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Dipartimento Politiche Antidroga

2013 NATIONAL REPORT

European Monitoring Centre
for Drugs and Drug Addiction

Reitox
Italian Focal Point

2013 National Report (2012 data) to the EMCDDA
by the Reitox Italian Focal Point

ITALY

New Development and Trends

REITOX

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New Developments and Trends

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Index

SUMMARY

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

National and EC Regulatory Acts

In 2012, a total of 6 national and EC Regulatory Acts were approved which fell in the sphere of competence of the Department for Anti-drug Policies. 5 of these were national Regulatory Acts and one was international. The latter dealt with regulations for the monitoring of trade in drug precursors between the Community and third-party countries.
As was also the case in 2011, most national Acts approved during the course of 2012 involve the updating and completion of the tables containing descriptions of narcotic and psychotropic substances (in accordance with DPR 309/90).
The proposal amending Regulation (EC) No. 273/2004 was approved (with some minor conditions) by the 12th Commission of the Senate of the Republic, which expressed its views, "on the application of the principles of subsidiarity and proportionality", pursuant to Protocol No. 2 of the Treaty on the Functioning of the European Union.

Assessment of the National Action Plan

2012 saw the launch of the second phase of assessment of the National Action Plan on Drugs (NAPD), which consisted of a structured interview. Unlike the 2011 assessment, which focused on collecting the opinions of professionals in the field regarding the Plan's overall structure and specific action areas, this second phase aimed principally to monitor the degree of actualization of the different NAPD goals in relation to actions carried out by the Regions. It also aimed to bring to light existing best practices.
The results of the analyses of the data collected on the degree to which the NAPD goals have been actualized are presented in the appropriate chapters (primary prevention, treatment, rehabilitation and the prevention of drug-related diseases). As far as best practices are concerned, 52 were brought to light in 18 Regions. Most of these best practices lie in the spheres of prevention and treatment. In 3 out of 4 cases, moreover, these are structured actions, and in 1 out of 4 they are project-type activities.

The 2012 Projects Plan: €5,543,990 in invested budget

Since 2009, the DAP has funded a total of 207 projects. 29 of these were carried out in 2012, for an investment of €5,543,990, of which over 50% was devoted to the area of prevention (€1,850,990) and epidemiology (€1,150,000).

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

During the year 2012, the Department for Anti-drug Policies further reinforced its involvement in activities in the international arena through participation in numerous activities abroad.
2012 saw further strengthening of the scientific collaboration agreement between the DAP and the NIDA (the American *National Institute on Drug Abuse*), with a series of initiatives whereby representatives from both organisations attended important conventions, each at the other's invitation (the Third International Conference on the Neurosciences: "Addiction: new evidence from neuroimaging and brain stimulation") and participated in training events within the Outcome project and at the National School on Addictions.
Other international collaborations of note include cooperation with the UNODC, which led to the creation of the "International Consortium of Solidarity for the Prevention of Drug Use", as well as Italy's activities as part of the Commission on Narcotic Drugs (CND) of the United Nations, where it saw the approval of the EU resolution to "promote strategies and measures targeting the specific needs of women in the context of

programmes and strategies that are comprehensive and integrated in the reduction in the demand for drugs", which Italy had championed in the European arena.
Moreover, during the course of 2012, the Department maintained its institutional and technical relationships with other international organizations working in the drug sphere, which included the United Nations (the UN Commission on Narcotic Drugs, the General Assembly, UNODC - the United Nations Office on Drugs and Crime, INCB - the International Narcotics Control Board) and with the European Union (the Horizontal Drugs Group – HDG, National Coordinators, the European Action on Drugs – EAD, the Dublin Group, the S.O.N. project - the European Programme for the Prevention of and Fight Against Crime (ISEC), the ERANID - ERA-NET on illicit drugs project) and with the European Council (the Pompidou group – Ministerial Conference, Permanent Correspondents and Platforms), as well as collaborating in the realization of international projects (Italy-USA bilateral agreements, the Pompidou Group MedNET network, the Project Drugs, Alcohol and Women (DAWN) Network).

The social costs linked to the phenomenon of drug use

According to the definition of "social costs" as the costs directly and indirectly borne by the citizens and the population as a whole which derive from the consequences of drug use and the drug market, the overall social cost of the drug use in Italy in 2011 has been estimated at €28,491,680,073.96, equivalent to 1.8% of Italian gross domestic product (GDP) during that same period, which, in per capita terms, amounts to 715 euros per year per member of the population age 15-64. The direct costs borne by the public administrations for drug-fighting activities and for activities to reduce and suppress drug demand and supply, together with social and healthcare costs, amount to over 3 million euros (€3,224,946,252), or 11% of the overall social cost, an 18.7% decrease over the 2011 figure. The cost category which accounts for the greatest portion of the total is that of expenditures for the purchase of drugs which amount to approximately 20.6 million euros.

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

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

In the 2012 general population survey (conducted on a sample group of 18,898 subjects between the ages of 18 and 64) the following percentages of drug users (who reported having used drugs in the 12 months prior to the survey) emerged: heroin 0.1% (0.2% in 2010); cocaine 0.6% (0.9% in 2010); cannabis 4.0% (5.3% in 2010); stimulants – amphetamines – ecstasy 0.1% (0.3% in 2010); hallucinogens 0.2% (0.2% in 2010).
In 2012, in order to provide support for the epidemiological results obtained by means of the general population study, the Department for Anti-drug Policies once again entrusted the Mario Negri Pharmacological Research Institute of Milan with the collection and analysis of wastewater samples collected during the month of October in 17 cities throughout the country, all of which had been involved in the project in 2011 as well, in order to measure the concentrations of drug residues present in the samples.

Cannabis was the drug used in the most substantial amounts

In 2012, the drug used in the most substantial amounts was cannabis, with an average of 33.3 doses per day per 1,000 population, a small decrease with respect to the numbers obtained during the same collection period in 2011 and 2010; this decrease is the result of a significant decline in use prevalences in Central Italy.

Cocaine use figures remain stable, as do those for heroin, ketamine and ecstasy during the two-year period of 2011-2012

Turning our attention to cocaine, we find that, after an overall decline in use in 2011, use levels over the last year shifted to match those for 2010. Fluctuation during this three-year period has been most significant in the northeastern and central areas of the country.
Use levels remained lower and more stable during the last two years for heroin (an average of 2 doses per day per 1,000 population), a decline with respect to the 2010 figure. Moreover, during the three-year period of reference, after an initial rise in use levels, figures for ecstasy and ketamine remained largely stable in 2012.

Dose numbers and use prevalence figures higher for:
- cannabis in Northern Italy
- cocaine in Central Italy

On the other hand, if we compare quantities of drugs used (grams per day per 1000 population), detected by means of the wastewater study conducted during the month of October 2011, with the prevalence of use estimates for the thirty days prior to the population surveys conducted during the first half of 2012, we find that distribution was similar in the different geographical areas in both studies.
Focusing our attention on cannabis, we find that use levels for this drug were slightly higher in Northern Italy than in other geographical areas, while Central Italy stands out for its higher levels of cocaine use.

2013 survey of students age 15-19: long-term overall trends show a decline in drug use

Parallel to the general population studies, the student population survey was once again carried out in 2013 (conducted on a sample group of 35,719 subjects between the ages of 15 and 19). The following percentages of drug users (students who reported having used drugs in the 12 months prior to the survey) emerged: heroin 0.4% (0.3% in 2012); cocaine 2.1% (1.9% in 2012); cannabis 21.6% (19.1% in 2012); stimulants – amphetamines – ecstasy 1.6% (1.1% in 2012); hallucinogens 2.1% (1.7% in 2012).
An analysis of the figures for subjects who had used drugs in the last 30 days confirmed the above-mentioned trend, also showing a slight but not significant fluctuation in the prevalence of cannabis and stimulant use.
An analysis of overall trends in drug use during the 12 months prior to the survey for the years 2003 to 2013 shows a general decline in use levels, although not as large a decline as that which was observed in 2011-2012.

Strong trend towards polydrug use

Polydrug use, the use of more than one type of licit or illicit psychoactive drug, is becoming the most characteristic and widespread pattern of drug use among users, with a strong tendency toward the concomitant or consecutive use of alcohol (between 73.0% and 82.6% in the general population and between 86.7% and 92.3% of the student population) and cannabis (between 35.6% and 37.9% in the general population and between 81.3% and 84.3% in the student population), in the 30 days prior to the survey.

New drugs reported in Italy by the National Warning System

Recent years have witnessed the rise of a never-before-seen phenomenon which has revolutionized drug use trends among, but not limited to, young people. The traditional drugs (cannabis, cocaine, heroin, etc.) have been joined by synthetic molecules, which are still widely available online, where they can be sold easily and quickly due to the difficulty inherent in monitoring and patrolling an environment in such constant fluctuation and evolution as the internet is.
To combat this phenomenon, the Department for Anti-drug Policies, by means of its National Early Warning System, has put into operation an internet monitoring unit to identify websites selling these new drugs, which include synthetic cannabinoids, synthetic cathinones and methoxetamine.

3. PREVENTION

Results of the monitoring of drug-use prevention actions, as part of the monitoring of the overall application of the NAPD on the part of the Regions and Autonomous Provinces, show that prevention programmes in schools tend to be routine. These routine activities are bolstered by project activities to inform students of the risks and harm associated with drug use, drug-use prevention activities and early detection activities, as well as programmes for parents and educators.

Approximately 25.5 million euros invested in prevention by the Regions; a 47% decline with respect to 2011

A total of approximately 12,279,000 euros was invested in universal prevention in 2012, and a further 13,297,000 euros in selective prevention, for a total of approximately 25.5 million euros. An initial assessment shows a drop of approximately 47% in investments in the area of prevention, in particular in universal prevention; this was the first time that less had been invested in universal prevention than in selective prevention, with a gap of approximately one million euros between investment figures for the two areas.

The number of activities, centres, courses, and active plans and projects increased (+36%) as did the number of communication campaigns (+16%).

Of the initiatives launched by the Regions and Autonomous Provinces in 2012, most (55, or 83.3%) were universal prevention campaigns as opposed to selective, and only four Regions launched at least one campaign in both areas , while three did so in 2011.

Universal and selective prevention campaigns

Activities for the promotion and organization of information campaigns to raise awareness regarding drug-use prevention among the general population were conducted not only by the Regional Administrations, but also by the Department for Anti-drug Policies, which organized and launched three important information campaigns (“Elementary, but not too elementary...”, “Free from all drugs, Free from all mafias. People who buy drugs finance the mafias, their violence and their terrorism” and the “Safe Beaches Summer Campaign”).

4. PROBLEM DRUG USE AND TREATMENT

279,500 is the estimated number of subjects in need of treatment

Subjects who suffer from drug addictions (drug addicts who require treatment) were found to number approximately 279,500, thus representing 7.1/1000 population between the ages of 15 and 64. Of these, 174,000 require treatment for opiate use (4.5/1000 population) and approximately 105,500 for cocaine use (2.6/1000 population).

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

The National Information System on Addictions (SIND) decree

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

Data transmission by the Regions and Autonomous Provinces

The new information flow substitutes the previous flow, which was based on aggregate data (Ministerial Decree 20 September 1997), however, in 2012, not all Regions and Autonomous Provinces had adopted the new information flow, and therefore not all Regions provided all the information they were required to produce.

1,661 social-

On 31 December 2012, there were reported to be a total of 1,661 social-

healthcare facilities dedicated to the treatment and rehabilitation of individuals with drug-use problems: 633 were Local Public Drug Addiction Service Units (known as SerT).

healthcare treatment facilities

There were 1,028 private non-profit social-rehabilitative facilities, of which 66.5% were residential, 18.6% were semi-residential and 14.9% were outpatient service units.

633 Local Public Drug Addiction Service Units (SerT)
1,028 Communities

With respect to 2011, there was a 3.7% decrease in the number of social-rehabilitative facilities (39 facilities).

Closure of 39 communities

Based on the aggregate data provided by the Ministry of Health on the clientele of outpatient addiction services, comprising new clients entering care in 2012, those already known to services (both those which began a new treatment in 2012 and those already undergoing treatment when 2012 began), and also based on estimates calculated upon receiving the partial information from the new data flow, we can estimate that 167,139 individuals received assistance from public drug addiction services in 2012, a decline of 2.9% over the previous year's figures. Of this population, over 18% were beginning their first-ever treatment of any kind with drug addiction services, while the remainder were returning clients already known to services; this latter group is further subdivided into those who began a new treatment programme in 2012 (returning) and those who had already begun their treatment programme before the year of reference began (already in care).

A total of 167,139 people receiving care from public drug addiction services, according to the aggregate data provided by the Ministry of Health

Over the most recent three-year period, we can see a decline in the number of new clients entering care, which fell from 34,625 in 2010 to 30,888 in 2012. This downturn, which can be observed among clients already known to services as well, can be explained in part by the criteria used when calculating the estimate, in part by the different information flows employed and in part by the lower level of information-flow coverage.

Number of new clients decreased over the last year

The subjects taken into consideration for the TDI comprise 85% of clients in care, and consist of: 26,745 new subjects and 27,875 returning subjects, meaning that the latter group is already known to services and that they did not have a treatment programme already on-going when the year began. 85% of the sample taken into consideration were male and 49% were entering the care of a Local Public Drug Addiction Service Unit (SerT) for the first time.

TDI protocol 2.0

Turning our attention to primary drugs of use, 2012 data is in line with results found in 2011: 55.5% reported opiates as their primary drug, followed by cocaine (24.2%) and cannabis (17.1%). Cocaine and cannabis were also the most commonly used secondary drugs (35% for both).

Most commonly used primary drugs: heroin, cocaine, cannabis

As far as injecting drug use was concerned, there was a slight drop in the percentage of injecting opiate users during the last year (53.7% in 2011 vs. 50.8% in 2012).

As has also been seen in studies conducted during previous years, the average age at first drug use and the average age at first treatment vary based upon the type of drug first used by a subject: younger for cannabis, older for heroin and older still for cocaine. The same differences based on drug type are reflected in the lengths of latency periods. Moreover, latency periods tend to be shorter overall among women than among men, the result of a younger age at first treatment among women, despite the same age at first use.

Shorter latency periods for women

When we draw a distinction between clients undergoing psycho-social-rehabilitative treatment and those in integrated pharmacological treatment, we find that 51.3% of patients were receiving integrated pharmacological treatment, in comparison with 66.2% in 2011; the remaining 48.7% of

51.3% of clients were receiving pharmacological treatment

clients received no pharmacological treatment during the course of 2012.

6. HEALTH CORRELATES AND CONSEQUENCES

Information flows on infectious diseases are partial

The National Information System on Addictions (SIND), established under the SIND Decree of 11 June 2010, took the place of the previous aggregate data flow which existed under the Ministerial Decree of 20/09/1997. Under the new system, there have been a series of problems and technical difficulties (typical when launching complex new information systems) with the flow of information on 2012 client test results for HIV, hepatitis B virus and hepatitis C virus from the Regions to the Ministry of Health, as well as with the subsequent transfer of data to the Department for Anti-drug Policies (DAP). Therefore, the DAP decided to analyse only the drug-related infectious disease data from the Regions whose data covered an acceptable portion of the population (over 50% of clients in the care of addiction services): Emilia-Romagna, Lombardy and Umbria.

Turning our attention to hepatitis B testing in 2012, we find that approximately 60% of those who were eligible for testing were actually tested in Emilia Romagna and Lombardy, while fewer still were tested in Umbria (39%). The percent of these whose results were positive, on the other hand, was higher in Umbria and in Emilia Romagna (approximately 20%), although percentages differed between different types of clients; this figure was much lower in Lombardy (13.1%).

