5% for the first time used Salvia divinorum, 2.6% cocaine, about 2% Ecstasy, hallucinogenic mushrooms, opium and poppers, and seven subjects (0.6%) heroin.
61% have been using marijuana, 56% hashish, 21% cocaine, 13% amphetamines, LSD and Ecstasy, and 6% heroin for more than five years.

Table 6 – Time elapsed since first use by substance –percentage comparison

	past month	%	past year	%	from 2 to 5 years	%	from 5 to 10 years	%	> 10 years	%
Total	**12**	**1.1**	**30**	**2.7**	**330**	**30.2**	**403**	**36.9**	**258**	**23.6**
Heroin	**7**	**0.6**	**12**	**1.1**	**54**	**4.9**	**40**	**3.7**	**28**	**2.6**
Opiates	**9**	**0.8**	**26**	**2.4**	**89**	**8.1**	**52**	**4.8**	**32**	**2.9**
Benzodiazepine	**2**	**0.2**	**7**	**0.6**	**13**	**1.2**	**15**	**1.4**	**7**	**0.6**
Cocaine	**28**	**2.6**	**57**	**5.2**	**221**	**20.2**	**167**	**15.3**	**60**	**5.5**
Crack	**2**	**0.2**	**13**	**1.2**	**48**	**4.4**	**21**	**1.9**	**9**	**0.8**
Amphetamines	**15**	**1.4**	**27**	**2.5**	**125**	**11.4**	**103**	**9.4**	**36**	**3.3**
Hashish	**7**	**0.6**	**25**	**2.3**	**293**	**26.8**	**374**	**34.2**	**241**	**22.0**
Marijuana	**7**	**0.6**	**32**	**2.9**	**307**	**28.1**	**386**	**35.3**	**284**	**26.0**
LSD	**11**	**1.0**	**19**	**1.7**	**118**	**10.8**	**107**	**9.8**	**40**	**3.7**
Ketamine	**11**	**1.0**	**39**	**3.6**	**83**	**7.6**	**32**	**2.9**	**3**	**0.3**
Mushrooms	**23**	**2.1**	**50**	**4.6**	**182**	**16.7**	**89**	**8.1**	**24**	**2.2**
Salvia	**52**	**4.8**	**79**	**7.2**	**78**	**7.1**	**28**	**2.6**	**2**	**0.2**
Opium	**21**	**1.9**	**43**	**3.9**	**123**	**11.3**	**46**	**4.2**	**15**	**1.4**
Methadone	**5**	**0.5**	**6**	**0.5**	**9**	**0.8**	**8**	**0.7**	**4**	**0.4**
Ecstasy	**22**	**2.0**	**31**	**2.8**	**141**	**12.9**	**118**	**10.8**	**29**	**2.7**
Poppers	**20**	**1.8**	**40**	**3.7**	**173**	**15.8**	**132**	**12.1**	**37**	**3.4**
Psychotropic drugs	**9**	**0.8**	**18**	**1.6**	**38**	**3.5**	**35**	**3.2**	**15**	**1.4**

In the past year, 3% used a narcotic substance for the first time. For the first time in the past year, 12% used Salvia divinorum, 8% cocaine, 7% hallucinogenic mushrooms, 6% opium and poppers, 5% Ecstasy and ketamine, 4% amphetamines and marijuana, 1.7% heroin.
Among males, in the past year 3.4% used a narcotic substance for the first time: 14% used Salvia divinorum, 7% cocaine and opium, 6% poppers and hallucinogenic mushrooms, 5% Ecstasy, 4% ketamine and amphetamines, 3% marijuana, 1.6% heroin for the first time.

Among females, in the past year 4.6% used a narcotic substance for the first time: 10% used cocaine, 9% Salvia divinorum, 7% hallucinogenic mushrooms, 5% Ecstasy, poppers and ketamine, 4% marijuana, opium and amphetamines, 2.1% heroin for the first time.
Use of various types of narcotics - Whereas more than half of subjects who tried cannabinoids at least once also consumed during the past month, for heroin use this ratio involves one in three. Among subjects having tried heroin, cannabinoid use is frequent; among those who have tried cannabinoids, one in ten have also tried heroin.
In terms of recent use, 14% who consumed cannabinoids in the past month have tried heroin at once ever and 5% have used it recently.
Table 7 shows the results of the multivaried analysis relating to narcotic substances used during the past month. The number of subjects involved number 1,093. The variables input into the model, in terms of the past month, include all narcotic substances, and having declared having used multiple narcotics (mix) and narcotics together with alcohol in the same evening. Figures shown in bold are 95% statistically significant. This analysis seeks to identify the most frequent forms of multiple use, the association between the use of various types of narcotics and the association between narcotics and alcohol.

In terms of the mix of narcotics, we find a 95% statistically significant probability for those having used the following in the past month: Heroin (O.R. 2.5 I.C. 1.1 – 6.1), Cocaine (O.R. 4.2 I.C. 2.9 – 6.1), Amphetamines (O.R. 2.0 I.C. 1.2 – 3.3), Hallucinogenic mushrooms (O.R. 3.9 I.C. 1.9 – 8.1), Ecstasy (O.R. 4.5 I.C. 2.8 – 7.4) and Poppers (O.R. 4.0 I.C. 2.1 – 7.7).

In terms of narcotics mixed with alcohol, we find a 95% statistically significant probability for those who in the past month used Cocaine (O.R. 1.7 I.C. 1.1 – 2.6), Hashish (O.R. 1.5 I.C. 1.1 – 2.2), Marijuana (O.R. 1.8 I.C. 1.2 – 2.7) and Poppers (O.R. 2.9 I.C. 1.3 – 6.7).

Table 7: Relationship between substances used in past month: logical regression – Odds Ratio(figures in bold are 95% statistically significant)

?	Heroin	Benzo.	Cocaine	Crack	Anph.	Hashish	Marijuana	Lsd	Keta.	Mshrms	Salvia	Opium	Ecstasy	Poppers	Psycot.
month_mix	2.5	**0.3**	4.2	**3.2**	2.0	**1.5**	**1.1**	**1.9**	**2.0**	3.9	**1.0**	**1.2**	4.5	4.0	**1.1**
mix_alc	**1.2**	**0.5**	1.7	**0.7**	**1.4**	1.5	1.8	**1.0**	**0.9**	**1.3**	**0.8**	**0.7**	**1.4**	2.9	**0.9**
Heroin		**4.0**	**1.6**	**5.0**	3.9	**0.6**	**1.5**	**0.5**	**2.2**	**0.8**	**1.0**	**1.0**	**1.2**	**0.9**	4.5
Opiates	3.6	**2.8**	**1.3**	**0.8**	**1.4**	**0.8**	**0.6**	**1.7**	**1.2**	**1.0**	**1.2**	3.1	**1.5**	**1.8**	**0.8**
Benzodiazepine	5.4		**1.1**	**0.8**	**0.4**	**0.5**	**1.0**	9.4	**5.2**	**0.4**	**0.4**	6.3	**2.2**	**0.2**	23.0
Cocaine	**1.6**	**1.1**		6.4	2.6	**1.4**	**0.7**	**1.4**	2.5	**1.6**	**1.2**	1.9	**1.2**	3.7	**0.8**
Crack	5.2	**0.7**	7.0		**1.2**	**1.1**	**0.8**	**2.5**	**1.1**	4.0	**0.9**	**1.2**	3.7	**0.6**	**0.3**
Amphetamines	4.1	**0.5**	2.8	**0.8**		**2.1**	0.2	2.6	6.9	2.4	**1.8**	**1.5**	7.3	**1.9**	**1.3**
Hashish	**0.7**	**0.7**	**1.4**	**0.8**	**1.8**		12.2	**0.8**	**0.9**	**1.3**	**3.5**	**1.3**	**1.5**	**1.2**	**2.7**
Marijuana	**1.5**	**1.4**	**0.7**	**0.8**	0.3	12.2		**0.8**	**1.9**	6.5	**3.9**	2.9	**0.8**	3.1	**0.7**
Lsd	**0.5**	7.2	**1.7**	**2.1**	2.6	**0.8**	**0.7**		**2.1**	5.1	**1.7**	4.3	**1.8**	2.8	**0.4**
Ketamine	2.5	**2.0**	3.1	**1.0**	7.4	**0.7**	**2.0**	**2.2**		**2.1**	2.6	**1.4**	3.2	**0.5**	**0.6**
Funghi	**0.9**	**0.5**	**1.6**	3.9	**2.2**	**1.3**	5.4	5.2	**1.7**		**2.1**	**1.4**	**0.5**	2.7	**3.2**
Salvia	**1.2**	**0.8**	**1.3**	**0.6**	**1.5**	**3.0**	**3.3**	**1.2**	**1.7**	**1.9**		**1.9**	**1.5**	**2.0**	**1.7**
Opium	**1.1**	**3.4**	2.0	**1.0**	**1.4**	**1.1**	**2.4**	4.0	**1.2**	**1.4**	**1.9**		2.1	**0.6**	**3.3**
Methadone	35.1	**2.4**	**4.0**	**4.5**	**0.7**	**0.5**	**1.2**	**1.0**	**0.8**	**1.5**	**0.3**	**2.2**	**1.4**	**1.3**	**6.0**
Ecstasy	**1.2**	**2.1**	**1.2**	3.6	7.2	**1.5**	**0.8**	**1.6**	2.4	0.4	**1.3**	1.9		2.7	**0.8**
Poppers	**0.9**	**0.4**	3.9	**0.6**	**1.9**	**1.1**	**3.1**	2.4	**0.5**	2.9	2.6	**0.6**	2.8		**1.2**
Psychotropic drugs	6.3	13.0	**0.8**	**0.2**	**1.6**	**2.9**	**0.6**	**0.4**	**1.0**	3.9	**2.5**	**2.8**	**0.7**	**1.2**	