Similarly alarming numbers for both percentage of clients being tested and the percentage of clients testing positive were found for HCV in 2012: approximately 60% of clients were tested for HCV in the Regions of Emilia Romagna and Lombardy (55.8% and 63.1%, respectively) and the percentage was much lower in Umbria (33.6%). In all three regions in 2012, the prevalence of positive test results among those tested stood at around 50%, and was higher among returning clients than among new.

A slightly smaller number of clients are tested for HIV by addiction services than are tested for the two previously mentioned diseases, and this is particularly true in Umbria (13.6%).

The prevalence of clients testing positive for HIV among those tested in 2012 is markedly lower than the prevalence of positive results for the other types of tests in all three of the Regions.

A slight increase in the number of drug-related traffic accidents in 2011

Traffic accidents are a serious problem, not only for drug and alcohol users, but also third parties involved in them. Focusing our attention on drug-related traffic accidents, we find that there was a slight increase in the number of these types of accidents and in the number of fatalities caused by them in 2011 (in comparison with the previous two-year period); the percentage of injuries in these types of accidents, however, remained largely stable with respect to the 2009 and 2010 percentages. This indicates that, in addition to having increased in number, drug-related accidents have also become more frequently fatal for the persons involved in comparison with previous years.

Drug-related acute mortality (overdose, etc.) has remained stable over the most recent three-year period

Between 1999 and 2003 there was a drop in drug-related deaths, a trend more pronounced in Italy than in Europe as a whole. Between 2004 and 2007, numbers remained largely stable at approximately 600, despite some fluctuation. Following years saw a further decline, with numbers reaching their low point in 2011. However, there was a slight increase of 7.7% in 2012, when the number reached 390. Deaths among female subjects have increased in proportion to deaths among male subjects, and the ratio now stands at approximately 9 male deaths for each female death. The average age at time of death has also risen.

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

During the course of 2013, the Department for Anti-drug Policies conducted a study to monitor actions at a Regional level in the sphere of drug-related disease prevention. These were divided according to objectives within the action area and evaluated in relation to the National Action Plan on Drugs 2010-2013.

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

The NAPD actions for which no initiatives have been undertaken in any of the Regions or Autonomous Provinces but one are the following: defining new national operational guidelines and directions for work to prevent drug-related diseases at a Regional level and the activation of gender-oriented programmes. In most cases, these two goals are either absent from the Regions or present as goals only within Regional plans.

NAPD goals with the lowest levels of actualization in the Regions

Turning our attention to actions to reduce the transmission of HIV, hepatitis and other infectious diseases, to reduce risk of death by overdose, to reduce drug-related social risks and drug-related family problems, we find that most of the Regions and APs have incorporated these as routine activities, especially in the northern Regions.

NAPD goals with the highest levels of actualization in the Regions

The data collected from the Regional Administrations by means of Structured Questionnaire (SQ) 23, regarding the “Prevention and reduction of drug-related diseases and of acute drug intoxication mortality”, show a lower number of priority programmes for the prevention of death by acute drug intoxication being in effect in 2012.

In comparison with 2011, the amount of funds set aside for the prevention of acute mortality grew by nearly two-million euros (+23.9%). This was largely a consequence of the large investments made in this area by the Region of Lombardy.

8.8 million euros invested in 2012 for the prevention of drug-related acute mortality

The Regions launched targeted, structured services in support of policies and strategies encouraging the prevention of drug-related diseases and risk limitation.

From an examination of Hospital Discharge Records from the three-year period from 2009-2011, we can see that the number of drug-related hospital admissions fell by 3.6% during that time, with a rate of 2 per thousand total hospital admissions.

A decrease in drug-related hospital admissions

Information regarding drug-related infectious disease prevention initiatives in prisons and in social-rehabilitation facilities, collected from Regional Administrations, shows that the most common prevention initiatives were, specifically, those concerning infectious disease risk assessment and individual counselling, with 87.5% of the Regions and Autonomous Provinces reporting that such actions had been carried out both in therapeutic communities and in prisons; all other types of initiatives were more common in communities than in prisons, across the board.

Initiatives for the prevention of drug-related infectious diseases in therapeutic communities and in prisons, by Region

8. SOCIAL CORRELATES AND SOCIAL REINTEGRATION

During the course of 2013, a study was conducted to monitor actions conducted by the Regions and Autonomous Provinces in the sphere of rehabilitation and social and work reintegration of drug addicts, divided according to objectives within the action area and evaluated in relation to the National Action Plan on Drugs 2010-2013.

Monitoring the application of NAPD objectives in the action area of rehabilitation and reintegration

Only three Regions had actualized the majority of the goals through routine activities (Friuli Venezia Giulia, Liguria, the Autonomous Province of Trento and Sardinia), a confirmation that the degree of actualization of the NAPD at a national level is quite low.

NAPD goals with the lowest levels of actualization in the Regions

Especially in the southern regions, we find goals actualized as project

activities, but none as routine activities.

34.2% of Local Public Drug Addiction Service Unit (SerT) clients are unemployed. The employment situation appears to be more critical among returning clients, of whom 35.5% are unemployed, compared to 32.6% of new clients. Furthermore, there is a higher percentage of unemployed among heroin users than among cocaine and cannabis users. 5.0% of SerT clients were found to be homeless.

Employment situation: 66% of clients have jobs

In comparison with 2011, there has been a dramatic overall decrease in funding (-21.4%), largely attributable to the discontinuance of funding in Calabria, Emilia Romagna, Marche and Sicily. Total funding stood at 7.3 million euros.

21.4% less funding for social reintegration than in 2011

In 2012, as was the case in 2011, half of Regions and Autonomous Provinces reported having created housing programmes specifically targeting individuals undergoing social and healthcare treatment for drug use. 53% of Regions and APs report that they provide residential facilities for the social reintegration of drug addicts.

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

In 2012, as in the past, workplace reintegration was reported as being a high priority goal by the Regions and the Autonomous Provinces. Employment and job training programmes created exclusively for current and former drug users were put into effect in 53% of the Regions and Autonomous Provinces. If we include in this figure programmes which are open to other socially disadvantaged groups as well, the percentage rises to 71%. This action area has improved greatly with respect to the 2011 figures (52.9% vs. 35% and 70.6% vs. 35%).

Few job training programmes launched

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

In 2012, a total of 32,694 persons were reported pursuant to Art. 75, of whom 30,628 were male (accounting for 93.7%). Over the last four years, there has been a slight decrease in the percentage of subjects reported for possession for personal use for heroin, in comparison with an increase in the percentage for cannabinoids since 2010 (75% of the total in 2010 vs. 77% in 2012).

32,694 subjects reported by Law Enforcement under Art. 75

Turning our attention to activities in the fight against drug-law violations, Law Enforcement Agencies conducted 22,748 anti-drug operations in Italy in 2012, resulting in 34,971 charges filed for offences related to the production, trafficking and sale of illegal substances, conspiracy with intent to traffic and other crimes and offences in violation of Presidential Decree DPR 309/90, registering a 5% decrease in comparison with 2011.

In 2012: 34,971 charges filed for offences under DPR 309/90: 5.0% less charges than in the previous year

The percentage of foreigners apprehended and brought before the Judicial Authorities decreased in 2012 (35% of the total number of persons charged during the course of anti-drug operations). In addition, the number of women reported to the Judicial Authorities in 2012 stood at 2,978, a 4.6% decrease in comparison with the 2011 number.

With respect to 2011, 2012 saw a drop in the overall number of subjects entering prisons, which fell from 76,982 to 63,020. The number of subjects with drug-related social and healthcare problems entering prisons also fell, by 18.4%, dropping from 22,413 to 18,285, but still accounted for 29% of the total.

An 18.4% decrease in the number of drug-addicted subjects in prison, which fell by 4,128

According to data supplied by health services which provide care for drug addicts in prisons, 23.5% of inmates (13,964 subjects) were diagnosed with a clinical substance addiction, while a total of 34.2% of inmates (20,320 subjects) were users, although not all of these were addicted.

Only 34.7% of drug addicts in prison were tested for HIV upon entering prison (28.5% in 2011), 38.6% (30.8% in 2011) were tested for HCV and a

Few tests for HIV, HCV and HBV

further 29.4% (29.25 in 2011) for HBV. Prevalences of positive results among those tested stood at 5.6% for HIV, 36.9% for HCV and 16.5% for HBV.

Regarding drug-addiction treatment, it was found that 90.6% of inmates with drug-related problems undergo treatment in prison. The type of treatment most frequently used appears to be integrated psycho-social and pharmacological treatment, which is provided to over 6,300 inmates.

90.6% of drug-addicted inmates receive addiction treatment and prevention treatment

In 2012, a total of 10,018 new persons were placed in the care of social services. Of these, 2,518 were drug addicts granted probation or parole under Art. 94 of DPR 309/90, accounting for a total of 25% of the total number of persons placed in the care of social services.
Apart from a slight fluctuation in 2011, the number of subjects who have benefited from alternatives to imprisonment has increased steadily from 2007 to the present (+7.8% in 2012 in comparison with the previous year).

In 2012, 25% of persons placed on probation or parole into the care of social services were drug addicts

2,518 drug addicts placed on probation or parole with services (7.8% more than in 2011)

10. DRUG MARKETS

There were a total of 22,748 anti-drug operations in 2012, of which 84.3% led to the seizure of illicit drugs, 8.5% to additional crime detection and 6.6% to the discovery of quantities of drugs.

Decrease in the number of anti-drug operations

In 2012, as in the previous year, there was a significant increase in marijuana seizures, which rose by 97.1%. There was also an 8.1% rise in hashish seizures. The largest quantities of cannabis derivatives were seized in Apulia (29.2% of the total), Lombardy (18.9%) and Liguria (13.3%). There was a 16.1% decrease in the amount of cocaine seized (5.3 tons).

Increase in volume for marijuana

Significant increase in numbers of cannabis plants

From 2002 to 2012, average prices fell from €96 to nearly €70 per gram for cocaine and from approximately €29 to little more than €25 for a dose of LSD. The average price of hashish fell, while the average prices of marijuana, brown heroin, white heroin and synthetic drugs remained unchanged. Overall, price trends were found to be continuing to decline.

Overall trend in average prices between 2002 and 2012 shows a downturn

In 2012, the average percentage of active principle found in the samples analysed increased both for cannabinoids (THC), rising from 6% to 10%, and for cocaine, rising from 47% to 50%. The percentage of pure drug in heroin decreased slightly, while the number of mg of MDMA contained in each pill/unit dropped from 84 mg in 2011 to 68 mg in 2012.

Increase in percentages of active principle in cannabinoids and cocaine

Part A

New Developments and Trends

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

1.1. Legal framework

Legal framework

The national legal framework applicable in cases related to illegal psychotropic substances did not undergo any changes in 2012, remaining the same as in the previous year. This framework consists of the Consolidated Law covering regulations in the field of narcotic drugs and psychotropic substances, prevention and treatment of drug addiction and rehabilitation of drug addicts, approved with Presidential Decree No. 309 on 9 October 1990. The Single Convention on Narcotic Drugs of 30 March 1961, the 26 March 1972 Protocol Amending the Single Convention of 1961, the 21 February 1971 Convention, based on the principle of banning the use of psychotropic substances if not for medical and scientific needs and which likewise regulates and monitors the legal drug market, controlling and monitoring, albeit less strictly, approximately one-hundred additional substances not covered under the 1961 Convention, as well as the 20 December 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, also remain applicable in this context.

1.1.1 The new COM (2012) 548 Proposal for a Regulation of the European Parliament and of the Council, and national and international regulatory measures issued in 2012

In the National Action Plan on Drugs, within the Action area dealing with legislation, Goal no. 4, Action 4.1 calls for on-going monitoring, in coordination with the competent Administrations, of legislative activities to ensure that laws regarding drug precursors are in compliance with regulations established and governed by the following EU regulations:

- No. 273/2004 of the European Parliament and of the Council, of 11 February 2004
- No. 111/2005 of the Council, of 22 December 2004
- No. 1277/2005 of the Commission, of 27 July 2005, as modified by EU regulation no. 297/2009 of the Commission, of 8 April 2009.

Pursuant to Article 16 of Regulation (EC) No. 273/2004 and to Article 32 of Council Regulation (EC) No. 111/205 on the monitoring and control of trade in drug precursors, on 7 January 2010 the Commission presented a Report evaluating the implementation and functioning of the afore-mentioned regulations three years after they had entered into force. The report contains, among other points, a recommendation to modify existing regulations so as to strengthen monitoring and control of category 2 precursors, which include acetic anhydride (the main drug precursor for heroin).

The Department for Anti-drug Policies, in line with this goal, has complied with the new COM (2012) 548 Proposal for a Regulation of the European Parliament and of the Council amending Regulation (EC) No. 273/2004 on drug precursors. The Department views the Proposal in a favourable light, in the belief that its overall assessment of Community legislation and the recommendation mainly to improve the prevention of the diversion of acetic anhydride (the main drug precursor for heroin) is a positive one and in line with the national interest. With the main goal of disrupting the drug market, the Department has long sought to improve authorization as well as monitoring and control systems, applying recommendations found in

secondary Community legislation, as well as elsewhere. Moreover, in the belief of this Department, the impact this will have on our national system, taking into consideration the effects of European action on our regional and national systems, on the organization of Public Administrations and on the activities of individuals and businesses, will be quite limited. Furthermore, it is believed to be largely feasible from a legal standpoint, especially in light of a recent piece of national legislation (Legislative Decree No. 50 of 24 March 2011), which provides for a complete overhaul of the laws regarding drug precursors contained within the Consolidated Law regulating narcotic drugs and psychotropic substances and the prevention, treatment of conditions of drug addiction and rehabilitation therefrom, approved with Presidential Decree No. 309 of 9 October 1990.
The proposal in question was approved (with some minor conditions) by the 12th Commission of the Senate of the Republic, which expressed its views "on the application of the principles of subsidiarity and proportionality", pursuant to Protocol No. 2 of the Treaty on the Functioning of the European Union, as being in agreement with the principle of subsidiarity as far as it concerns the need for action to be taken on the part of EU institutions. The Commission, in accordance with the principle of proportionality, also held that the proposal was completely in line with objectives to be pursued.

National and international regulatory measures issued in 2012

Table 1.1: National and international regulations issued in 2012.

National Regulatory Acts	Field of Application
Ministry of Health Decree of 11 June 2012	Updating the tables containing descriptions of narcotic and psychotropic substances, in accordance with the requirements of Presidential Decree No. 309 of 9 October 1990 and subsequent amendments and additions. The addition of 6-monoacetylmorphine, or 6-MAM, and 3- monoacetylmorphine, or 3-MAM, to Table I and the substitution of the chemical name of analogues structurally derived from the substance called Butylone.
Ministry of Health Decree of 16 November 2012	Amending Article 2 of the Decree of 31 March 2010, containing: "An update to the tables containing descriptions of narcotic and psychotropic substances and related medicinal compounds, in accordance with the requirements of Presidential Decree No. 309 of 9 October 1990 and subsequent amendments and additions, with substitution of Table II, Section D of the Consolidated Law."
Ministry of Health Decree of 10 December 2012	Updating the tables containing descriptions of narcotic and psychotropic substances, in accordance with the requirements of Presidential Decree No. 309 of 9 October 1990 and subsequent amendments and additions. The addition of 5-IT, or 5-(2-Aminopropyl)indole, to Table I.
Ministry of Health Decree of 14 November 2012	The annual list, updated to 30 September 2012, of businesses authorized to manufacture, use and act as wholesalers of narcotic and psychotropic substances and of businesses holding licenses for drugs classified as Category-1 drug precursors.
Ministry of Health Decree of 08 November 2012	Establishing the amounts of narcotic and psychotropic substances which can be manufactured and put on sale in Italy and abroad during the course of the 2013 calendar year.

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

1.2. National action plan, strategy, evaluation and coordination

Action plan

In the session held on 29 October 2010, the Council of Ministers approved the National Action Plan on Drugs for 2010-2013. This document represents the point of reference for policies relating to the field of drugs for the three-year period in which it will be in effect. It lays out the action strategies in a practical and straightforward fashion, beginning with the analyses shared during the 5th National Conference in Trieste and by the post-conference working groups, and maintains its consistency with the instructions laid out in the European Action Plan throughout. It is therefore a particularly important instrument for determining the direction to be taken when developing concrete actions, organised and coordinated through combined efforts of the National Department and the Regions/Autonomous Provinces.
All of the actions and recommendations contained within the National Action Plan on Drugs (NAPD) are consistently supported by project activities created by the Department through the delineation of appropriate project plans (Section 1.2.2).
In 2012, a study was conducted to assess the NAPD, by means of the distribution of an assessment questionnaire. The results of this study will be presented within this document.

1.2.1 Monitoring of the National Action Plan on Drugs (2010 – 2013)

The goals of the National Action Plan (NAPD) monitoring which was carried out over the course of 2012 were:

- To identify the relationship between regional regulations governing the field of addictions and the NAPD.
- To identify action priorities established and actions overseen at the regional level.
- To monitor the degree to which NAPD goals have been actualized, in relation to actions carried out by the Regions.
- To bring to light existing best practices
- To bring to light models for the governance of addictions being put to use in the different Regions of Italy as well as existing information systems.

Identifying the connection between regional regulations governing the field of addictions and the NAPD

Regional regulations were examined by means of an evaluation of the following conditions in each individual Region / Autonomous Province (AP):

- Regions and APs characterized by regulations of reference before and after the NAPD was approved (October 2010)
- Regions and APs characterized by regulations of reference before the NAPD was approved (October 2010)
- NAPD adopted through regional and AP regulations
- Creation of a Regional Action Plan (RAP) on Addictions (individual regional programmes).

This analysis made it possible to determine that the situation is as follows.

Table 1.2: Adoption of the NAPD: regional addiction regulations in existence before and after adoption of the NAPD.

Region/AP	Regulations before and after	Regulations before	NAPD adopted	RAP created
Abruzzo		X		
Basilicata		X		
Calabria	X		X	X
Campania	X		X	
Emilia Romagna	X			X
Friuli Venezia Giulia	X			
Lazio	X		X	
Liguria		X		
Lombardy		X		
Marche	X			
Molise		X		
AP of Bolzano	X			
AP of Trento		X		
Piedmont	X			X
Apulia	X			
Sardinia	X		X	
Sicily	X			
Tuscany	X			
Umbria		X		
Valle d'Aosta		X		
Veneto		X		

Regulations governing addictions exist in all of the Regions and APs. In nine cases, these were found to have been in force before the NAPD was approved, while the remaining 12 issued updated regulations after the NAPD had been approved. In 4 cases the NAPD had been formally adopted, while in 3 cases individual regional programmes comprised Regional Action Plans.

Identifying the priority action areas as established at the regional level and the actions subject to oversight on the part of the Regions

This type of information was provided by the AP of Bolzano and by the regions of Veneto, Friuli Venezia Giulia, Marche, Umbria, Lazio, Abruzzo, Molise, Campania and Calabria. In almost all of the Regions and APs, the activities being overseen or coordinated directly by central authorities represented only a small number of the activities carried out; the principle actions were: Planning, Coordination and Monitoring and Evaluation.

The activities being overseen or coordinated directly by central authorities mainly involve project planning (86%) and fall within the action area of prevention. Nearly all Regions and APs which describe activities subject to oversight or coordination by central authorities include in those descriptions actions connected to the NAPD or funded by the Department for Anti-drug Policies (DAP). (Of all the Regions and APs which provided information, only Veneto and Marche made no direct reference to the NAPD or the DAP).

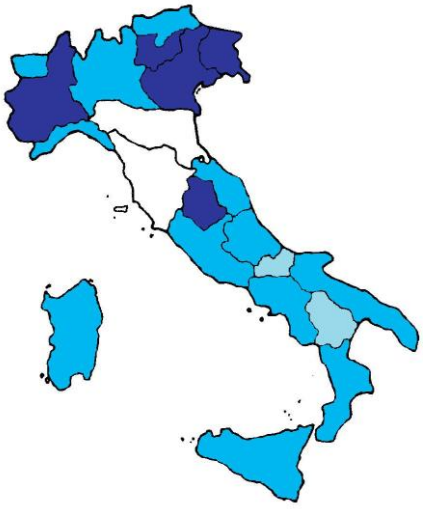
Monitoring of the degree to which NAPD goals have been actualized, in relation to actions carried out by the Regions

Thanks to information gathered through interviews, it was possible to identify the goals which have been actualized in each Region and AP throughout the country, whether in the form of special projects or of routine actions falling within one of the four NAPD action areas: Prevention; Treatment and Prevention of Drug-related Diseases; Rehabilitation and Reintegration; Monitoring and Assessment.

The degree of actualization of each action area's goals can be shown as a percentage.

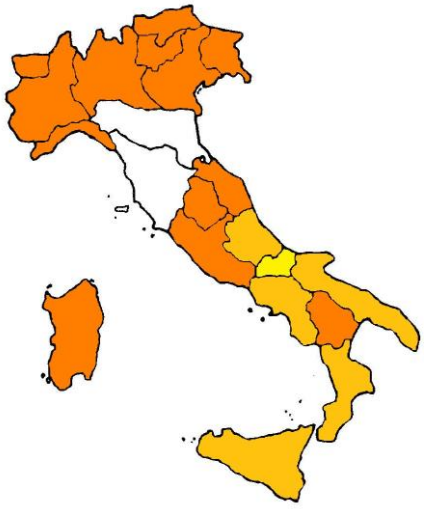
Figure 1.1: Assessment of overall compliance (on a scale of 1 to 4).

Action Area: Prevention



- < 31% (5 goals out of 16)
- from 32% to 63% (between 6 and 10 goals out of 16)
- > 64% (at least 11 goals out of 16)
- n.a.

Action Area: Treatment and Prevention of Drug-related Diseases



- < 32% (7 goals out of 22)
- from 33% to 64% (between 8 and 14 goals out of 22)
- > 65% (at least 15 goals out of 22)
- n.a.

Action Area: Rehabilitation and Reintegration

- < 27% (3 goals out of 11)
- from 28% to 64% (between 4 and 7 goals out of 11)
- > 65% (at least 8 goals out of 11)
- n.a.

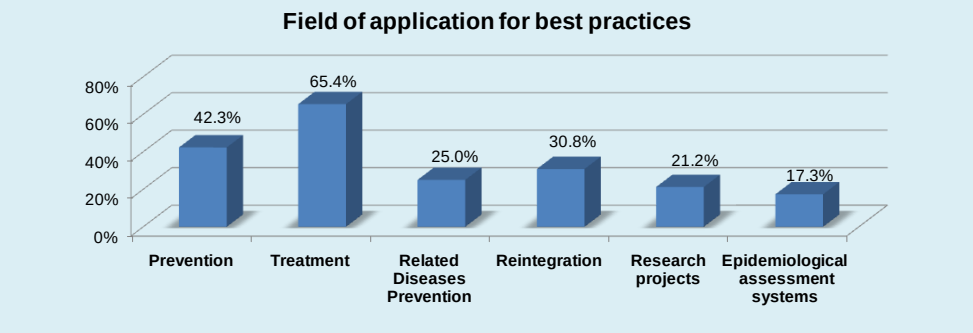
Action Area: Monitoring and Assessment

- < 33% (3 goals out of 9)
- from 33% to 67% (between 4 and 6 goals out of 9)
- >68% (at least 7 goals out of 9)
- n.a.

52 best practices were identified in 18 Regions. Most of these best practices lie in the spheres of prevention and treatment. In 3 out of 4 cases, moreover, these are structured actions, and in 1 out of 4 they are projects-type activities.

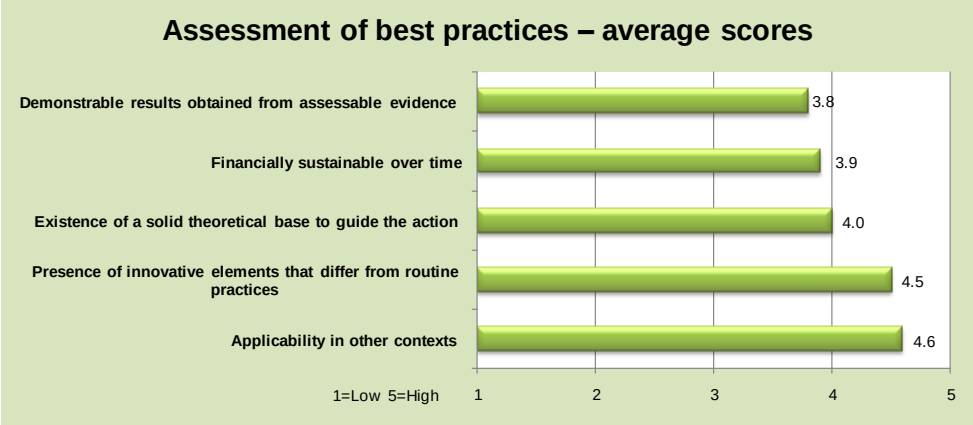
Identifying existing best practices

Figure 1.2: Field of application for best practices (expressed as %).



Nearly half of all best practices originate with the Local Health Authorities (ASL), followed by the Regions and then the Provinces. Assessment of best practices tended to be quite positive, largely due to their applicability in multiple contexts and to their innovative elements.

Figure 1.3: Assessment of best practices (on a scale of 1 to 5).



Best Practices

The study of best practices was preceded by an examination of the general information framework (Chart 1), an analysis of regional activities subject to direct regional supervision (Chart 2) and a description of the best practices themselves (Chart 3). It was accompanied first by an interview with regional supervisors, and, finally, by an on-site visit to the place where the best practice was being overseen.

There are best practices to be found in all of the Regions consulted to date, and they can be found in the following areas:

- Legislation and planning
- Regional oversight of activities
- Special projects or routine activities carried out within the Regions.

What all these Regions were found to have in common was a paucity of best practices in the area of regional legislation. There are many possible reasons for this. Firstly, it could be caused by the way in which the field of addictions is divided into sectors or by the fact that it is subject to different bodies of regulations, such as those governing the health sector or the field of social policies. Secondly, the speed at which the drug phenomenon evolves does not allow administrations to make suitable adaptations to

procedures employed in the drafting of administrative legislation. The instrument most often employed, and which provides sufficient visibility, is the Council Resolution. However, it makes the process of outside consultation very difficult. In a few cases, such as that of Piedmont, where the effort was to make legislation coherent while employing the instruments provided by the "consolidated laws", the length of time for which this effort had to continue made the reorganization process quite 'burdensome'. In smaller geographical areas with administrative autonomy, such as the Autonomous Province of Bolzano or Friuli Venezia Giulia, a 'base' legislation exists which, however, does not take into account any evolution that has occurred as a consequence of local experience. In yet other cases, such as those of Basilicata, Campania or Calabria, we must go back into the past to find any actions of innovational significance, such as the structuring of public services or their integration with private non-profits.
Regarding those activities being overseen directly by Regional Authorities, the study brought to light the formidable limitations caused by funding shortages. Especially in those Regions subject to debt-repayment plans, a shortage of funds restricts experimentation, even when interesting ideas could be put into action. It also limits implementation of new ideas in the fields of policy or as small-scale trials. The Region of Lazio, despite having to adhere to a repayment plan, has proven itself very adept in seeking out new sources of funding for activities believed to be of importance for the effectiveness of public addiction policies, such as training activities for professionals working in the sector or the improvement of epidemiological assessment systems.

1.2.2 Coordination arrangements

The Department for Anti-drug Policies – 2012 Organisation and Activities

The Department as a permanent organization within the Presidency of the Council of Ministers

On 29 October 2009, a Decree of the President of the Council of Ministers ensured that the Department for Anti-drug Policies became a permanent organization whose aim was to assist in the promotion, coordination and interconnection of Government actions in the field of anti-drug policies. Its organizational structure was established by a second Presidential Decree on 31 December 2009.

Minister Andrea Riccardi receives addictions appointment

With the Decree of the President of the Council of Ministers of 13 December 2011, Minister Andrea Riccardi was appointed to promote and direct policy for preventing, monitoring and fighting the spread of drug addiction and the related problem of alcoholism, in accordance with the Consolidated Law regulating narcotic drugs and psychotropic substances and the prevention and treatment of conditions of drug addiction and rehabilitation therefrom, approved by Decree of the President of the Republic (D.P.R.) No. 309 on October 9, 1990 and its subsequent amendments.
When Legislative Decree 52/2012, containing new regulations under the Spending Review, was enacted as Law 94 of 6 July 2012, the Department of Anti-drug Policies underwent some internal reorganization as a result of restructuring within the Presidency of the Council of Ministers, but maintained its position therein.

Activities carried out in 2012 and the 2010-2013 Action Plan

Activities carried out by the Department during the course of 2012 resulted in the continuation of activities on-going in previous years. 2012 also saw the launch of new activities further implementing actions foreseen as part of the National Action Plan on Drugs 2012-2013, approved during the 29 October 2010 session of the Council of Ministers and upheld by the government under Monti.

National Monitoring Centre

The National Monitoring Centre operates within the Department, as established by paragraph 7 of Article 1 of D.P.R. 309/90. Over the course of 2012, in addition to the institutional tasks assigned to the Service (the Annual Report to the Parliament, the National Report and Standard Tables for the Monitoring Centre in Lisbon, the statistical flows for UNODC), the National Monitoring Centre participated in the realization and assessment of all on-going projects, collaborating in the planning of those in the development and launch phases. The Monitoring Centre also worked closely with the National Focal Point to continue necessary activities for the reorganization of national data flows and of data flows from the regional monitoring centres for addiction, aligning them with European standards (these flows consist of the National Information System on Addictions [SIND] Support project and the Italian Network of Addiction Monitoring Centres [NIOD]). The objective is to update these flows to comply with adaptations approved by the Monitoring Centre in Lisbon.