Among subjects having used Heroin in the past month, there is a strong likelihood of use of Crack (O.R. 5.0 I.C. 1.5 – 16.2), Amphetamines (O.R. 3.9 I.C. 1.5 – 9.7) and Psychotropic drugs (O.R. 4.5 I.C. 1.1 – 18.1). As for Crack, we find a relationship with Heroin (O.R. 5.2 I.C. 1.8 – 15.2), Cocaine (O.R. 7.1 I.C. 2.6 – 19.0), Hallucinogenic mushrooms (O.R. 4.0 I.C. 1.4 – 11.0) and Ecstasy (O.R. 3.7 I.C. 1.5 – 9.5). As for Benzodiazepine, we find the use of Heroin (O.R. 5.4 I.C. 1.1 – 25.2), LSD (O.R. 9.4 I.C. 1.5 – 60.3), Opium (O.R. 6.3 I.C. 1.3 – 31.0) and Psychotropic drugs (O.R. 23.0 I.C. 3.5 – 150.1). Ketamine with Heroin (O.R. 2.5 I.C. 1.0 – 6.1), Cocaine (O.R. 3.1 I.C. 1.6 – 6.0), Amphetamines (O.R. 7.4 I.C. 3.6 – 15.2), Salvia divinorum (O.R. 2.6 I.C. 1.1 – 5.9) and Ecstasy (O.R. 3.2 I.C. 1.6 – 6.3). Psychotropic drugs with Heroin (O.R. 6.3 I.C. 1.8 – 22.8), Benzodiazepine (O.R. 13.0 I.C. 2.8 – 61.4) and Hallucinogenic mushrooms (O.R. 3.9 I.C. 1.1 –14.5).

As regards Cocaine, we find a relationship with the use of Crack (O.R. 6.4 I.C. 2.3 – 17.7), Amphetamines (O.R. 2.6 I.C. 1.6 – 4.2), Ketamine (O.R. 2.5 I.C. 1..31 – 4.8), Opium (O.R. 1.9 I.C. 1.1 – 3.3) and Poppers (O.R. 3.7 I.C. 2.1 – 6.5). Amphetamines with Heroin (O.R. 4.1 I.C. 1.7 – 9.8), Cocaine (O.R. 2.8 I.C. 1.7 – 4.5), LSD (O.R. 2.6 I.C. 1.2 – 5.6), Ketamine (O.R. 6.9 I.C. 3.3 – 14.2), Hallucinogenic mushrooms (O.R. 2.4 I.C. 1.1 – 5.2), Ecstasy (O.R. 7.3 I.C. 4.4 – 12.0) and a negative relationship with the use of Marijuana (O.R. 0.2 I.C. 0.1 – 0.4). LSD with Benzodiazepine (O.R. 7.3 I.C. 1.5 – 35.5), Amphetamines (O.R. 2.6 I.C. 1.2 – 5.6), Hallucinogenic mushrooms (O.R. 5.1 I.C. 2.3 – 11.1), Opium (O.R. 4.3 I.C. 2.0 – 9.1) and Poppers (O.R. 2.8 I.C. 1.3 – 6.3). Hallucinogenic mushrooms with Crack (O.R. 3.9 I.C. 1.4 – 10.8), Marijuana (O.R. 5.4 I.C. 1.0 – 29.2), LSD (O.R. 5.2 I.C. 2.4 – 11.4) and Poppers (O.R. 2.7 I.C. 1.3 – 5.6). Opium with Cocaine (O.R. 2.0 I.C. 1.1 – 3.5), LSD (O.R. 4.0 I.C. 1.9 – 8.3) and Ecstasy (O.R. 2.1 I.C. 1.1 – 4.0). Ecstasy with Crack (O.R. 3.6 I.C. 1.4 – 9.5), Amphetamines (O.R. 7.2 I.C. 4.4 – 11.9), Ketamine (O.R. 2.4 I.C. 1.2 – 4.7), Opium (O.R. 1.9 I.C. 1.0 – 3.7), Poppers (O.R. 2.7 I.C. 1.4 – 5.2). Poppers with Cocaine (O.R. 3.9 I.C. 2.3 – 6.8), LSD (O.R. 2.4 I.C. 1.1 – 5.2), Hallucinogenic mushrooms (O.R. 2.9 I.C. 1.4 – 5.9), Salvia divinorum (O.R. 2.6 I.C. 1.3 – 5.2), Ecstasy (O.R. 2.8 I.C. 1.5 – 5.1). As regards Hashish we find a strong relationship with use of Marijuana (O.R. 12.2 I.C. 8.1 –

18.2), and as for Marijuana we find a relationship with the use of Hashish (O.R. 12.2 I.C. 8.2 – 18.2), Opium (O.R. 2.9 I.C. 1.1 – 7.8), Poppers (O.R. 3.1 I.C. 1.1 – 9.1), and a negative relationship with Amphetamines (O.R. 0.3 I.C. 0.1 – 0.5).

Table 8 shows the results of the multivaried analysis in relation to narcotic substances tried at least ever. The variables input into the model are all the narcotic substances which the interviewees reported having used at least once. The subjects numbered 1,581. The figures shown in bold are 95% statistically significant.

Table 8: Relationship between substances used ever: logical regression – Odds ratio (figures in bold are 95% statistically significant)