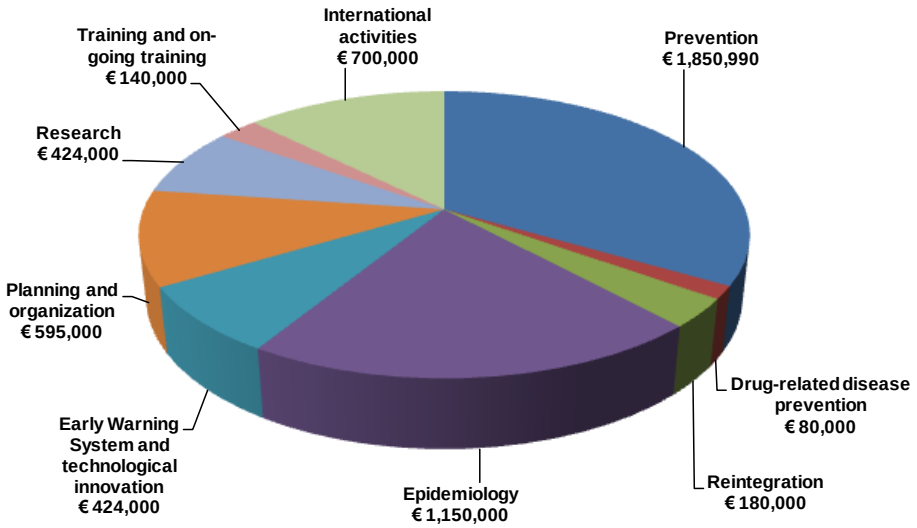
The National Statistical Programme

As part of developing a national network for the management of data flows and making it fully operational, the DAP has begun, with the help of the National Institute of Statistic's (ISTAT) National Statistical System (SISTAN), to study and put together a plan to enter its statistics into the National Statistical Programme (PSN), which is the official national statistics report. The Monitoring Centre's activities and their outcomes will thus be validated by the ISTAT, in terms of both methodology and results, and will be published as part of Italy's official statistical data.

Projects Plan 2012

Since 2009, the DAP has funded a total of 207 projects. 29 of these were carried out in 2012, for an investment of €5,543,990, allocated as shown in the figure below.

Figure 1.4: Allocation of funds within the 2012 Projects Plan.



Source: The Department for Anti-drug Policies

Early Detection for Early Intervention

In April, a three-day workshop was organized specifically for Early Detection for Early Intervention training. It was attended by 70 professionals from different areas of the drug-addictions field who came from throughout the nation, all of whom are involved in local application of a prevention model focusing on early drug-use detection and intervention.

Scientific collaboration between the DAP and the NIDA

2012 saw further strengthening of the scientific collaboration agreement between the DAP and the NIDA (the American *National Institute on Drug Abuse*), with a series of initiatives whereby representatives from both organisations attended important conventions, each at the other's invitation. In particular, eminent U.S. representatives directly collaborated and participated in training events within the Outcome project, and contributed to a special two-day session at the National School on Addictions devoted solely to the NIDA. Furthermore, in November, the Third International Conference on the Neurosciences was held in Verona: "Addiction: new evidence from neuroimaging and brain stimulation". Nearly 100 participants attended.

The DAP was invited to present the results of its activities during two important events it was asked to attend in the U.S.A.: the APA Conference in May and the NIDA International Forum in June.

These reciprocal invitations and resulting event attendance also provided an opportunity to agree upon and launch new areas of joint research, thus further strengthening our binational collaboration.

International Consortium of Solidarity

Other international collaborations of note include cooperation with the UNODC, which led to the creation of the "International Consortium of Solidarity for the Prevention of Drug Use". The Consortium was presented in October during the course of an international conference attended by delegations from 57 countries and representatives of the most important international institutions in the addictions field.

Institutional activities in the international arena

Areas of involvement

During the year 2012, the Department for Anti-drug Policies further reinforced its involvement in activities in the international arena, in collaboration with both European institutional bodies and international organizations as well as through bilateral agreements.

UN - CND

Italy's activities at the United Nations consist principally of its participation in the Commission on Narcotic Drugs (CND), established by the Economic and Social Council of the United Nations (ECOSOC) by Resolution 9 (I) of 16 February 1946 as a subsidiary body in the field of drugs. The 55th Session of the UN Commission on Narcotic Drugs, held in Vienna on 12-16 March 2012, constituted, as it does every year, the principal UN event for discussing the global drug problem and agreeing upon common international strategies for dealing with it. This session, like the 54th before it, was of great importance for Italy, as it saw the approval of an EU resolution which Italy had championed in the European arena, namely, to "promote strategies and measures targeting the specific needs of women in the context of programmes and strategies that are comprehensive and integrated in the reduction in the demand for drugs". This was the first time that a resolution was approved that acknowledged gender differences in the sphere of drug use and addiction.

This resolution's main objective is to encourage Member States to develop guidelines and put into effect the necessary actions to effectively respond to the specific needs of women in every aspect of treatment, as well as promote gender-oriented strategies and actions for women at risk. These

actions should, at the same time, contribute to fighting phenomena linked to discrimination and the psychological abuse of women. Nations outside of the European Union have taken on the commitment of funding and creating a like resolution in their own countries. These are the United States, Israel, El Salvador, the Ukraine, the Philippines, Croatia, Albania, Peru and Thailand.

Bilateral agreements Italy - USA

Building upon agreements previously reached establishing close collaboration between Italy and the U.S., 2012 saw a strengthening of the bilateral relationship between the two countries. The goal was to collaborate a variety of areas including prevention, research in the field of the neurosciences and the rehabilitation of drug addicts, as well as in general policy and strategy actions. The most significant concrete consequence of these collaborations has been an on-going and fruitful exchange of information between our two nations' institutions.

With this important alliance with the U.S.A. as a starting point, Italy has striven to strengthen other international partnerships (with countries both inside and outside Europe) in order to develop and actualize strategies based upon scientific data and human rights, in line with UN conventions on drugs.
The World Federation Against Drugs' Third World Forum Against Drugs was held in Stockholm on 21-23 May. It focused on three main topics: human rights and the rights of minors to be protected from drugs; illicit drug use and trafficking problems in Latin America; primary prevention and its role in drug policy. During the Forum, the Department, together with other nations including Sweden, Russia, the United Kingdom and the United States of America, signed an important joint statement for the promotion of a shared, balanced approach focused on prevention and on the rehabilitation of drug addicted individuals. This approach would combine effective law enforcement aimed at reducing drug supply with efforts to reduce demand.

UN UNODC – INCB

Furthermore, during the course of 2011, cooperative collaboration actively continued with the principal United Nations organizations working in the drug field: in particular, with the United Nations Office on Drugs and Crime (UNODC), the organ of the United Nations in charge of the fight against drugs and international crime. The Department renewed its participation with UNODC for the year 2012 in a joint program launched in 2009, in collaboration with the World Health Organization (WHO), dealing with the treatment and care of drug addiction in the Balkan region. The program's objective consists of reducing demand for illicit drugs and reducing the suffering and harm related to drug use for individuals, family, the community and society. Cooperation between the two organizations in this field is fundamental and aims to promote effective treatments and care for drug addicts as well as reinforce specific obligations taken on by the national and international players involved, with respect to their responsibilities in the fight against the international drug problem.
October saw the launch of an important initiative focusing on training policy makers. The initiative involves various different geographical regions, in particular East and Central Asia, Central America and Northern Africa. This joint DAP and UNODC Initiative, called "Prevention Strategy and Policy Makers", aims to disseminate the UNODC International Standards on Drug Use Prevention and support policy makers in planning national drug prevention systems that are health-centred and based on scientific evidence. This Initiative involves the creation of regional

prevention hubs and the training of policy makers in order to provide them with concrete tools to improve their national prevention systems, and guarantees them, among other things, access to an archive of effective drug prevention sample programs and materials. As part of this initiative, the “Prevention Strategy and Policy Makers. A Solidarity Consortium” conference was held in Rome on 9-10 October. Those attending were invited to take part in two satellite events. The first, organized by the National Association of Drug Court Professionals (NADCP), focused on promoting alternative judicial models for drug-related crimes. The second, organized by the United Nations Interregional Crime and Justice Research Institute (UNICRI) focussed on improving participants’ drug monitoring systems in order to strengthen the capabilities of national control bodies.
In 2012, the DAP prepared the questionnaire on new psychoactive substances and, as in previous years, in collaboration with other competent Administrations, it prepared the Annual Report Questionnaire (ARQ) and coordinated its administration using the 2011 data in its possession, in accordance with reporting requirements established by the 1961 United Nations Convention. The ARQ focuses on the functioning of international treaties dealing with drug control and the measurement of progress made on the National Action Plan and Political Declaration. The new psychoactive substances questionnaire, on the other hand, focuses on gathering all useful information on newly identified psychoactive substances currently in use within Member States, in order to update the 2011 UNODC report, “Synthetic cannabinoids in herbal products”, with the purpose of providing a timely information tool for all States and competent authorities.
Furthermore, in order to present its position, the DAP also promoted two coordination meetings with other Administrations concerned with Bolivia’s request for re-adherence, with reservation, to the 1961 UN Single Convention.Moreover, work with the International Narcotics Control Board (INCB), the independent monitoring body for the implementation of the United Nations international drug control conventions, involving the handling and filling out the questionnaires sent by the INCB in order to monitor current and emerging trends in drug abuse, continued throughout the course of 2012. In particular, the Department, in collaboration with other competent administrations, arranged for the handling, filling out and sending of the questionnaire on the implementation of the Council Recommendation of 18 June 2003 on the Prevention and Reduction of Health-related harm Associated with Drug Dependence.

EU Activities – Horizontal Drugs Group (HDG)

Italian activity in the European Union arena is characterized by Italy’s active and on-going participation in the work of the Horizontal Drugs Group (HDG), the interdisciplinary Working group of the Council of the European Union whose responsibility it is to launch, monitor and coordinate all activities that fall within the drugs field, developing the Council’s anti-drug policy.During the first months of the year, the DAP coordinated delegation worked to promote a European resolution promoting strategies and measures targeting the specific needs of women, to be presented during the UN Commission on Narcotic Drugs. Through important work accomplished during the course of HDG meetings held in January, February and March, Italy was able to ensure that Europe presented a united front to Commission on Narcotic Drugs, with a document presented by Denmark, the then holder of the rotating EU Presidency. The resolution was subsequently approved by the Commission on Narcotic Drugs.

A new European Strategy

The Department also made a significant contribution to the creation of the new EU Drugs Strategy for 2013-2020. This document provides a shared overall framework for an evidence-based approach to the drugs problem. The strategy is the result of coordinated action conducted on the European level in response to the need to take on drug-related issues in a global context. The strategy aims to contribute to reducing not only drug demand and supply within the European Union, but also health and social issues caused by the use and availability of drugs. It would do this by means of a strategic approach that both provided support for and integrated States' national policies, providing a framework for coordinated joint actions. The DAP played an active role in discussions concerning the two action areas included in the strategy – demand reduction and supply reduction – emphasising the need for a balanced approach.

EU Activities – National Coordinators

The Department also took part in the activities of the National Anti-drug Coordinators. Coordinator meetings are called twice a year by the Presidency of the Council of the European Union, as set forth in the EU Action Plan for the fight against drugs 2009-2012. The purpose of these meetings is to guarantee effective coordination and ensure that a real impact is made on a strategic level concerning specific and/or urgent matters. The topics addressed in these meetings are decided by the nation which holds the rotating Presidency of the Council of the EU.
Moreover, the Department was called to offer its expertise in the role of "mentor country" at the National Drug Coordinators Meeting, held in Cyprus in September of 2012, during the six-month period when Cyprus held the Presidency.

EU Activities – Miscellaneous

The Department's European activity also involves participating and working jointly assist in filling out questionnaires sent by the institutions of European nations. For the purpose of carrying out this activity, the Department has enlisted and coordinated other Italian central administrations competent in the field. In 2012, specifically, the Department participated in the following initiatives:

- Questionnaire for services carrying out drug prevention activities among ethnic minorities, migrants and immigrants
- Questionnaire on women and access to treatment
- Questionnaire on the implementation of the Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence
- Questionnaire: "Towards a more effective European response to drugs"
- Interview on the topic of substitution treatment as part of addiction treatment (part of the European research project ALICE RAP [Addiction and Lifestyles in Contemporary Europe - Reframing Addictions Project]).

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

In addition to these activities, the Department considers fundraising activities to be of the utmost importance. To this end, the Department plays an active role in promoting and/or providing support for new projects on both European and international levels, in the interests of moving towards an ever-more effective anti-drug policy.
Specifically, in the context of the European Programme for the Prevention

of and Fight Against Crime (ISEC), the Department is currently involved in the execution of a project co-funded by the European Commission: “Save Our Net (S.O.N.): Drug Sale and Trade under Attack. Let the Civil Society give Minors a Safer Internet”. The goal of this project is to develop a new and efficient method for monitoring and discouraging the sale and trafficking of harmful substances online by minors and, at the same time, to create information campaigns, targeting parents, on the dangers of the internet. The Department has involved a number of partner organizations in the project, including the Italian Central Directorate for Anti-Drug Services (DCSA), the Customs Agency, Addiction Department ULSS 20 Verona, the Italian Parents Movement (MOIGE) and the Italian Parents Association (AGE). Together, we are developing a multidisciplinary and coordinated working methodology that will allow us to work successfully in a field known for its fluidity: that of online drug sales. The agreement with the European Commission was signed in November 2011, marking the project’s official inception. 2012 saw the launch of important activities, such as a comparative study of existing regulations and legislation in this field in EU Member States and elsewhere, with the aim of being able to develop guidelines to effectively fight the sale of potentially harmful substances to minors over the internet. Also in 2012, an interdisciplinary working group was launched, involving experts from various partner organizations. The project has received a six-month extension from the Commission and will therefore conclude its activities in May 2014.

The European Union – the ERANID project

In the European arena and within the context of the 7th Framework Programme for Research and Technological Development (2007-2013), the Department was an active participant in developing the ERANID (ERA-NET on illicit drugs) project proposal, presented to the European Commission in February 2012, to create a Consortium of European States which appreciate the importance of shared research in the field of drugs. The DAP, the leader of the Project Area dealing with the Communication and Dissemination of the ERANID results, in its role as Consortium partner, signed the agreement with the Commission whereby the Project, which involves six countries, coordinated by the Netherlands, was officially launched.

The Dublin Group

The Department also attended the semi-annual meetings of the Dublin Group, a body which informally coordinates regional cooperation policies and which consists of 27 EU Member States, the European Commission, the United States, Australia, Norway and Japan. The Group’s active operations continued throughout the course of 2012. The Department supported coordination on the part of the Italian delegation, which continued, in 2012, to preside over the Dublin regional mini-group which monitors the Central Asian countries, meaning Tajikistan, Uzbekistan, Kazakhstan, Kirghizstan and Turkmenistan.

European Council Activities

Italian activity in the context of the European Council is characterized by its participation in the Pompidou Group, an inter-governmental body for cooperation in combating drug abuse and illicit drug trafficking. The Group makes it possible for its 37 Member nations to share national policies and practices, with the objective of standardizing their respective actions and strategies and making these consistent and effective.
The Group’s policy follows the Work Programme approved for the period 2011-2014. This programme sets forth a more balanced approach between demand and supply reduction activities, strengthening the latter; it aims to develop a multidisciplinary strategy and ever closer cooperation

between different Member States. The Department also participated in an informal consultation regarding the Republic of Moldova's request to join the Group.

Pompidou Group – Permanent Correspondents

During the course of 2011, the Department continued to contribute to the activities of the Pompidou Group, periodically submitting comments through its contributions and proposals, maintaining its on-going participation in the meetings of the single ad-hoc Groups and of the Permanent Correspondents (representatives of each Member nation belonging to the Group who represent their countries in all questions concerning drugs and drug addiction and whose task it is to monitor and manage the progress of the Pompidou Group's activities and prepare the work programme).
The 70th meeting of the Committee of Permanent Correspondents was held in Strasbourg on 6-7 June 2012. During the meeting, not only was the report from the previous meeting adopted, but Dr. Elisabetta Simeoni, Service I Coordinator of the "National Monitoring Centre and International Relations", was appointed the Pompidou Group's Gender Equality Rapporteur, with the aim of promoting gender equality within the working groups. During the meeting the progress of the various ad-hoc working groups created based on the Work Programme adopted in 2010 was also analysed.