?	Heroin	Benzo.	Cocaine	Crack	Anph.	Hashish	Marijuana	Lsd	Ketamine	Mshrms	Salvia	Opium	Ecstasy	Poppers	Psychot
Heroin		1.3	**2.1**	2.4	2.0	3.0	**0.4**	**1.6**	**1.1**	**1.0**	**1.2**	**2.4**	1.5	**0.7**	3.3
Benzodiazepine	**1.5**		**1.3**	**1.1**	**2.3**	**0.7**	**0.7**	**2.3**	**1.2**	**1.1**	**0.8**	**1.1**	**1.7**	**0.5**	8.8
Cocaine	**1.7**	**1.5**		8.8	2.6	1.6	**0.7**	**1.4**	1.6	**1.8**	**1.2**	1.6	3.6	3.1	**1.5**
Crack	2.4	**1.2**	11.0		**1.7**	0.3	**2.4**	**1.2**	1.8	**1.3**	2.4	**1.6**	**1.8**	**1.2**	**0.8**
Amphetamines	2.0	**2.3**	2.9	**1.4**		2.4	0.3	2.2	3.8	**1.1**	**1.5**	**1.3**	4.4	2.1	**1.2**
Hashish	**2.1**	**0.6**	1.5	**0.4**	2.1		3.2	**3.1**	**0.8**	**1.9**	**4.0**	**0.9**	**1.8**	**1.3**	**1.4**
Marijuana	**0.7**	**1.1**	**0.7**	**1.6**	0.4	3.1		**1.6**	**1.6**	**1.4**	3.8	**2.3**	**1.8**	2.5	**1.4**
Lsd	**1.6**	2.7	1.5	**1.3**	**2.2**	3.2	**1.2**		1.8	**2.9**	**1.0**	**2.7**	**3.0**	1.4	**1.3**
Ketamine	**1.2**	**1.1**	2.0	1.8	3.7	**0.8**	**1.2**	1.8		2.6	**1.3**	**1.4**	1.9	**1.4**	**1.0**
Funghi	**1.0**	**1.0**	2.0	**1.2**	**1.0**	2.3	**1.1**	2.9	2.5		2.8	2.7	2.0	2.5	**1.1**
Salvia	**1.2**	**0.9**	**1.3**	2.3	**1.4**	3.4	**2.9**	**1.0**	**1.2**	2.7		1.8	**1.2**	**1.9**	**0.9**
Opium	2.5	**1.0**	1.6	**1.7**	**1.2**	**0.8**	**2.3**	2.7	**1.5**	2.8	1.9		**0.8**	**1.4**	**0.9**
Ecstasy	1.4	**1.3**	3.6	**1.6**	4.3	**2.0**	**1.3**	3.0	1.8	2.1	**1.2**	**0.8**		1.7	**1.5**
Poppers	**0.6**	**0.5**	3.0	**1.2**	1.9	**1.2**	2.1	**1.3**	**1.3**	**2.4**	**1.9**	**1.3**	1.5		**3.2**
Psychotropic drugs	3.3	8.8	**1.7**	**0.8**	**1.1**	**1.4**	**1.2**	**1.3**	**0.9**	**1.1**	**1.0**	**0.9**	**1.5**	3.0	

Those who have tried Heroin have also probably used Cocaine (O.R. 2.1 I.C. 1.1 – 4.3), Crack (O.R. 2.4 I.C. 1.4 – 4.2), Amphetamines (O.R. 2.0 I.C. 1.1 – 3.8), Opium (O.R. 2.4 I.C. 1.4 – 4.1), Psychotropic drugs (O.R. 3.3 I.C. 1.9 – 5.7). As for Benzodiazepine with Opiates (O.R. 2.5 I.C. 1.2 – 5.0) and Psychotropic drugs (O.R. 8.8 I.C. 4.5 – 17.1). Crack with Heroin (O.R. 2.4 I.C. 1.4 – 4.2), Cocaine (O.R. 11.0 IC. 3.1 – 39.2), Ketamine (O.R. 1.8 I.C. 1.1 – 3.0) and Salvia divinorum (O.R. 2.4 I.C. 1.5 – 3.9) and a negative probability for the use of Hashish (O.R.0.3 I.C. 0.1 – 0.9). Ketamine with Cocaine (O.R. 2.0 I.C. 1.1 – 3.8),Crack (O.R. 1.8 I.C. 1.1 – 3.0), Amphetamines (O.R. 3.7 I.C. 2.2 – 6.2), LSD (O.R. 1.8 I.C. 1.1 – 2.9), Hallucinogenic mushrooms (O.R. 2.6 I.C. 1.6 – 4.2) and Ecstasy (O.R. 1.9 I.C. 1.1 – 3.2). Psychotropic drugs with Heroin (O.R.3.3 I.C. 1.9 – 5.6), Benzodiazepine (O.R. 8.8 I.C. 4.5 – 17.2), and Poppers (O.R. 3.0 I.C. 1.8 – 5.1). Cocaine with Crack (O.R. 8.8 I.C. 2.4 – 31.9), Amphetamines (O.R. 2.6 I.C. 1.7 – 3.9), Hashish (O.R. 1.7 I.C. 1.1 – 2.3), Hallucinogenic mushrooms (O.R. 1.8 I.C. 1.3 – 2.6), Ecstasy (O.R. 3.6 I.C. 2.5 – 5.4), Poppers (O.R. 3.1 I.C. 2.2 – 4.2). Amphetamines with Heroin (O.R. 2.0 I.C. 1.1 – 3.7), Hashish (O.R. 2.4 I.C. 1.2 – 5.1), Cocaine (O.R. 2.9 I.C. 1.9 – 4.3), LSD (O.R. 2.2 I.C. 1.5 – 3.3), Ketamine (O.R. 3.8 I.C. 2.3 – 6.4), Ecstasy (O.R. 4.4 I.C. 3.9 – 6.4), Poppers (O.R. 2.1 I.C. 1.4 – 3.0) and a negative probability for the use of Marijuana (O.R. 0.3 I.C. 0.2 – 0.6).
LSD with Benzodiazepine (O.R. 2.7 I.C. 1.1 – 6.8), Cocaine (O.R. 1.5 I.C. 1.0 – 2.2), Amphetamines (O.R. 2.2 I.C. 1.5 – 3.3), Hashish (O.R. 3.2 I.C. 1.5 – 6.8), Ketamine (O.R. 1.8 I.C. 1.1 – 2.9), Hallucinogenic mushrooms (O.R. 2.9 I.C. 2.0 – 4.2), Opium (O.R. 2.7 I.C. 1.8– 4.1), Ecstasy (O.R. 3.0 I.C. 2.1 – 4.4) and Poppers (O.R. 1.4 I.C. 1.0 – 2.1). Hallucinogenic mushrooms with Cocaine (O.R. 2.0 I.C. 1.4 2.8), Hashish (O.R. 2.3 I.C. 1.2 – 4.2), Ketamine (O.R. 2.5 I.C. 1.5 – 4.2), Salvia divinorum (O.R. 2.8 I.C. 1.9 – 4.0), Opium (O.R2.7 I.C. 1.8 – 4.1), Ecstasy (O.R. 2.0 I.C. 1.4 – 3.0) and Poppers (O.R. 2.5 I.C. 1.8 – 3.4). Salvia divinorum with Crack (O.R. 2.3 I.C. 1.4 – 3.7), Hashish (O.R. 4.0 I.C. 1.6 – 10.1), Hallucinogenic mushrooms (O.R. 2.7 I.C. 1.9 – 4.0), Opium (O.R. 1.8 I.C. 1.2 – 2.7) and Poppers (O.R. 1.9 I.C. 1.3 – 2.7). Opium with Heroin (O.R. 2.5 I.C. 1.5 – 4.3), Cocaine (O.R. 1.6 I.C. 1.0 – 2.4), LSD (O.R. 2.7 I.C. 1.8 – 4.0), Hallucinogenic mushrooms (O.R. 2.8 I.C. 1.9 – 4.1) and Salvia divinorum (O.R. 1.9 I.C. 1.3 – 2.7). Ecstasy with Cocaine (O.R. 3.6 I.C. 2.5 – 5.3), Amphetamines (O.R. 4.3 I.C. 3.0 – 6.3),

LSD (O.R. 3.0 I.C. 2.1 – 4.4), Ketamine (O.R. 1.8 I.C. 1.1 – 3.0), Hallucinogenic mushrooms (O.R. 2.1 I.C. 1.5 – 3.1) and Poppers (O.R. 1.7 I.C. 1.2 – 2.4). Poppers with Cocaine (O.R.3.0 I.C. 2.2 – 4.1), Amphetamines (O.R. 1.9 I.C. 1.3 – 2.7), Marijuana (O.R. 2.1 I.C. 1.1 – 4.1), Hallucinogenic mushrooms (O.R. 2.4 I.C. 1.7 – 3.4), Salvia divinorum (O.R. 1.9 I.C. 1.3 – 2.7), Ecstasy (O.R. 1.5 I.C. 1.1 – 2.2) and Psychotropic drugs (O.R. 3.2 I.C. 1.9 – 5.3). Hashish with Cocaine (O.R. 1.5 I.C. 1.0 – 2.2), Amphetamines (O.R. 2.1 I.C. 1.0 – 4.2), Marijuana (O.R. 3.2 I.C. 2.1 – 4.9), LSD (O.R. 3.1 I.C. 1.5 – 6.7), Hallucinogenic mushrooms (O.R. 1.9 I.C. 1.0 – 3.6) and Salvia divinorum (O.R. 4.0 I.C. 1.6 – 11.1). Marijuana with Hashish (O.R. 3.1 I.C. 2.0 – 4.7), Salvia divinorum (O.R. 3.8 I.C. 1.1 – 12.7), Poppers (O.R. 2.5 I.C. 1.3 – 4.9) and a negative probability for Amphetamines (O.R. 0.4 I.C. 0.2 – 0.8).

Problems encountered – In terms of the past year, six out of 10 subjects have had a psychological problem; the most common are depression, anxiety and sleep disturbances. 3% have received treatment with psychotropic drugs and 1% have had psychiatric disturbances. 9% have had addiction problems, and 0.5% have overdosed. 15% have had significant economic problems, 6% problems with law enforcement, and 13% at least one traffic accident. Compared to males, females are more likely to experience psychological problems; males have a higher prevalence than females in terms of economic problems, problems with law enforcement, traffic accidents, addiction, memory problems and hallucinations.

At-risk profile – A multivaried analysis was done relative to any type of problem encountered in the past year. The variables input into the model were: gender, age, nationality, job situation, housing situation, schooling, use of alcohol ever, C.AG.E. test (at least two positive answers) and, for the past year, drug mix, drug+alcohol mix, driving after drinking, drug use. Included subjects numbered 1,996.

Table 9 shows the results of the multivaried analysis; those values that are 95% statistically significant are shown in bold.

Table 9: At-risk profile for problems en countered in past year – Odds Ratio (Figures shown in bold are 9 statistically significant)

?	econ	law	accid	addict	psych.	anxty	panic	paranoia	persec	memory	sleep	phys.	halluc	depress
concerts	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**
raves	**1.0**	**1.6**	2.0	1.2	**0.9**	**1.0**	0.5	**0.9**	0.4	**1.2**	**1.0**	1.6	**1.5**	**0.9**
Arezzo	**1.4**	**2.0**	3.3	**2.1**	**0.6**	2.0	0.6	**1.3**	0.4	**1.3**	1.9	2.3	**1.3**	1.9
males	**0.9**	2.1	**1.3**	**1.5**	**0.8**	0.4	0.3	0.6	**0.8**	**0.8**	0.7	0.5	**1.3**	0.5
age >=25	**1.2**	**0.7**	**0.7**	**1.2**	2.5	**1.2**	**1.2**	**0.9**	**1.2**	**1.0**	1.5	**1.3**	0.5	1.4
foreigners	**1.3**	**0.2**	**1.4**	**1.0**	**3.7**	**1.3**	**1.4**	**0.7**	**2.2**	**0.8**	**0.7**	**1.0**	**1.2**	**0.7**
Family	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**
with others	1.8	**1.4**	**1.0**	**1.4**	**1.1**	**1.3**	**1.1**	**1.0**	**0.8**	1.5	**0.9**	**1.1**	**1.1**	**1.0**
alone	**1.5**	**1.4**	**1.2**	**1.6**	**1.1**	**1.1**	**1.0**	**0.9**	**0.9**	**0.7**	**1.2**	**1.1**	**1.1**	**1.0**
work	1.6	**0.8**	1.6	**1.0**	0.3	**1.1**	**0.8**	**1.0**	**0.7**	**1.0**	**1.1**	**0.7**	**1.5**	**1.0**
school	**1.0**	0.5	**1.0**	**1.2**	**0.7**	1.4	**1.1**	**1.1**	2.2	1.5	**1.3**	**1.2**	2.1	1.4
middle school	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**
secondary school	0.7	0.4	**0.8**	**0.8**	**1.1**	**0.9**	**1.0**	0.7	0.4	0.7	**0.9**	**0.9**	0.4	**0.8**
university	0.5	0.1	**0.7**	**0.6**		**1.3**	**0.7**	0.3	0.3	0.4	**0.9**	**0.9**	**0.4**	**0.8**
mix	1.8	2.6	1.4	3.4	2.8	1.6	2.1	1.9	**1.9**	3.5	1.5	1.4	9.8	2.2
alcohol mix	**0.9**	**1.1**	**1.2**	**0.7**	0.3	**0.9**	**0.7**	**1.4**	**0.7**	**0.9**	**1.1**	**0.9**	**1.3**	0.7
driving after drinking	**1.0**	**1.4**	1.6	**1.1**	**1.9**	1.4	**1.0**	**1.4**	**1.2**	**1.3**	**0.9**	1.4	**1.1**	1.3
alcohol always	1.4	**1.1**	**1.0**	**1.0**	**0.6**	1.3	**1.2**	**1.2**	**1.3**	**1.2**	1.3	**1.2**	**1.3**	**1.1**
C.AG.E.	1.7	1.8	1.4	1.9	3.2	1.5	1.7	1.6	2.8	1.8	1.7	1.9	1.7	1.8
drug use year	1.7	3.3	**1.1**	2.8	**1.3**	**1.1**	**1.2**	1.9	**1.9**	1.6	**1.1**	**1.0**	**1.5**	1.6

In terms of economic problems, there is a higher statistically significant probability for those living "with others" R. 1.8 I.C. 1.3 – 2.5), for those working (O.R. 1.6 I.C. 1.1 – 2.8), for those who during the past year mixed multiple narcotics at least once in the same evening (O.R. 1.8 I.C. 1.3 – 2.4), for those who drink regularly (O.R. 1.4 I.C. 1.0 – 1.8),for those who responded affirmatively to at least two items on the C.AG.E. test (O.R. 1.7 I.C. 1.3 – 2.3), for those who used narcotics during