Gender Equality Oriented

In 2012, the Department joined the Transversal Programme on Gender Equality, launched by the Secretary General to improve the visibility and impact of the Council of Europe's gender-equality work in Member States. Indeed, in a Statement, the Committee of Ministers exhorted Member States to "make gender equality a reality". In this context, the programme will seek to mobilise all Council of Europe bodies (including intergovernmental structures) and its external partners. Every gender-equality rapporteur must watch over the programming process of his or her committee (i.e. the process of identifying priorities, preparing activity proposals, setting up and implementing the activities and evaluating the results) in order to ensure that a gender perspective is properly integrated.
After having been appointed as gender equality rapporteur, Dr. Elisabetta Simeoni also attended two meetings of the Gender Equality Commission, which took place in June and November.

Ad-hoc Group on Work

The ad-hoc group on Work operates in the area of drug use and alcohol consumption in the workplace. Italy contributed by identifying experts whom they sent to the Group's third meeting, held in Paris on 9-10 February.
In addition, the Department participated in the high level Conference on "Alcohol, drugs and prevention in the workplace: What are the issues and challenges for the Government, the Company and the Staff?", held in Strasbourg on 14-15 May 2012. During the conference, whose aim was to promote guidelines to ensure the safety and security of all parties and thus improve workplace functioning, the Final Declaration, to be passed on to the representatives of all the governments and international organizations attending the conference, was adopted.

Ad-hoc Group on Strategy

During the course of the year, the ad-hoc group on Strategy put together a policy paper aiming to provide guidance for policy makers for the development of coherent policies for licit and illicit drugs, taking into account the experience of single Member States and existing EMCDDA, UNODC and WHO guidelines and instruments. Italy sent a contribution and comments to assist in the creation of this document providing

guidance for policy makers in the field of anti-drug policy.

CoherPol ad-hoc Group

The main objective of the CoherPol ad-hoc Group is to identify effective approaches in the area of the development of coherent policies for licit and illicit drugs through the use of six indicators, to be developed during the group's tenure. The Department took an active part in the Group's work, sending experts to its April 2012 meeting and producing reports for the creation of a document on policy markers.

Ad-hoc Group on Supply

The ad-hoc Group on Supply is developing a model intended to reduce drug supply on a global scale, in order to contribute to creating more coherent approaches to national activities for supply reduction and improve international drug control strategies. The Department contributed by identifying an expert, consulting with involved Ministries to do so.

Ad-hoc Group on Precursors

The ad-hoc Group on Precursors deals with preventing the diversion of drug precursors. Its work consists of exploring possibilities for improving information exchange and coordination among law enforcement agencies, regulating authorities and public ministries at an international level, examining lacunae in the legal process (from the identification of suspicious shipments to legal procedures and sanctions applied). The Department contributed, in coordination with the Ministries concerned, by identifying experts who were then sent to participate in the November conference.

Pompidou Group – The Airports Group network

The Airports Group network is an important forum for the exchange of practical information on problems and operational practice. Its objective is to harmonise tools and systems for drug detection in European airports. Topics dealt with in 2012 included: the study of the diversion of precursors and drug seizures in airports, with particular emphasis on the threat posed by drug trafficking at small- to medium-sized airfields. The Department was responsible for guaranteeing participation in the Group's operations, maintaining relationships and ensuring there was an on-going information exchange with experts, especially on the occasion of the preparatory meeting for the annual meeting, held in Paris on 26-27 January, and the 27th Annual Meeting, held in Strasbourg on 20-22 June.

The Pompidou Group's MedNET network

The MedNET network – the Mediterranean network for cooperation on drugs and addictions – aims to foster cooperation, exchanges and transfers of knowledge and experience between the countries of the southern Mediterranean, who are the beneficiaries of the activities being conducted, and the northern Mediterranean, who serve as providers.

In the context of MedNET, the Department has continued to support the activities set forth in the Network programme. The 12th Meeting of the MedNET network was held in Rome on 18 June 2012, organized and coordinated by the Department, which also took care of follow-up, in the form of translation and dissemination of the documents produced during the course of the meeting. The Department also attended the 13th Meeting of the MedNET network, held in Strasbourg on 15 November. The objective of this meeting was to examine the work done in 2012 by each of the countries involved in the network, assess activities carried out by MedNET and adopt the 2013 work programme, including the administration of surveys under the MedSpad project and the creation of National Drug Monitoring Centres and various other support activities in Egypt, Jordan, Lebanon, Tunisia and Morocco. Additionally, during this meeting, the Department's proposal, regarding the funding of Round Tables for the anti-drug policy field and for action plans to be implemented during the course of 2013, was accepted. These would allow countries

involved in the MedNET network to participate in and receive on-site training from international experts on the topics connected to anti-drug policy most useful to their country's needs.

Project Drugs, Alcohol and Women (DAWN) Network

The First Scientific-Technical Office coordinated activities for the launch of the Project Drugs, Alcohol and Women (DAWN) Network, overseen by the United Nations Interregional Crime and Justice Research Institute (UNICRI). It involves the realization of micro-projects in the sphere of prevention (for young women who have not yet developed addictions but are considered to be at risk) and in the spheres of addiction support and of care and reintegration (for girls and women who have already developed addiction problems and have already more or less entered the addiction services system). Specifically, a multidisciplinary Group was created, composed of national and international experts who have been tasked with developing operational guidelines which take into account gender differences and gender-specific risk factors, motivational factors and factors that determine the success of projects targeting the female gender. To give the project even greater visibility, at the 55th Session of the United Nations Commission on Narcotic Drugs and on the occasion of the approval of the Resolution on women presented by the EU on Italian proposal, the Department, in collaboration with UNICRI, organized a side event, held in Vienna on 15 March 2012, to present the project and the results it has achieved. Moreover, in the context of this project, a second conference was organized, following the one held in 2011, and it took place at the headquarters of the FAO in Rome on 20-21 June 2012. The objective of this meeting was to reaffirm support for effective projects and programmes in the fields of prevention, treatment, rehabilitation and cure of addiction among women, taking account their gender-specific needs.

DAP/EMCDDA Collaboration

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

The EMCDDA Management Board

During the course of 2012, the Department guaranteed attendance of biannual meetings of the Management Board, actively participating in discussions on the agenda regarding the management of the EMCDDA budget, the definition of the Board's annual work programme and the revision of the definitions and protocols of a number of key epidemiological indicators.

Contractual activities carried out in 2012

In 2012, as in the past, the Italian Focal Point stipulated its annual contract with the Reitox Coordination of the EMCDDA and brought all prescribed activities to their conclusions. In particular, these were:

- Preparation and submission to the EMCDDA of the National Report
- Preparation and submission to the EMCDDA of the Standard Statistical Tables and Structured Questionnaires
- Activities to implement the 5 key epidemiological indicators: a) surveys conducted among the general and student populations on drug use b) treatment demand c) estimates of problematic drug use d) drug-related deaths and mortality e) drug-related infectious diseases
- Fulfilling obligations established under the "Council Decision on

information exchange, risk-assessment and the control of new psychoactive substances" and participation in activities of the European "Early Warning System"
- Revision and updating with respect to institutional, legislative and policy developments on a national level
- Revision of national data and information submitted to the EMCDDA and contained within the European Annual Report and online statistical bulletin
- Linguistic revision of EMCDDA publications during their translation into Italian.

Participation in meetings

In addition, the Italian Focal Point guaranteed the participation of its representatives and experts in all the meetings scheduled on the calendar, which were:

- The biannual meetings of the heads of National Focal Points
- Annual meetings on the 5 Key Epidemiological Indicators
- Annual meeting on the Early Warning System
- Annual meeting of correspondents for the legal database
- Technical meeting on "Drug use among prison population: scope and responses"
- Technical meeting on the "Revision of TDI protocol"
- Technical meeting on "Strategies and perspectives for the promotion of Best Practices for the Development of National Focal Points".

Accreditation meeting

A "Technical meeting on Reitox Accreditation System Project", which took place in Lisbon on 6-7 March 2012, was organized by the EMCDDA, on the initiative of the Italian Focal Point.
Numerous international experts attended the meeting, along with representatives of the National Focal Points of the Reitox Network.

1.3. Economic analysis

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

The social costs linked to the phenomenon of drug use

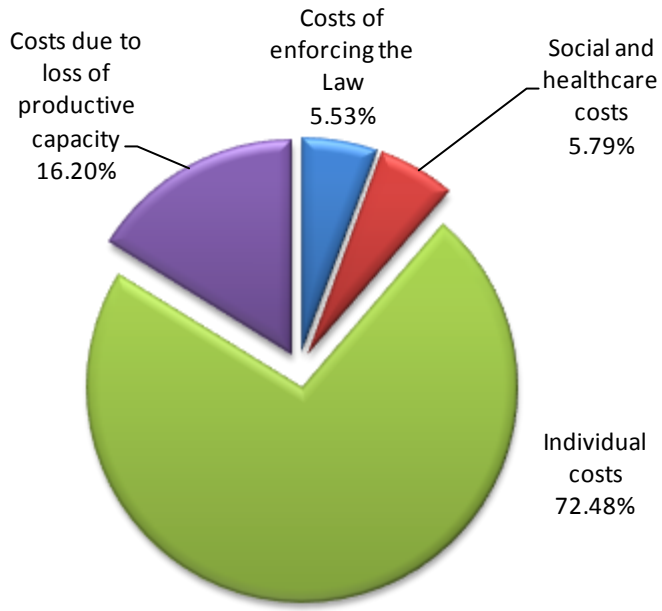
What follows is a theoretical calculation of the monetary value of the elements of this phenomenon which have the most significant impact on society, according to the established definition of the concept of "social costs".

1.3.1. Estimate of social costs

Approximately 28.5 billion euros is the overall estimated social cost of the drug phenomenon for 2011 (1.8% of GDP)

Using the methodological criteria consolidated over the course of previous years, in accordance with the suggestions put forward by the European Monitoring Centre, it has been estimated that the overall social cost of illicit drug use in Italy over the course of 2011 was €28,491,680,073.96, equivalent to 1.8% of Italian gross domestic product (GDP) during that same period. When calculated in terms of cost per capita, this is equivalent to 715 euros per year for every member of the public 15-64 years of age.

Figure 1.5: Distribution of the social costs by macro-category. The year 2011.



Source: The Department for Anti-drug Policies

Table 1.3: Social costs of the drug-use phenomenon. The year 2011.

Cost category	Cost	Percentage
Individual costs	€ 20,651,056,123.84	72.48%
Costs due to loss of productive capacity	€ 4,615,677,697.81	16.20%
Costs of enforcing the Law	€ 1,574,434,036.73	5.53%
Social and healthcare costs	€ 1,650,512,215.58	5.79%
Total	€ 28,491,680,073.96	100.00%

Source: Compiled by the Department for Anti-drug Policies

The greatest cost is that of expenditures for the purchase of drugs by consumers: 20.6 billion euros

Regarding the four principal cost components identified in the introductory portion of this section, calculated according to the criteria described in the methodological section, the greatest social cost is due to expenditures for the purchase of drugs (€20,651,056,123.84) which account for 72.5% of the overall cost (Figure 1.5).

Table 1.4: Estimate of costs due to loss of productive capacity. The year 2011.

€4.6 billion in costs due to loss of productive capacity

Cost category	Cost	Percentage
Loss of productivity	€ 3,052,584,011.45	66.14%
Loss due to premature death	€ 539,940,587.65	11.70%
Cost due to traffic accidents	€ 1,023,153,098.70	22.17%
Total	€ 4,615,677,697.81	100.00%

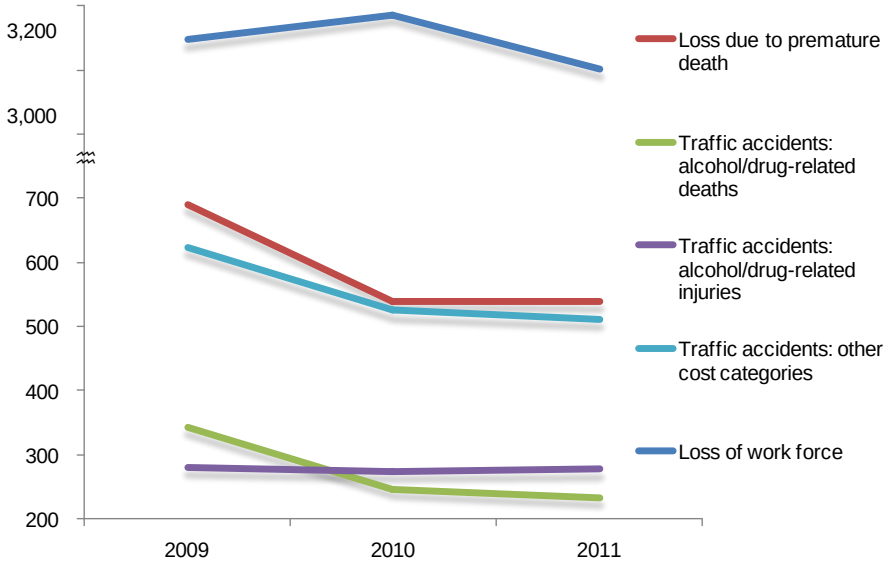
Source: Compiled by the Department for Anti-drug Policies

The second-largest cost category overall, accounting for 16.2%, of the total social costs, is the cost due to the loss of productive capacity (€4,615,677,698), which includes loss of productivity due to loss of professional employment (3,053 million euros), cost due to loss of productivity as a result of premature death (540 million euros) and the social cost attributable to drug users involved in traffic accidents (1,023

million euros).

In comparison with 2010, when the costs for loss of productivity stood at 4.77 billion euros (figure revised in 2012), 2011 saw a decrease of 3.3%. During the three-year period spanning 2009-2011, there was a significant decrease in costs related to deaths caused by traffic accidents (-31.7%) and loss due to premature death (-22.0%), as well as a decrease in other administrative costs tied to the decrease in traffic accidents (-18%).

Figure 1.6: Trends in social costs linked to loss of productivity, by micro-category (figures represent thousands of euros). The years 2009-2011.



Source: the Department for Anti-drug Policies

Activities related to the fight against drugs and the reduction and suppression of drug supply and demand account for approximately 5.5% (1,574,434,037 euros) of the overall social costs, of which over half are borne by the Ministry of Justice for the imprisonment of persons reported for crimes in connection with DPR 309/90 or of drug-addicted subjects held for other crimes. 13% of the costs of enforcing the law are spent by Law Enforcement Agencies in the area of prevention-related activities (Articles 121 and 75 of DPR 309/90) and for the fight against the production, trafficking and sale of drugs, in addition to traffic checks targeting drivers operating their vehicles while under the influence of alcohol or drugs (Articles 186 and 187 of the Traffic Code).

Table 1.5: Estimate of the costs attributable to enforcing the Law. The year 2011.

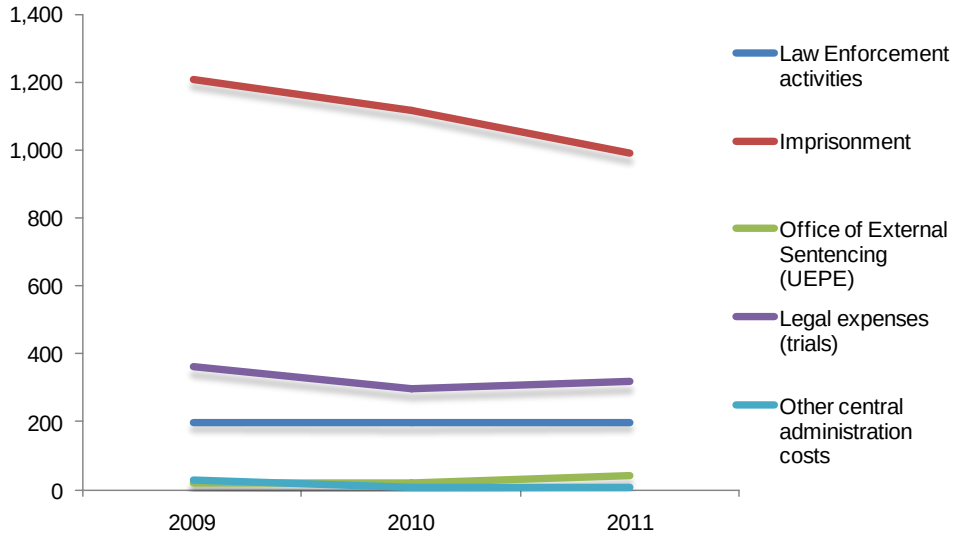
Cost category	Cost	Percentage
Law Enforcement Activities	€ 204,604,327.40	13.00%
Prison and alternative measures	€ 1,038,013,287.92	65.93%
Trials and legal expenses	€ 319,832,54 .60	20.31%
Other Central Administration costs	€ 11,983,878.81	0.76%
Total	€ 1,574,434,036.73	100.00%

Source: Compiled by the Department for Anti-drug Policies

€1.6 billion is the cost of activities related to the fight against drugs, reduction and suppression of drug supply and demand

The three-year period of 2009-2011 shows a progressive decrease in costs of imprisonment (-18%) with a concomitant 87% increase in the costs for other measures offering drug addicts alternatives to imprisonment. There was also a marked decrease in other Central Administration costs, which dropped by 60% during the three-year period in question.

Figure 1.7: Trends in the social costs related to enforcing the law, by micro-category (figures represent thousands of euros). The years 2009-2011.



Source: the Department for Anti-drug Policies

1.6 billion euros spent on social and healthcare assistance for persons undergoing treatment

Social assistance and healthcare accounts for a total of 1,650,512,216 euros, which is equivalent to 5.8% the overall social cost of the drug use phenomenon. The highest costs are those for the cost of outpatient care provided by drug addiction services (689,167,477 euros), closely followed by the cost of treatment for subjects suffering from infectious diseases (in particular HIV and HCV) (621,614,588 euros).
Inserting clients who are receiving care from local services into socio-rehabilitative programmes accounts for a further expenditure of approximately 244 million euros, while hospitalisations of drug users account for 3.3% (approximately 55 million euros).

Table 1.6: Estimate of social and healthcare costs. The year 2011.

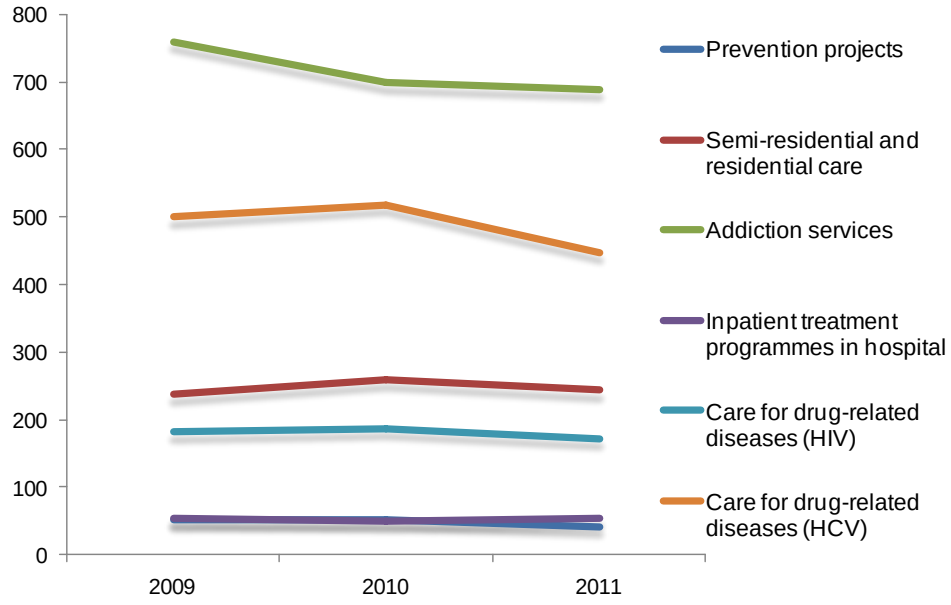
Cost category	Cost in euros	Percentage
Addiction services	€ 689,167,477.37	41.75%
Semi-residential and residential care	€ 243,638,249.91	14.76%
Inpatient treatment programmes in hospital	€ 54,700,173.37	3.31%
Care for drug-related diseases	€ 621,614,588.00	37.66%
Prevention projects	€ 41,391, 26.93	2.51%
Total	€ 1,650,512,215.58	100.00%

Source: Compiled by the Department for Anti-drug Policies

The average cost per capita of social assistance and healthcare ranges from 15 euros per capita per year in Calabria to 75 euros in Liguria

Per capita, taking into consideration the costs sustained by the Addiction Services, the costs for residential and semi-residential assistance and the cost of providing therapies and treatment for drug-related infectious diseases, the national average cost borne by the individual member of the public between 15-64 years of age, on a national level, is equal to approximately 40 euros per year. Figures vary greatly from one Region or Autonomous Province to the next, ranging from a minimum of 15 euros per capita per year in the Region of Calabria to a maximum of 75 euros in the Region of Liguria.

Figure 1.8: Trends in social costs related to social assistance and healthcare, by micro-category (figures represent thousands of euros). The years 2009-2011.



Source: the Department for Anti-drug Policies

In comparison with 2010, costs for social assistance and healthcare decreased by 6.7%. Among the different categories comprising social and healthcare costs, those whose cost fell most steeply during the three-year period spanning 2009-2011 were those related to projects for the promotion and launch of actions for the prevention (-19.3%) and care of drug-related hepatitis C and related conditions. These decreased by 13.5% in relation to a decrease in numbers of addiction services clients, accompanied by a 9% decrease in costs borne by addiction services.

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

Methodological limitations of general population surveys and low response rate

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

New multi-observational complementary methodologies launched

Since 2010, this reasoning has led the Department of Anti-drug Policies to launch complementary and supplementary studies which apply alternative methods for collecting data on drug use, the first through a microbiological analysis of wastewater in water catchment areas, and the second through the analysis of the atmospheric concentration of certain substances.

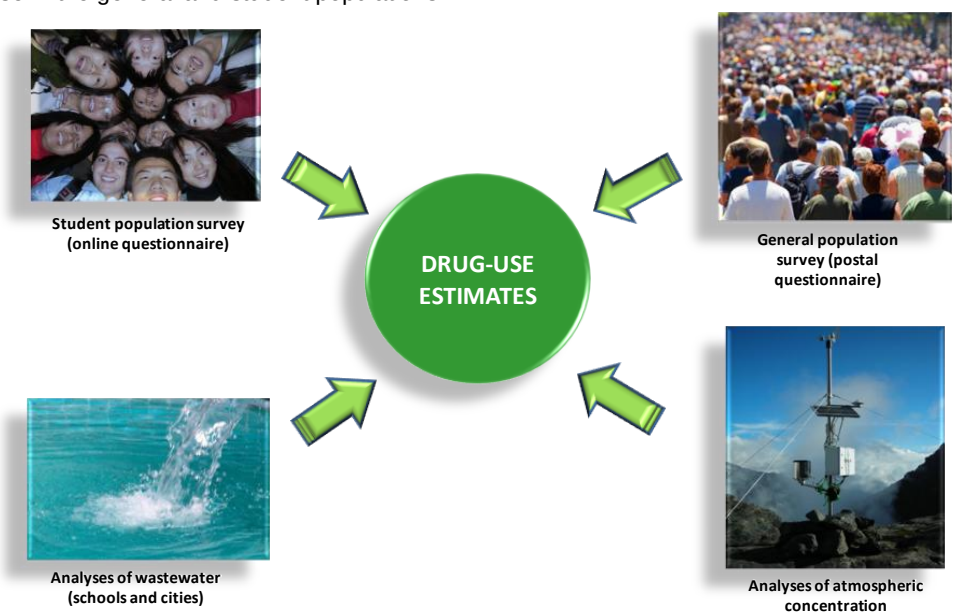
Analyses of wastewater and of airborne microparticles

Although these methods do not allow for a direct estimate of drug use prevalence (in terms of percentage of the population), they are able to provide information on the quantity of drugs used in specific places at specific times.

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

Estimates based on multidimensional observations

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



Source: Department for Anti-drug Policies

This chapter contains the results of the general and student population surveys conducted in 2012 and during the first half of 2013, as well as a final section devoted to the results of the wastewater analyses and to drug use in specific target groups.

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

Survey of the population 18-64 years of age

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

(Standard Table 01)

Methodological aspects

Representative samples

The general population survey was conducted by means of a paper postal questionnaire, created according to instructions provided by the EMCDDA in the document entitled, "Handbook for survey on drug use among general population".
From a methodological standpoint, the sampling plan for the statistical units was designed taking the age groups of 18-24, 25-34 and 36-64 years of age within the geographical areas of the northwest, the northeast, Central Italy and Southern Italy / the Islands as stratification variables. The sample size was determined so as to produce significant estimates for each of the strata identified above. In order to compensate for the effect of a low response rate (typical for these types of surveys) on prevalence of use estimates, the sample design was appropriately planned based upon the response rates observed in previous surveys.
The design of the statistical sampling units selected for the survey consisted of two stages: during the first stage, the selection of the statistical sampling units (city selection) and during the second stage, the selection of residents from the census data supplied by the selected cities.
The selection of the cities in the first stage was carried out using a stratified sampling plan in two strata in self-representative cities (cities of a larger size, with a population of over 100,000 inhabitants) and non-self-representative (cities with 1,000 – 100,000 inhabitants) belonging to the different provinces (two cities per province). Each of these chosen cities then underwent the selection of the second stage statistical units (residents), which were divided into strata according to age group using a simple random sampling procedure in order to guarantee the random nature of the statistical units selected.

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

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

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

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

High percentage of response to the postal questionnaire

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

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

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

Response rate highest in the northeast, followed by the northwest

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

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

18,898 questionnaires completed

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

Integration with the student population survey

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

Summary of drug use

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

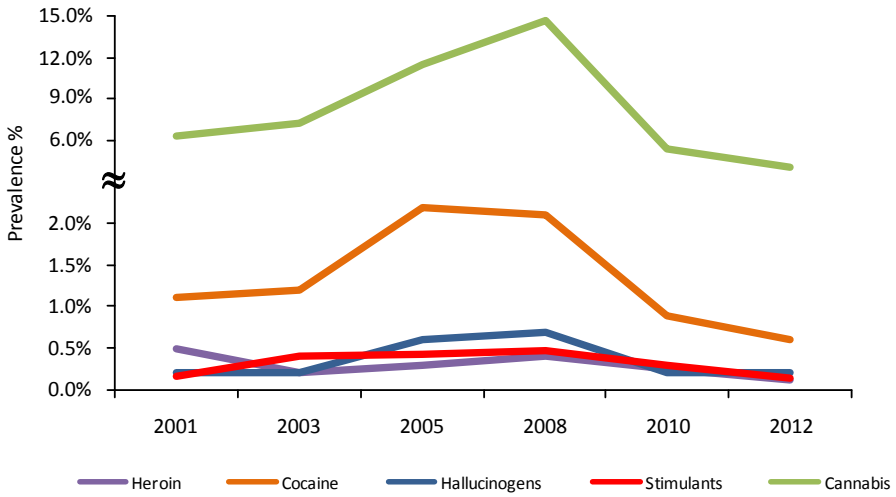
Table 2.3: Prevalence of drug use in the general population aged 15-64 (one or more times in the last 12 months). The years 2010 and 2012

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

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

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

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



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

Source: IPSAD Italy 2001 – 2008, GPS-DPA 2010-2012 Surveys – Department for Anti-drug Policies*
**IPSAD= Italian Population Survey on Alcohol and other Drugs, conducted by the National Research Council*

Polydrug use

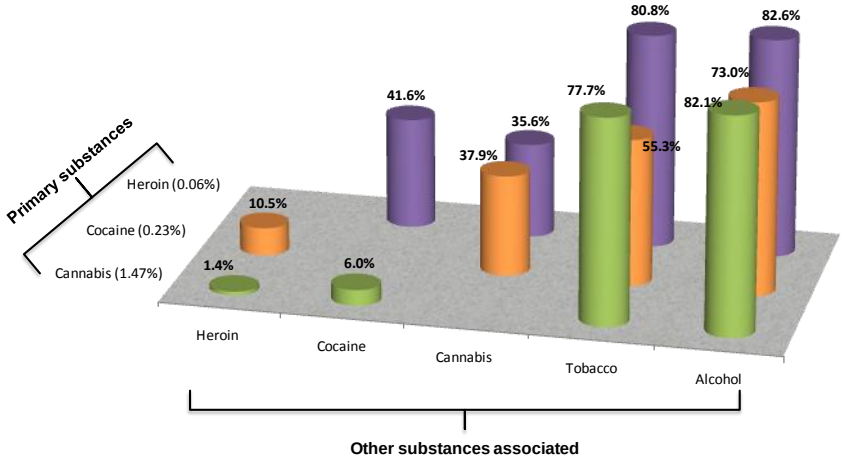
The assessment of polydrug use gives a complete picture of the overall prevalence of illicit drug use in the general population aged 18-64. Table 2.9 shows the distribution of prevalence of the concomitant or consecutive use of two different drugs, licit or illicit, among the population sample who reported having used illicit drugs in the 30 days prior to the survey.
It is estimated that 1.5% of the Italian population used cannabis in the month prior to the survey, of whom 82.1% had also consumed alcoholic beverages during the same time period, 77.7% had smoked tobacco, 6.0% had used cocaine and 1.4% had used heroin.
0.2% of subjects between 18 and 64 years of age reported having used cocaine at least once during the 30 days prior to the survey. Of these, 73.0% had also consumed alcoholic beverages, 55.3% had smoked, 37.9% had used cannabis and 10.5% had made concomitant or consecutive use of heroin.
Of all the Italian population of reference, 0.06% reported having used heroin during the 30 days prior to the survey. Of these users, 82.6% reported having consumed alcohol during the same period, while 80.8% reported having smoked cigarettes, 35.6% had used cannabis and 41.6% had used cocaine.

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

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

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

Figure 2.3: Conditional prevalence distribution of polydrug users in the general population aged 18-64 who had used drugs in the 30 days prior to the survey, in relation to primary drug of use: cannabis, cocaine or heroin. The year 2012.



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

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

Comparison between the population surveys and the wastewater study

Limitations of the population survey

The AquaDrugs Project

Epidemiological studies conducted among the general population represent the principal element of studies on drug use. Nonetheless, they are strongly influenced by subjective factors; in other words, they depend on the participants' willingness to answer questions about illicit or socially unacceptable behaviour in a truthful manner. For this reason, the Department for Anti-drug Policies (DAP) of the Presidency of the Council of Ministers has, for a number of years now, been promoting an additional study for the gathering of data on drug use, based upon wastewater analysis. The Mario Negri Pharmacological Research Institute of Milan is entrusted with the development and execution of the project (AquaDrugs).