the past year (O.R. 1.7 I.C. 1.1 – 2.7). The probability is lower for those who graduated from upper middle school (O.R. 0.7 I.C. 0.5 – 0.9) and for those with a university degree (O.R. 0.5 I.C. 0.3 – 0.8) compared to subjects having graduated only from lower middle school.
In terms of problems with the law, there is a higher statistically significant probability for males (O.R. 2.1 I.C. 1.3 – 3.5), for those who in the past year mixed multiple narcotics at least once in the same evening (O.R. 2.6 I.C. 1.6 – 4.19), for those who answered affirmatively to at least two items on the C.AG.E. test (O.R. 1.8 I.C. 1.1 – 2.7), for those who used narcotics in the past year (O.R. 3.3 I.C. 1.2 – 8.6). The probability is lower for students (O.R. 0.5 I.C. 0.3 – 0.9) an d declines for those with an upper middle school diploma (O.R. 0.4 I.C. 0.3 – 0.7) and for those with a university degree (O.R. 0.1 I.C. 0.0 – 0.4) compared to subjects with only a lower middle school education.
In terms of traffic accidents, there is a higher statistically significant probability for subjects interviewed at the Street rave Parade (O.R. 2.0 I.C. 1.2 – 3.6) and at Arezzo Wave (O.R. 3.3 I.C. 2.0 – 5.6) compared to those interviewed at concerts; for those who work(O.R. 1.6 I.C. 1.1 – 2.3), for those who during the past year mixed multiple narcotics in the same evening (O.R. 1.4 I.C. 1.0 – 2.0), for those who in the past year drove at least once after drinking(O.R. 1.6 I.C. 1.2 – 2.2) and for those who answered affirmatively to at least two items on the C.AG.E. test (O.R. 1.4 I.C. 1.0 – 2.0).
In terms of addiction problems, there is a higher statistically significant probability for subjects interviewed at the Street rave Parade(O.R. 2.1 I.C. 1.1 – 4.0) compared to interviewed at concerts, for those who during the past year mixed multiple narcotics at least once in the same evening(O.R. 3.4 I.C. 2.3 – 5.2), and for those who answered affirmatively to at least two items on the C.AG.E. test(O.R. 1.9 I.C. 1.3 – 2.7), for those who used narcotics during the past year (O.R. 2.8 I.C. 1.5 – 5.6).
In terms of psychiatric problems, there is a higher statistically significant probability for those living older than the average (O.R. 2.5 I.C. 1.1 – 5.8), for those who during the past year mixed multiple narcotics in the same evening (O.R. 2.8 I.C. 1.1 – 7.2), and for those who answered affirmatively to at least two items on the C.AG.E. test (O.R. 3.2 I.C. 1.5 – 7.2), and lower for those who work (O.R. 0.3 I.C. 0.1 – 0.7) and for those who during the past year at least once used alcohol together with narcotics in the same evening(O.R. 0.3 I.C. 0.1 – 0.7).
In terms of symptoms of anxiety, there is a higher statistically significant probability for subjects interviewed at the Street Rave Parade(O.R. 2.0 I.C. 1.5 – 2.8) compared to those interviewed at concerts; for students(O.R. 1.4 I.C. 1.0 – 1.8), for those who during the past year mixed multiple narcotics in the same evening(O.R. 1.6 I.C. 1.2 – 2.2), for those who in the past year drove at least once after drinking(O.R. 1.4 I.C. 1.1 – 1.8)for those who drink frequently (O.R. 1.3 I.C. 1.0 – 1.6), and for those who answered affirmatively to at least two items on the C.AG.E. test(O.R. 1.5 I.C. 1.1 – 1.9). There is also a lower probability for males than for females.(O.R. 0.4 I.C. 0.3 – 0.5).
In terms of panic attacks, there is a lower statistically significant probability for subjects interviewed at the Street Rave Parade(O.R. 0.6 I.C. 0.4 – 0.9)and at the Street Rave Parade(O.R. 0.5 I.C. 0.3 – 0.8) compared to those interviewed at concerts, and higher for those who during the past year mixed multiple narcotics at least once in the same evening(O.R. 2.1 I.C. 1.4 – 3.2), and for those who answered affirmatively to at least two items on the C.AG.E. test(O.R. 1.7 I.C. 1.2 – 2.5). There is also a lower probability for males than for females.(O.R. 0.3 I.C. 0.2 – 0.5).
In terms of paranoia, there is a higher statistically significant probability for those who during the past year mixed multiple narcotics in the same evening(O.R. 1.9 I.C. 1.4 – 2.6), for those who in the past year drove at least once after drinking(O.R. 1.4 I.C. 1.1 – 1.9), and for those who answered affirmatively to at least two items on the C.AG.E. test(O.R. 1.6 I.C. 1.2 – 2.2) for those who used narcotics during the past year(O.R. 1.9 I.C. 1.2 – 3.0).
There is also a lower probability for males than for females (O.R. 0.6 I.C. 0.4 – 0.7) and for those with an upper middle school education(O.R. 0.7 I.C. 0.5 – 0.9) and for those with a university degree(O.R. 0.3 I.C. 0.2 – 0.6) compared to subjects with only a lower middle school education.
In terms of feelings of persecution there is a lower statistically significant probability for subjects interviewed at Arezzo Wave(O.R. 0.4 I.C. 0.2 – 0.8) and at the Street Rave Parade(O.R. 0.4 I.C. 0.2 – 0.8) compared to those interviewed at concerts; for students(O.R. 2.2 I.C. 1.2 – 4.1), for those who during the past year mixed multiple narcotics in the same evening(O.R. 1.9 I.C. 1.1 – 3.3), and for those who answered affirmatively to at least two items on the C.AG.E. test (O.R. 2.8

I.C. 1.7 – 4.5). There is also a lower probability for those with an upper middle school education(O.R. 0.4 I.C. 0.3 – 0.7) and for those with a university degree(O.R. 0.3 I.C. 0.1 – 0.9) compared to subjects with only a lower middle school education.
In terms of memory problems, there is a higher statistically significant probability for those living "with others" (O.R. 1.5 I.C. 1.1 – 2.0), for students(O.R. 1.5 I.C. 1.1 – 2.1), for those who during the past year mixed multiple narcotics in the same evening (O.R. 3.5 I.C. 2.6 – 4.7), and for those who answered affirmatively to at least two items on the C.AG.E. test(O.R. 1.8 I.C. 1.4 – 2.4) for those who used narcotics during the past year(O.R. 1.6 I.C. 1.0 – 2.4). There is also a lower probability for those with a university education (O.R. 0.4 I.C. 0.2 – 0.6) compared to subjects with only a lower middle school education.
In terms of sleep disturbances, there is a higher statistically significant probability for subjects interviewed at Arezzo Wave *O.R. 1.9 I.C. 1.3 – 2.6) compared to those interviewed at concerts; for those over age 25(O.R. 1.5 I.C. 1.2 – 2.0), for those who during the past year mixed multiple narcotics in the same evening (O.R. 1.5 I.C. 1.1 – 2.0), and for those who answered affirmatively to at least two items on the C.AG.E. test(O.R. 1.7 I.C. 1.3 – 2.2)and for those who drink frequently(O.R. 1.3 I.C. 1.1 – 1.7). There is also a lower probability for males (O.R. 0.7 I.C. 0.6 – 0.9) compared to females.
In terms of physical and psychosomatic disturbances, there is a higher statistically significant probability for subjects interviewed at Arezzo Wave(O.R. 2.3 I.C. 1.6 – 3.4) and at the Street Rave Parade(O.R. 1.6 I.C. 1.0 – 2.5) compared to interviewed at concerts, for those who during the past year mixed multiple narcotics at least once in the same evening (O.R. 1.4 I.C. 1.1 – 2.0), and for those who answered affirmatively to at least two items on the C.AG.E. test(O.R. 1.9 I.C. 1.4 – 2.5), for those who in the past year drove at least once after drinking(O.R. 1.4 I.C. 1.1 – 1.8). There is also a lower probability for males (O.R. 0.5 I.C. 0.4 – 0.6) compared to females.
In terms of hallucinations, there is a higher statistically significant probability for those under age 25(O.R. 0.5 I.C. 0.3 – 0.9), for students(O.R. 2.1 I.C. 1.2 – 3.6), for those who during the past year mixed multiple narcotics in the same evening (O.R. 9.8 I.C. 5.3 – 17.9), and for those who answered affirmatively to at least two items on the C.AG.E. test(O.R. 1.7 I.C. 1.1 – 2.7). There is also a lower probability for those with an upper middle school education(O.R. 0.4 I.C. 0.2 – 0.6)compared to subjects with only a lower middle school education.
In terms of states of depression, there is a higher statistically significant probability for subjects interviewed at Arezzo Wave(O.R. 1.9 I.C. 1.3 – 2.6)compared to those interviewed at concerts; for those aged over 25 (O.R. 1.4 I.C. 1.0 – 1.8), for students (O.R. 1.4 I.C. 1.0 – 1.8), for those who during the past year mixed multiple narcotics in the same evening (O.R. 2.2 I.C. 1.7 – 2.9), and for those who answered affirmatively to at least two items on the C.AG.E. test (O.R. 1.8 I.C. 1.4 – 2.4), for those who in the past year drove at least once after drinking(O.R. 1.3 I.C. 1.0 – 1.7) for those who used narcotics during the past year (O.R. 1.6 I.C. 1.1 – 2.3).There is also a lower probability for males (O.R. 0.5 I.C. 0.4 – 0.6) compared to females.
An additional multivaried analysis was done to define the profile for each type of problem encountered relating to substances used in the past year. As possible confounders, gender, age, nationality, job situation, housing situation, schooling, use of alcohol ever, C.AG.E. test (at least two positive answers), time elapsed since first use of narcotics, age at first use of narcotics, and, for the past year, drug mix, drug+alcohol mix, driving after drinking, narcotic substances in detail were used. The subjects included numbered 1,215. Table 10 shows the results of the multivaried analysis relating to substances used in the past year; values that are 95% statistically significant are shown in bold.