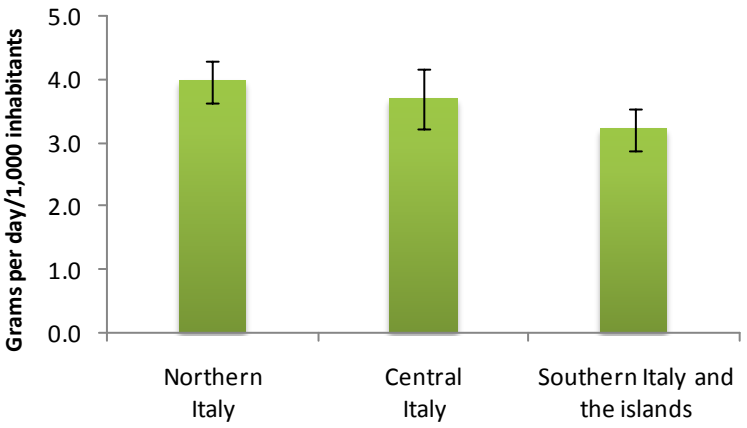
17 cities involved in the study

In this section, we will compare the drug use estimates obtained from an analysis of wastewater in the 17 cities included in the study in October 2011 with drug use estimates from the general population survey obtained during the first half of 2012 (referring to the 30 days prior to survey participation). The 17 sample cities selected to for the study were: Turin, Milan, Merano, Gorizia, Verona, Bologna, Florence, Rome, Pescara, Perugia, Terni, Naples, Bari, Potenza, Palermo, Cagliari, Nuoro.

Drugs chosen for the comparison

The drugs chosen to be employed for the comparison of the two different investigation methods were cannabis and cocaine, because their widespread use makes it possible to more accurately measure their use with both of the methodologies employed in the two studies. The objective was therefore to compare quantities of cannabis and cocaine used (grams per day per 1000 inhabitants), based on the 2011 wastewater analyses conducted in the 17 cities involved, with prevalence of use estimates based upon the population surveys conducted in 2012 (and referring to the 30 days prior to survey participation). The comparison was carried out through an analysis of trends (rising or falling) revealed in use estimates in specific geographical areas: Northern Italy (Gorizia, Verona, Merano, Milan, Bologna, Turin), Central Italy (Perugia, Terni, Florence, Rome), Southern Italy/the Islands (Pescara, Naples, Bari, Potenza, Palermo, Cagliari, Nuoro).

Figure 2.4: Distribution of the average number of doses per day (per 1,000 inhabitants) of cannabis (THC) found to have been used in the 17 cities, by geographical area.

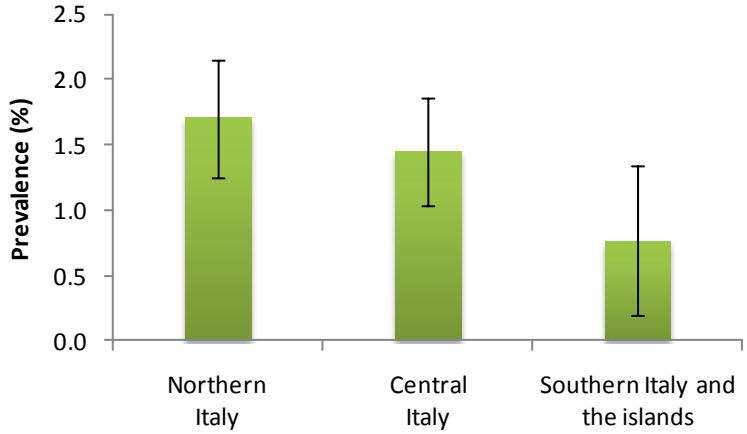


Source: AquaDrugs Study 2011 – Mario Negri Pharmacological Research Institute

Average doses and use prevalence of cannabis higher in Northern Italy

Analyses of the wastewater in the municipal water treatment plants of the Northern Italian cities detected average daily doses of THC (per 1,000 population) which were slightly higher than in other geographical areas (4.0 gr/day per 1,000 population vs. 3.2 gr/day per 1,000 population in Southern Italy and the Islands), with no statistically significant differences found. (Figure 2.4). Findings for the thirty days previous to the general population survey GPS-DAP (Figure 2.5) reflected the same trends in cannabis (hashish and marijuana) use prevalence, estimated based upon the 17 cities involved in the AquaDrugs study.

Figure 2.5: Distribution of prevalence (%) of cannabis (hashish and marijuana) use in the 30 days prior to the survey in the 17 selected cities, by geographical area

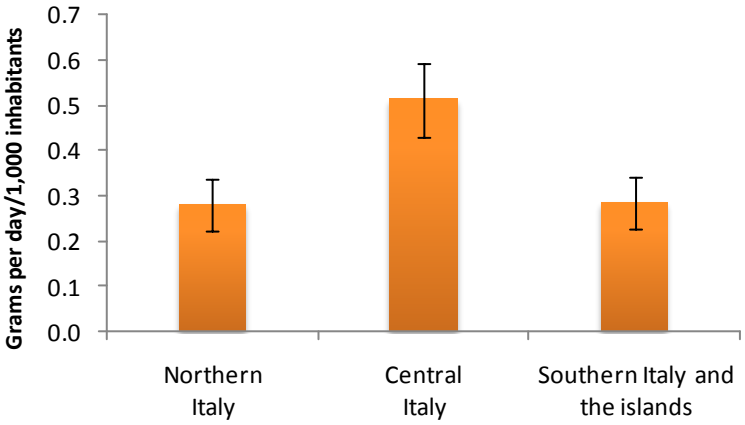


Source: GPS-DAP Survey 2012 – The Department for Anti-drug Policies

Average doses and prevalences of use for cocaine higher in Central Italy

Regarding cocaine use, the analysis of wastewater in the municipal water treatment plants of the Central Italian cities detected higher daily averages (per 1,000 population) than in other geographical areas (0.51 gr/day per 1000 pop. vs. 0.28 gr/day per 1000 pop. in Northern Italy, Southern Italy and the Islands), with statistically significant differences (Figure 2.6).
Cocaine and/or crack use during the 30 days prior to surveys (Figure 2.7), estimated based upon all the municipalities involved in the DPS-DAP and SPS-DAP Surveys, showed a similar distribution (Figure 2.7), with no statistically significant differences.

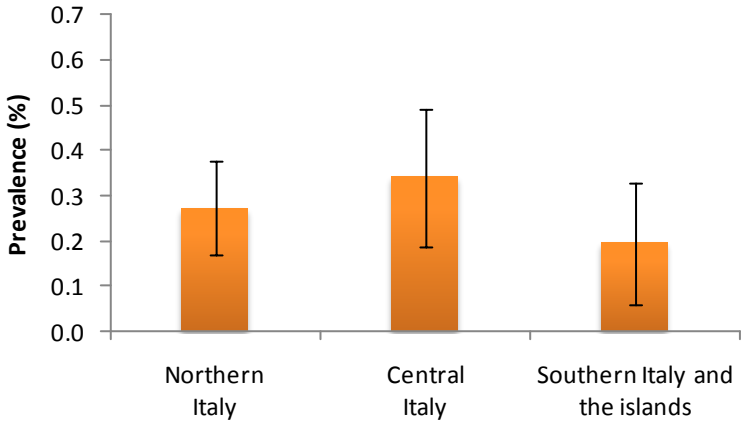
Figure 2.6: Distribution of the average number of doses per day (per 1,000 inhabitants) of cocaine found to have been used in the 17 cities, by geographical area



Source: AquaDrugs Study 2011 – Mario Negri Pharmacological Research Institute

Due to low numbers, it is not possible to estimate the use of cocaine based solely upon the 17 cities involved in the AquaDrugs study, unlike in the case of cannabis. For this reason, the prevalence estimate was calculated based upon all the municipalities involved in the general (GPS-DAP) and student (SPS-DAP) population studies.

Figure 2.7: Distribution of prevalence (%) of cocaine and/or crack use in the 30 days prior to the survey in the 17 selected cities, by geographical area



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

Trends in drug use according to wastewater analyses

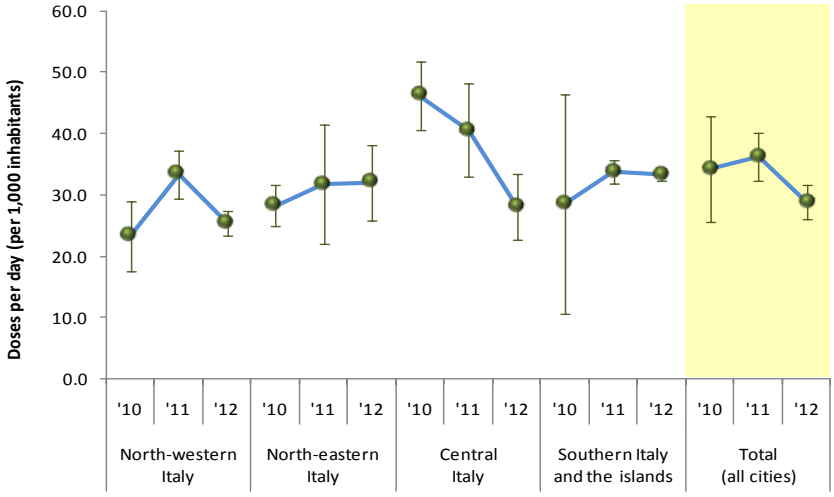
This section presents the results of the analyses of wastewater conducted in eight cities during the three year period spanning 2010-2012 and the trends in drug use revealed as a result.

Comparison between 2010, 2011 and 2012 data gathered

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

In 2012, the highest levels of cannabis use, an average of approximately 33.3 doses per day per 1000 population (Figure 2.8) was found in Southern Italy / the Islands. This was an increase over the average figure found in 2010 (28.5 doses/day per 1000 pop.), but in line with the 2011 figure of 33.8 doses/day per 1000 inhabitants. In the 17 cities involved in the study, we can observe a decrease in cannabis use in 2012 in comparison with the data gathered during the same period in 2011 and 2010. Different trends exist in different geographical areas, with an increase in use levels in Northern Italy as well as in Southern Italy/the Islands between 2010 and 2012, in contrast with the steady decrease in use found in Central Italy (from 46.2 doses/day per 1000 inhabitants in 2010 versus 28.1 doses/day per 1000 inhabitants in 2012).

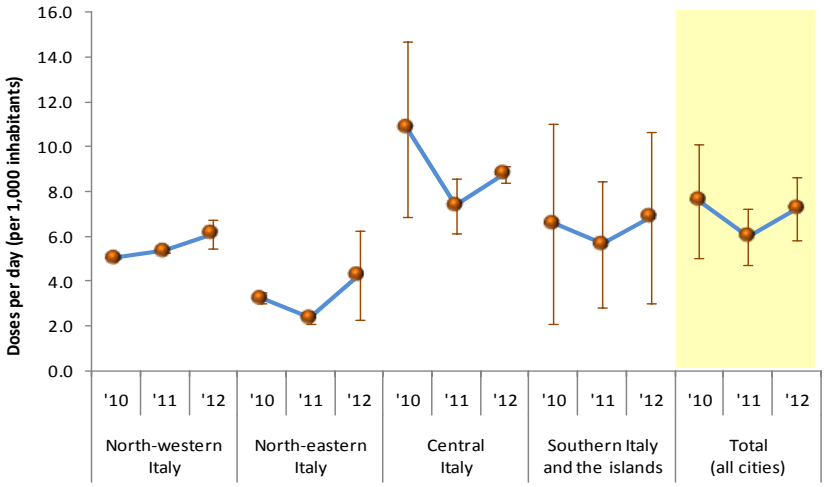
Figure 2.8: Distribution of the average number of doses of CANNABIS consumed per day (per 1,000 population) in each city over the three-year period 2010-2012 and corresponding confidence intervals, by geographic area



Source: AquaDrugs Study 2010-2012 – Department for Anti-drug Policies – Mario Negri Pharmacological Research Institute

Regarding cocaine (Figure 2.9), following an overall drop in use recorded in 2011 in comparison with 2010 figures (7.6 dose/day per 1000 inhabitants in 2010 vs. 5.9 doses/day per 1000 residents in 2011), use trends changed direction over the last year, showing figures similar to those recorded in 2010 (7.2 doses/day per 1000 residents in the eight cities involved in the study). Analysing the data geographically, we find that, during the three-year period in question, there was significant fluctuation in the northeast of the country (3.2 doses/day per 1000 pop. in 2010 vs. 2.4 doses/day per 1000 pop. in 2011 vs. 4.3 doses/day per 1000 pop. in 2012) and in the centre (10.8 doses/day per 1000 pop. in 2010 vs. 7.4 doses/day per 1000 pop. in 2011 vs. 8.8 doses/day per 1000 pop. in 2012).

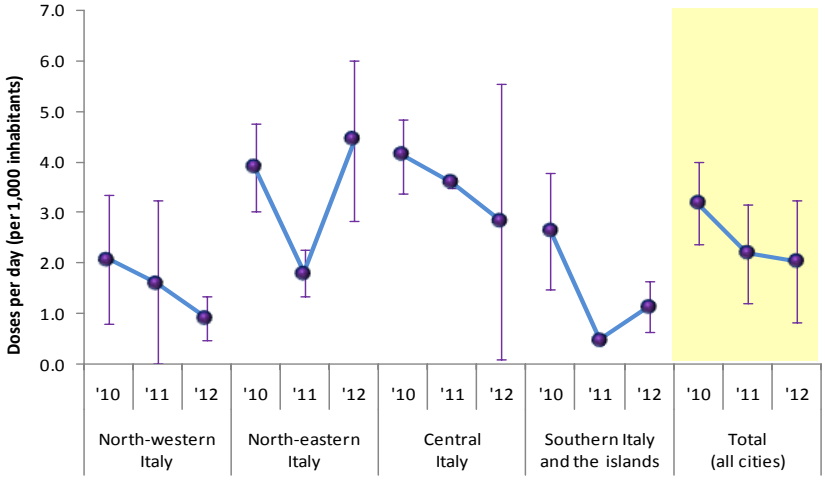
Figure 2.9: Distribution of the average number of doses of COCAINE consumed per day (per 1,000 population) in each city over the three-year period 2010-2012 and corresponding confidence intervals, by geographic area



Source: AquaDrugs Study 2010-2012 – Department for Anti-drug Policies – Mario Negri Pharmacological Research Institute

Compared to the drugs discussed above, heroin use is more limited (Figure 2.10), with the average concentrations found in 2011 at approximately 2 doses/day per 1000 population, a steep decrease in comparison with the figure recorded in 2010 (3.2 doses/day per 1000 pop.). In 2012, heroin use remained largely stable, despite significant variability in the northeastern part of the country during the three-year period in question (3.9 doses/day per 1000 pop. in 2010 vs. 1.8 doses/day per 1000 pop. in 2011 vs. 4.4 doses/day per 1000 pop. in 2012).