Table 10: At-risk profile for problems encountered in the past year substances used – Odds Ratio (Figures shown in bold are 95% statistically significant)

	econ	law	accid.	addict.	psychi.	anxiety	panic	paranoia	persec	memory	sleep	physic	halluc	depress
Heroin	2.2	2.3	**1.1**	2.5	15.2	**1.0**	**1.5**	**1.3**	2.8	**1.1**	**0.5**	**1.0**	**0.5**	2.0
Benzodiazepine	**0.7**	**1.3**	**0.3**	**2.1**	**0.2**	**1.4**	**1.5**	**1.6**	**1.4**	**0.9**	**0.8**	**0.8**	**0.6**	**1.5**
Cocaine	**0.8**	**1.3**	**1.1**	1.9	**0.2**	1.5	**0.9**	**1.2**	**0.5**	**1.2**	**1.3**	**0.9**	**1.4**	**1.0**
Crack	**0.9**	**1.3**	**0.6**	**1.1**	**1.9**	**1.1**	**0.8**	**0.8**	**0.5**	**0.7**	2.4	**0.9**	**1.9**	**1.0**
Amphetamines	**1.0**	**0.7**	**0.8**	**1.0**	**3.8**	**1.1**	**1.4**	**1.2**	**0.9**	**1.2**	**1.4**	**1.0**	**1.5**	**1.2**
Hashish	2.5	**1.6**	**1.3**	**0.9**	**0.6**	**1.3**	**1.0**	**0.9**	**1.0**	**1.4**	**0.8**	**0.9**	**0.8**	**1.1**
Marijuana	**0.6**	**1.5**	**0.9**	**1.5**	**0.3**	**0.8**	**0.7**	**0.9**	**1.2**	**1.1**	**1.7**	**1.2**	**1.0**	**1.4**
LSD	**1.0**	**1.0**	**1.5**	**0.7**	**3.7**	**0.8**	**0.7**	**0.7**	**0.8**	**1.0**	**1.3**	**1.0**	2.0	**1.0**
Ketamine	**1.1**	**2.0**	**1.5**	**1.0**	**3.8**	**0.6**	**0.6**	**0.8**	**1.9**	**0.9**	**1.0**	**1.1**	**1.3**	**0.8**
Mushrooms	**1.1**	**1.4**	**0.9**	**1.0**	**0.5**	**0.9**	**0.8**	**1.3**	**1.0**	**1.4**	**0.7**	**1.3**	1.8	**1.2**
Salvia	**0.7**	**0.9**	**1.0**	**1.1**	**0.2**	**0.8**	**1.1**	**1.0**	**1.2**	**1.3**	**0.7**	**0.9**	**1.1**	**0.9**
Opium	2.4	**1.8**	**0.7**	**1.4**	**0.2**	**1.1**	**1.3**	**1.6**	**0.6**	2.0	**1.5**	1.9	**1.9**	**1.4**
Ecstasy	**1.0**	**1.2**	**1.0**	**1.4**	**0.2**	**1.0**	**1.7**	**1.6**	**1.8**	**1.0**	**0.7**	**1.3**	**0.7**	**1.2**
Poppers	**1.0**	**1.4**	**1.0**	**0.9**	**2.6**	1.8	**1.2**	**1.5**	**1.2**	**1.2**	**1.4**	**1.1**	**0.9**	**1.1**
Psychotropic drugs	**0.7**	**0.5**	**1.3**	**0.7**	77.8	3.2	**1.6**	**1.5**	**0.7**	**0.5**	2.5	**1.7**	**1.9**	2.7

In terms of economic problems, there is a higher statistically significant probability for those living "with others"R. 2.2 I.C. 1.1 – 4.5), Hashish (O.R. 2.5 I.C. 1.4 – 4.6) and Opium (O.R. 2.4 I.C. 1.4 – 4.1).

In terms of problems with the law, there is a higher statistically significant probability for those using heroin in the past year (O.R. 2.3 I.C. 1.0 – 5.3).

In terms of addiction problems, there is a higher statistically significant probability for those having used heroin (O.R. 2.3 I.C. 1.4 – 3.9) and Cocaine in the past year (O.R. 1.9 I.C. 1.1 – 3.1).

In terms of psychiatric problems, there is a higher statistically significant probability for those living having used Heroin (O.R. 15.2 I.C. 1.8 – 128.3)and psychotropic drugs in the past year (O.R. 77.8 I.C. 9.5 – 636.6).

In terms of anxiety symptoms, there is a higher statistically significant probability for those having used cocaine (O.R. 1.5 I.C. 1.0 – 2.1) Poppers(O.R. 1.8 I.C. 1.2 – 2.7 and psychotropic drugs in the past year (O.R. 3.2 I.C. 1.6 – 6.5).

In terms of feelings of persecution, there is a higher statistically significant probability for those having used heroin in the past year(O.R. 2.8 I.C. 1.0 – 7.8).

In terms of memory problems, there is a higher statistically significant probability for those having used Opium (O.R. 2.0 I.C. 1.2 – 3.2).

In terms of sleep disturbances, there is a higher statistically significant probability for those having used Crack (O.R. 2.4 I.C. 1.2 – 4.8) and psychotropic drugs in the past year(O.R. 2.5 I.C. 1.2 – 4.9).

In terms of physical and psychosomatic problems, there is a higher statistically significant probability for those having used Opium in the past year(O.R. 1.9 I.C. 1.1 – 3.1).

In terms of hallucinations, there is a higher statistically significant probability for those having used LSD(O.R. 2.0 I.C. 1.1 – 3.9) and Hallucinogenic mushrooms in the past year(O.R. 1.8 I.C. 1.0 – 3.2).

In terms of states of depression, there is a higher statistically significant probability for those having used heroin(O.R. 2.0 I.C. 1.1 – 3.0) and psychotropic drugs in the past year (O.R. 2.7 I.C. 1.3 – 5.5).

To summarise: the at-risk profiles for the past year show greater probability for any type of problem for anyone having responded affirmatively to at least two items on the C.AG.E. test and for anyone having used multiple types of narcotics in the same evening; this probability drops in relation to the educational level.

For females we find a greater probability in terms of anxiety, panic attacks, paranoia, sleep disturbances, physical and psychosomatic disturbances, hallucinations and depression; for males, for problems with the law.

Psychiatric and sleep disturbances and depression generally affect older subjects.

In terms of individual substances, for those having used heroin we see an association with economic problems, legal problems, addiction, psychiatric problems, feelings of persecution and depression; for psychotropic drugs, there is an association with psychiatric problems, anxiety, sleep disturbances and depression.

Cocaine is associated with anxiety and psychiatric problems; crack with sleep disturbances; opium with economic problems, memory loss, physical and psychosomatic problems; poppers with anxiety; LSD and hallucinogenic mushrooms with hallucinations; hashish with economic problems.

Bad girls – The results of the study show a high prevalence of the use of narcotics and alcohol among the females interviewed. One out of two girls has consumed some illegal substance prior to age 16. A significant percentage (5%) used narcotics for the first time during the past year; during this period one out of 10 used cocaine, Salvia divinorum and hallucinogenic mushrooms for the first time. Females start using narcotics at an older age compared to males but female current consumers are on average younger.

Girls are not very satisfied with their lives and are very concerned about the future; they drink alcohol especially on weekends; one out of four thinks she should reduce her drinking, and at least one in ten are test positive in the C.AG.E. test..

Compared to males, problems of a psychological nature (depression, anxiety and sleep disturbances) are more common, as are treatment with psychotropic drugs and psychiatric problems.

Among the females interviewed, we find a higher prevalence of use of illegal substances compared with their peers in the general population; among upper middle school female students, the use of some illegal substance ever is higher compared to their male peers; in terms of the past year, this is noted for use in general, for the cannabinoids, cocaine and ketamine.

PART C: BIBLIOGRAPHY AND ANNEXES

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In addition to these national systems, a number of Regions have data bases available on aspects of the drug problem either through the relevant Regional Department or through Regional or Provincial Drugs Observatories. Amongst the most developed are those in Piemonte, Emilia-Romagna, Veneto, Lombardia, Liguria and Abruzzo.

Relevant internet addresses

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

Ministries and national institutions

La Presidenza del Consiglio	http://www.governo.it/Presidenza/index.html http://www.governo.it/Presidenza/DPAD/index.html
Dipartimento Nazionale per le Politiche Antidroga	http://www.politicheantidroga.it
Ministero della Difesa Direzione General Sanità Militare	http://www.difesa.it/ http://www.difesa.it/sgd/index.html
Ministero di Giustizia Dipartimento dell'Amministrazione penitenziaria Dipartimento per la Giustizia Minorile Le Statistiche della amministrazione penitenziaria Le Statistiche della giustizia minorile	http://www.giustizia.it/ http://www.giustizia.it/ministero/struttura/dipartimenti/dip_amm_penitenz.htm http://www.giustizia.it/ministero/struttura/dipartimenti/dip_giust_minorile.htm http://www.giustizia.it/misc/STATISTICHE.HTM http://www.giustizia.it/misc/STATISTICHEDAP.HTM
Ministero dell'Interno Direzione Centrale per i Servizi Antidroga (DCSA) Direzione Centrale per la documentazione e la statistica Dipartimento per le libertà civili e l'immigrazione Dati statistici	http://www.mininterno.it/ http://www.interno.it/sezioni/attivita/sicurezza/dip_ps/dcsa/s_000000223.htm http://pers.mininterno.it/ http://www.interno.it/sezioni/organizzazione/dipartimenti/s_000000218.htm http://www.poliziadistato.it/pds/online/antidroga/antidroga.htm
Ministero dell'Istruzione, dell'Università e della Ricerca Direzione Generale per lo status dello studente, per le politiche giovanili e per le attività motorie	http://www.istruzione.it/ http://www.istruzione.it/mpi/amministrazione/dg_studente.shtml
Ministero della Salute Direzione Generale della Prevenzione Dati di attività dei Ser.T.	http://www.ministerosalute.it/ http://www.ministerosalute.it/ministero/sezMinistero.jsp?label=dip2&id=43

Bollettino per le Farmacodipendenze e l'Alcolismo	http://www.unicri.it/min.san.bollettino/default.htm
Istituto Superiore di Sanita Osservatorio Fumo, Alcol e Droga Area laboratorio sostanze stupefacenti e psicotrope	http://www.iss.it/ http://www.ossfad.iss.it/ http://progetti.iss.it/ssps/
Ministero del Welfare	http://www.welfare.gov.it/default.htm
ISTAT	http://www.istat.it/

Other national organisations

Aduc	http://www.aduc.it/
Antiproibizionisti	http://www.antiproibizionisti.it/
Coordinamento Nazionale Comunità d'Accoglienza	http://www.cnca.it/
Coordinamenti Regionali Enti Ausiliari per le Tossicodipendenze	http://www.intercear.it/
Crescere ONLUS	http://www.crescereitalia.it/
DRONET	http://www.dronet.org/
EXODUS	http://www.exodus.it/
Fondazione Promozione e Solidarietà Umana	http://www.promozioneumana.it/home.asp
Federazione Italiana Comunità Terapeutiche	http://www.fict.it/
Federazione Italiana degli Operatori dei Dipartimenti e dei Servizi delle Dipendenze - FeDerSerD (Ser.T.)	http://www.federserd.it/
Gruppo S.I.M.S. (Studio e Intevento sulle Malattie Sociali)	http://www.sims.it/
I.E.F.Co.S	http://www.iefcos.it/
IREFREA Italia	http://www.irefrea.org/italia/inicio.htm
ITACA Italia	http://www.itacaitalia.it/
Medicina delle Tossicodipendenze	http://www.medol.com/mdt/
Movimento delle Associazioni di Volontariato Italiano	http://www.modavi.it/ http://www.spaziaperti.it/
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SITD (Società Italiana Tossicodipendenze)	http://www.sitd.org/
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Italian Regions

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

Progetto obiettivo "Sei unico" - Regione Abruzzo	http://www.seiunico.it/
Basilicata	http://www.regione.basilicata.it/
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Ser.T Distretto 49, A.S.L. Napoli 1	http://digilander.iol.it/sertd49aslna1
Ser.T. Distretto 51, A.S.L. Napoli 1	http://digilander.libero.it/sert51/
Emilia-Romagna	http://www.regione.emilia-romagna.it/
Agenzia Sanitaria Regionale - Emilia-Romagna	http://www.regione.emilia-romagna.it/agenziasan
Regione Emilia-Romagna "Progetto regionale	http://www.regione.emilia-

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Centro di Solidarietà di Parma	http://www.ceisparma.org/index.html
Centro di Solidarietà di Reggio Emilia	http://www.solidarieta.re.it/
Comunità San Maurizio	http://www.sanmaurizio.org/
Comune di Reggio Emilia - Unità di prevenzione	http://up.comune.re.it/
Dip&Doc	http://www.stradanove.net/dipdoc
Dipendenze patologiche Forlì	http://www.ausl.fo.it/giovani/Servizi/sert.htm
Dipartimento dipendenze Modena	http://www.giannimorandi.it/Prof/dipatol.htm
Drogaonline - Centro di Solidarietà Reggio Emilia	http://www.drogaonline.it/
On the Road	http://www.ontheroadonlus.it
Osservatorio epidemiologico AUSL Bologna	http://www.ossdipbo.org/
San Patrignano	http://www.sanpatrignano.org/
Ser.T di Cesena	http://www.ausl-cesena.emr.it/sert/Default.htm
Ser.T. della Provincia di Modena	http://www.monicaepaolo.it/
Ser.T. Faenza	http://www.ausl.ra.it/h3/h3.exe/aauragest/funicoweb?NRECORD=0000000094
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Ser.T di Imola	http://www.regione.emilia-romagna.it/web_gest/enti/usl/uslimola/dist-3.htm
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Ser.T. Rimini, Progetto SIDA	http://www.geocities.com/HotSprings/9949/italiano.html
Unità Mobile SerT	http://www.ossdipbo.org/UMobile/
Friuli-Venezia Giulia	(http://www.regione.fvg.it/)
Dipartimento delle Dipendenze, Trieste	http://www.ass1.sanita.fvg.it/sert/welcome.htm
Sert Udine	http://www.friuli.to/sert_ud/
Lazio	(http://www.regione.lazio.it/)
Servizi Tossicodipendenze - Regione Lazio	http://213.175.14.99/redazione/sanita/asl.nsf/sert?openview
Agenzia Comunale per le Tossicodipendenze	http://www.comune.roma.it/act
Centro Italiano di Solidarietà (CeIS)	http://www.ceis.it/
Dipartimento Disagio, Devianza, Dipendenze, ASL di Frosinone	http://www.asl.fr.it/dipar/dipar_d3d.html
Dipartimento delle Dipendenze, ASL Roma A	http://www.asl-rma.rm.it/DiD.htm
Fondazione Villa Maraini	http://www.villamaraini.it/
Gruppo Magliana '80	http://www.magliana80.it/home.htm
SERT, ASL Roma H (Ciampino, Nettuno,Velletri,Genzano, Frascati)	http://web.genie.it/utenti/s/sertnet/
Ser.T. ASL di Viterbo	http://www.asl.vt.it/cittadino/servizi/tossicodipendenze.html
Liguria	(http://www.regione.liguria.it/)
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ASL Bergamo, Dipartimento delle Dipendenze	http://www.asl.bergamo.it/web/intsert.nsf
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Associazione Saman	http://web.tin.it/saman/
Centro "Gulliver"	http://www.gulliver-va.it/
Centro per lo Studio e la Terapie delle Psicopatologie /Ce.S.Te.P)	http://www.cestep.it/
Comune di Milano	http://www.comune.milano.it/webcity/documenti.nsf/
La comunità Casa del Giovane	http://www.cdg.it/
Comunità Mondo Nuovo	http://www.mondonuovo.org/start.htm
Comunità Nuova	http://www.comunitanuova.it/
CONT@TTO - SPAZIO ADOLESCENTI	http://www.con-tatto.it/
Droga Milano	http://fc.retecivica.milano.it/Rete%20Civica%20di%20Milano/Societa'%20e%20Politica/Salute%20e%20Sanita'/DROGA%20MILANO%20SOS/
ECCAS	http://www.asl.bergamo.it/web/intsert.nsf/pages/Homepage
Reinserimento Socio Lavorativo per Tossicodipendenti	http://www.inserisciti.it/
Servizio Dipendenze, A.S.L. dell Provincia di Cremona	http://www.aslcremona.it/html/carta_servizi/sanitarie/dipendenze.htm
Ser.T. Montichiari	http://www.sdrogabrescia.it/SerT.htm
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Ser.T. di Pesaro	http://www.ausl1ps.marche.it/CarteServizi/CartaServiziPS/DipPatologiche.htm
Ser.T. di S. Benedetto del Tronto	http://www.asl12.marche.it/sert.html
Ser.T. di Senigallia	http://www.asl4.marche.it/territoriale/sert.htm
Molise	(http://www.regione.molise.it/)
Piemonte	(http://www.regione.piemonte.it/)
Osservatorio Epidemiologico delle Dipendenze, Regione Piemonte - ASL 5 - Servizio di Epidemiologia	http://www.oed.piemonte.it/italiano.htm
Associazione Fides	http://web.tiscalinet.it/Fides

l'Associazione Le Patriarche	http://www.lepatriarche.org/
Dialoghi di Tossicodipendenza	http://www.dialoghiditossicodipendenza.it/
Fermata d'Autobus	http://www.fermatadautobus.org/
Gruppo Abele	http://www.gruppoabele.org/
Ser.T. ASL 1 (Torino)	http://www.asl1.to.it/cartaservizi2001/sert.htm
Ser.T. ASL 7 (Settimo T.se - Chivasso - S. Mauro/Gassino)	http://www.asl7.to.it/medspec_asstossic.htm
Ser.T. ASL 9 (Ivrea)	http://www.asl.ivrea.to.it/sert/index.html
Ser.T. ASL 10 (Pinerolo)	http://www.asl10.piemonte.it/sert/index.htm
Ser.T. ASL 11 (Provincia di Vercelli)	http://www.asl11.piemonte.it/servizi/tossico.htm
Ser.T. ASL 13 (Provincia di Novara)	http://www.asl13.novara.it/intranet/I-Servizi-/Ser-T-/index.htm
Sert ASL 14 Verbano Cusio Ossola	http://www.asl14piemonte.it/ita/sert.htm
Ser.T. ASL 15 (Cuneo)	http://www.asl15.sanitacn.it/Sert.html
Puglia (http://www.regione.puglia.it/)	
Servizi Tossicodipendenze - Regione Puglia	http://www.servizisocialipuglia.it/
Cattedra di Tossicologia Forense	http://www.tossicologia.uniba.it/index.html#0
Comunità Emmanuel	http://www.emmanuel.it/alcooltossicodip/dipendenza.asp
Consorzio Promosud	http://www.promosud.it/
Cooperativa Sociale Teseo	http://digilander.libero.it/teseoct/Home%20page.html
Gruppo SIMS SAVA (TA)	http://www.geocities.com/simssava
Ser.T., ASL Bari 3	http://www.auslba3.it/ServiziTerritoriali/s45tossi.htm
Ser.T., ASL Bari 5	http://www.auslba5.it/DistrettiSocioSanitari/Sert.htm
Ser.T., ASL Brindisi 1	http://www.auslbr1.brindisi.it/seconda/CDSFrame2.htm#tossicodipendenza
Ser.T., ASL Lecce 2	http://www.asl2maglie.le.it/dipartimenti/TOSSICODIPENDENZE.HTM
Sardegna (http://www.regione.sardegna.it/)	
Associazione Mondo X - Sardegna	http://web.tiscalinet.it/mondoxsardegna/
Comunità Promozione Umana	http://www.insiemesenza.org/
Univerità di Cagliari, Dipartimento di Neuroscienze	http://vaxca1.unica.it/~saramu/new
Sicilia (http://www.regione.sicilia.it/)	
L'Associazione "Casa Famiglia Rosetta"	http://www.casarosetta.it/
Azienda USL 6 - Palermo	http://www.ausl6palermo.org/energia.htm
Il Centro di Solidarietà F.A.R.O.	http://www.farosol.it/
Cooperativa Fenice	http://www.fenicecoop.org/
Ser.T. in Sicilia	http://www.regione.sicilia.it/sanita/x(foglioA).htm
Ser.T. ASL 17 (Ragusa)	http://www.ausl7.rg.it/Strutture/servTossic.htm
Toscana (http://www.regione.toscana.it/index.htm)	
Associazione Genitori Comunità Incontro	http://www.agcionline.org/
Associazione Insieme	http://www.odissea.it/coorATanas/insieme.htm
Associazione Progetto Aliante (onlus)	http://www.progettoaliante.it/
Centro Documentazione e Ricerca sul Fenomeno delle Dipendenze Patologiche (Ce.Do.S.T.Ar.)	http://www.cedostar.it/

Centro di Solidarietà di Firenze - onlus	http://www.csfirenze.com/Index2.html
Centro di Solidarietà di Lucca	http://www.ceislucca.it/
Centro di Solidarietà di Prato	http://www.comune.prato.it/associa/centsol/
Centro Studi, Ricerca e Documentazione su Dipendenze e AIDS	http://www.cesda.net/
Centro Studi e Documentazione Provinciale sulle tossicodipendenze e l'emarginazione	http://www.cesdop.it/
Dipartimento Dipendenze, Firenze	http://www.asf.toscana.it/modules.php?op=modload&name=Sections&file=index&req=viewarticle&artid=41&page=1
Dipartimento delle Dipendenze, Grosseto	http://www.usl9.grosseto.it/pagine/info/dipen.htm
Gruppo SIMS	http://www.sims.it/associazioni/SIMS/
PROGETTO CEDRO.net	http://www.cedostar.it/cedro.htm
Ser.T.	http://www.sert.it/
Sert USL 2, Lucca	http://www.usl2.toscana.it/sert/
Ser.T. USL 3, Pistoia - Zona Valdinievole	http://www.usl3.toscana.it/UOAziendali/sertvdn/sito/default1.htm
Sert USL 6, Livorno	http://www.usl6.toscana.it/sert/home.htm
Sert USL 7, Siena	http://www.usl7.toscana.it/distretti/sert.html
Trentino-Alto Adige	(http://www.regione.taa.it/)
Azienda Provinciale per i Servizi Sanitari, Provincia Autonoma di Trento	http://www.aziendasanitaria.trentino.it/direzioni/cura/sert.htm
Azienda Servizi Sociali di Bolzano	http://www.aziendasociale.bz.it/se04_01_20.html
Centro Trentino di Solidarietà - ONLUS	http://digilander.libero.it/marcoligorio/cts/Home.html
Umbria	(http://www.regione.umbria.it/)
Agenzia SEDES - Regione Umbria	http://www.sedes.it/
Comunità Incontro	http://www.comunitaincontro.org/
Dipartimento per le dipendenze patologiche, ASL 3 di Foligno	http://www.asl3.umbria.it/carta/assterri/6.htm
Ser.T. ASL 4, Provincia di Terni	http://www.asl4.terni.it/azienda/sert/sert.htm
Valle D'Aosta	(http://www.regione.vda.it/)
Servizio Tossicodipendenze e Salute Mentale	http://www.regione.vda.it/sanita/servterritoriali/dipendenze/default_i.asp
Veneto	(http://www.regione.veneto.it/)
ASL Vicenza, Piani di Zona	http://www.pianodizonavi.org/
Auto Aiuto Corallo	http://www.autoaiutocorallo.org/
Centro "Don Lorenzo Milani"	http://www.ceisdonmilani.com/
Centro di Solidarietà di Belluno	http://www.sunrise.it/ceis
CeIS Treviso	http://www.ceistreviso.it/
Comunità terapeutica "Villa Renata"	http://www.villarenata.eurovenezia.org/
Dronet Veneto	http://veneto.dronet.org/
Itinerari di Sicurezza Sociale - Associazione Famiglie Veronesi Contro La Droga	http://www.itinerarisicurezza.org/
Ser.T. Vicenza	http://www.pianodizonavi.org/auto_strutture/sertvicenz949574680.htm

ANNEXES

Standard tables or structured questionnaires used in the text

Graphs used in the text

Tables used in the text

Figures used in the text

Abbreviations used in the text

C.N.C.A.	National Coordination of Reception Facilities
DCSA	Direzione Centrale per i Servizi Antidroga (Central Directorate for Drug Services
DNPA	National Department for Drugs Policy
FICT	Italian Federation of Therapeutic Communities
IPSAD	Italian Population Survey on Alcohol and Drugs
IFC – CNR	Istituto di Fisologia Clinica (Sezione di Epidemiologia), Consiglio Nazionale delle Ricerche (Epidemiology Section of the Institute of Clinical Physiology, National Research Council)
ISTAT	Istituto Nazionale di Statistica (National Statistics Institute)
ISS	Istituto Superiore di Sanità (National Health Institute)
MIUR	Ministry of Education, Universities and Research
OIDT	Osservatorio Italiano sulle droghe e sulle tossicodipendenze (Italian Monitoring Centre on Drugs and Drug Addiction)