Figure 2.10: Distribution of the average number of doses of HEROIN consumed per day (per 1,000 population) in each city over the three-year period 2010-2012 and corresponding confidence intervals, by geographic area

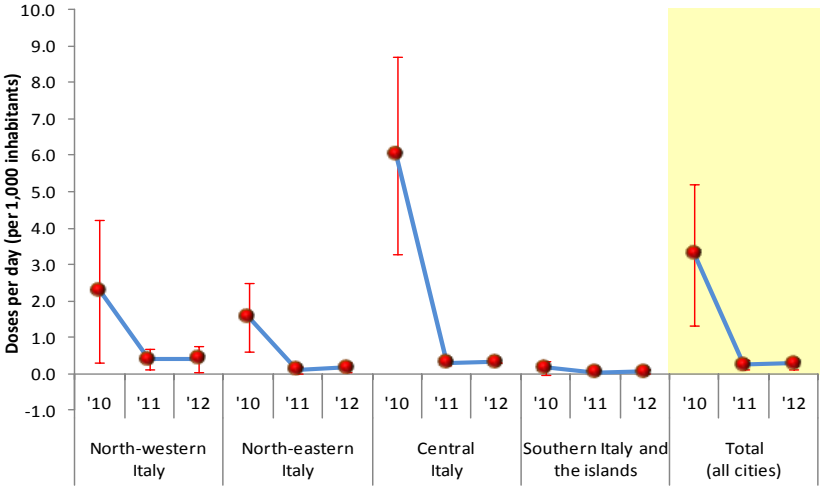


Source: AquaDrugs Study 2010-2012 – Department for Anti-drug Policies – Mario Negri Pharmacological Research Institute

2011 saw a considerable fall in methamphetamine use in comparison with the previous year (Figure 2.11), with residue concentrations of nearly zero found in the samples analysed, an indication that users could be "abandoning" these drugs; further analyses of figures could indicate a

switch to other drug types. The highest concentration was found in Central Italy, with average concentrations of 6 doses/day per 1000 population in 2010 (in comparison with 0.3 doses/day per 1000 population in 2011). In fact, use of these types of drugs showed no significant variation in 2012 in any of the cities involved in the study, holding steady at 2011 levels.

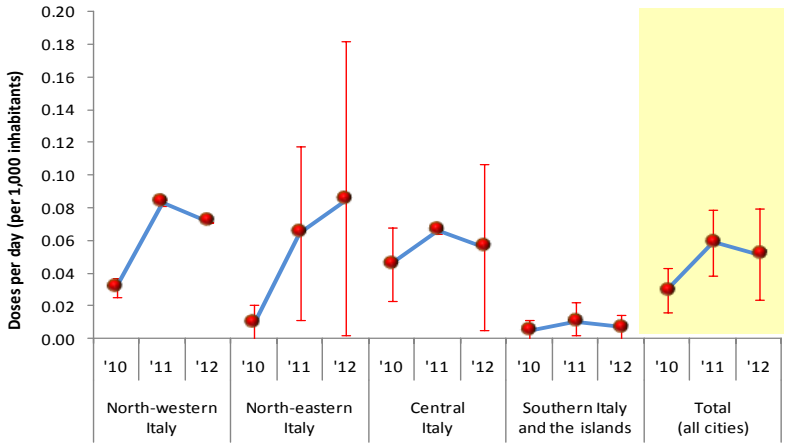
Figure 2.11: Distribution of the average number of doses of METAHAMPHETAMINE consumed per day (per 1,000 inhabitants) in each city over the three-year period 2010-2012 and corresponding confidence intervals, by geographic area



Source: AquaDrugs Study 2010-2012 – Department for Anti-drug Policies – Mario Negri Pharmacological Research Institute

Another of the drugs set to be detected in wastewaters is MDMA, more commonly known as Ecstasy (Figure 2.12). Overall, following a slight increase seen in 2011 (0.03 doses/day per 1000 pop. in 2010 vs. 0.06 doses/day per 1000 pop. in 2011), use figures in 2012 remained largely stable (0.05 doses/day per 1000 pop.). However, the trend observed in Northeastern Italy was the opposite of that seen in all other areas of the country, with MDMA use increasing over the three years in which the study has been conducted (from 0.01 doses/day per 1000 pop. in 2010 to 0.08 doses/day per 1000 pop.).

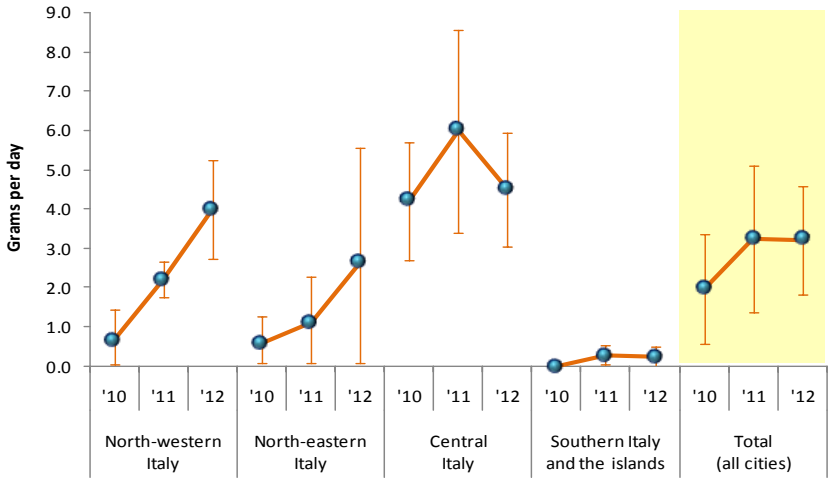
Figure 2.12: Distribution of the average number of doses of MDMA (ECSTASY) consumed per day (per 1,000 population) in each city over the three-year period 2010-2012 and corresponding confidence intervals, by geographic area



Source: AquaDrugs Study 2010-2012 – Department for Anti-drug Policies – Mario Negri Pharmacological Research Institute

Standardization for ketamine was carried out using grams per day as the unit of measure, following an overall increase in use recorded in 2011 (1.96 gr/day in 2010 vs. 3.24 gr/day in 2011). Use levels remained largely stable during the last year, at 3.22 gr/day (Figure 2.13).
Ketamine use in Southern Italy / the Islands was nearly null, unlike in the other areas of the country, where concentrations were higher, or in Northern Italy, where they increased between 2010 and 2012: from 0.7 gr/day in 2010 to 4 gr/day in 2012 in the northwest of the country and from 0.6 gr/day in 2010 to 2.6 gr/day in 2012 in Italy's northeast.

Figure 2.13: Distribution of grams per day of KETAMINE detected in each city over the three-year period 2010-2012 and corresponding confidence intervals, by geographic area



Source: AquaDrugs Study 2010-2012 – Department for Anti-drug Policies – Mario Negri Pharmacological Research Institute

2.2. Drug use in schools and among the youth population (the SPS-DAP Survey)

Study of 35,719 young students between 15-19 years of age

Data regarding the prevalence of licit and illicit psychoactive substance use among the Italian student population between 15-19 years of age was taken from the SPS-DAP (Student Population Survey) conducted during the first half of 2013 by the Department for Anti-drug Policies in collaboration with the Ministry of Education, Universities and Research and with the participation of the Regional Representatives for Health Education. The objective of the sample survey, conducted using a self-reported anonymous questionnaire, was to provide an estimate of the number of students 15-19 years of age who use psychoactive substances, in accordance with the ESPAD protocol.

Standard Table 02

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

Methodology

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

Sampling techniques chosen are ideal for ensuring the reliability of data gathered

Table 2.4: Distribution of the first-stage units by region and type of academic institution. The year 2013

Region	Secondary schools and *ex-magistrali**	Polytechnic institutes	Vocational institutes	Arts high secondary schools and colleges	Total
Abruzzo	6	4	4	4	18
Basilicata	5	2	4	1	12
Calabria	8	11	8	3	30
Campania	28	28	16	5	77
Emilia Romagna	10	10	8	2	30
Friuli Venezia Giulia	4	4	4	3	15
Lazio	22	17	8	6	53
Liguria	5	4	5	3	17
Lombardy	32	27	15	6	80
Marche	6	5	4	1	16
Molise	3	1	3	2	9
Piedmont / Valle D'Aosta	14	13	8	6	41
Apulia	14	16	11	5	46
Sardinia	7	6	4	2	19
Sicily	22	19	12	6	59
Tuscany	11	10	8	3	32
Trentino Alto Adige	3	7	2	2	14
Umbria	3	5	4	1	13
Veneto	14	13	7	4	38
Total	**217**	**202**	**135**	**65**	**619**

**t.n.* ex-magistrali *are secondary schools which formerly specialized in the education of teachers*

Source: SPS-DAP Survey 2013 – The Department for Anti-drug Policies

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

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

The use of European protocols

In 2013, as in 2012, the 2013 SPS-DAP Student Population Survey was conducted with the support of computer technology. The C.A.S.I. (Computer-Aided Self-Completed Interview) method was adopted, which made it possible to fill out the questionnaire online using a nonreplicable, unique and anonymous access ID.

Electronic innovation

The study was conducted during the first half of 2013, with the participation of 478 higher secondary schools, equivalent to 77.2% of the sample of schools which had been planned.

High percentages of response

A brief summary of drug use

The results of the study, which will be presented in the following sections, are the product of analyses conducted on the information collected from a sample of 35,719 questionnaires completed by Italian students aged 15-19 (following an assessment of data quality, approximately 4,000 students were eliminated from the original sample, most of whom [approximately 3,000] were older than the target age of the survey.).

A large sample: 35,719 subjects aged 15-19 on 30 June 2013

Table 2.5: Drug use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2012 and 2013

Type of drug	Prevalence 2012	Prevalence 2013	Difference 2012-2013
Cannabis	19.14	21.56	2.42
Cocaina	1.86	2.05	0.19
Heroin	0.32	0.36	0.04
Stimulants	1.12	1.35	0.23
Hallucinogens	1.72	2.13	0.41

Source: SPS-DAP 2012 and SPS-DAP 2013 Surveys – The Department for Anti-drug Policies

Used in the last 12 months:
- cannabis: +2.42
- cocaine: +0.19
- heroin: +0.04
- stimulants: +0.23
- hallucinogens: +0.41

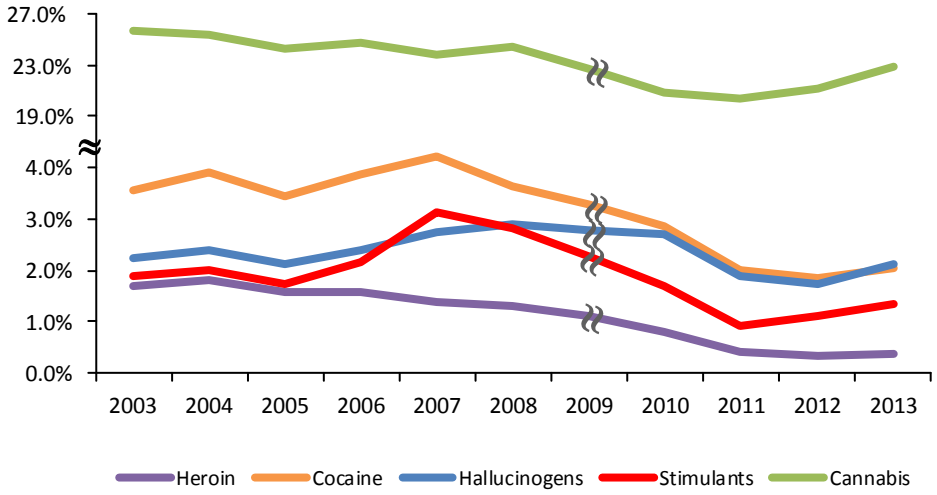
An assessment of overall patterns in drug use in the 12 month periods prior to the surveys conducted between 2003 and 2013 reveals an initial fall followed by a progressive decrease in cannabis use prevalence. This trend was characterized by a certain amount of fluctuation until 2008, followed by largely stable figures in the two-year period spanning 2010-2012, and a tendency to rise over the last year.

Long-term overall trends show a decline in drug use

The prevalence of cocaine use, after an initial increase during the period lasting until 2007, remained in constant and on-going decline until 2012, levelling off in 2013 at the prevalence levels seen in 2011. The drop in heroin use has been steady and continuous since 2004, when the highest use prevalence for this drug during the period of reference was recorded, albeit still at levels lower than 2% of the students who filled out the questionnaire. Heroin use has levelled off in recent years.

Stimulant use trends followed those of cocaine until 2011, but the last two years have shown a slight increase in their use. Finally, hallucinogen use prevalence rose slightly during the first years of surveys being conducted, until 2008; it fell between 2010 and 2012, however, hallucinogen use was found to have increased slightly during the last year.

Figure 2.14: Drug use in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2013



Users (LYP):
- cannabis: +2.42
- cocaine: +0.19
- heroin: +0.04
- stimulants: +0.23

hallucinogens: +0.41

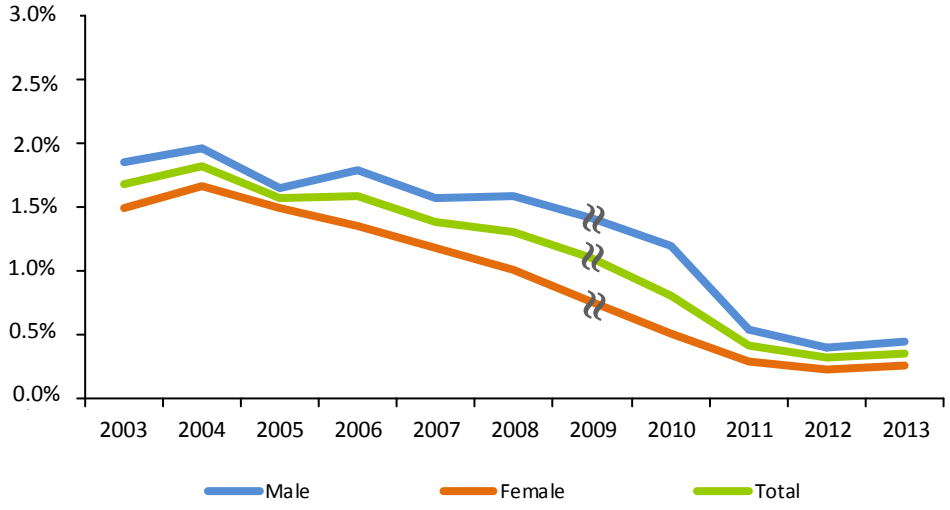
Source: ESPAD Italy 2003-2008,; SPS-DAP Surveys 2010-2013 – Department for Anti-drug Policies

Heroin use

A slight increase in heroin use

The trend in the number of students who had used heroin at least once in the 12 months prior to participating in the survey, as reported by the students who participated in the surveys conducted between 2003 and 2013, reveals a steady decline since the beginning of the decade; levelling off during the three-year period spanning 2011 – 2013.

Figure 2.15: Heroin use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2013



Source: ESPAD Italy 2003-2008,; SPS-DAP Surveys 2010-2013 – Department for Anti-drug Policies

In 2013, the percentage of Italian students who reported having used heroin was extremely low: 0.54% reported having used it at least once in their lives and 0.36% stated that they had used it at least once in the 12 months prior to the survey, while 0.21% reported having used it at least once in the month prior to filling out the questionnaire (Table 2.6). In comparison with 2012, there was an increase in the numbers of students

who had used heroin at least once in their lives as well as those who had used it at least once in the 12 months prior to the survey. This increase in heroin use is especially evident among male students. Meanwhile, there was a slight decrease in the number of students who reported having used the drug at least once in the month prior to the survey.

Table 2.6: Heroin use (% prevalence) in the student population aged 15-19. The years 2012-2013

	2012			2013		
Heroin use (%)	**M**	**F**	**Tot**	**M**	**F**	**Tot**
At least once in their lifetimes (LTP)	0.61	0.42	0.51	0.65	0.42	0.54
At least once in the last 12 months (LYP)	0.40	0.23	0.32	0.45	0.26	0.36
At least once in the last 30 days (LMP)	0.30	0.17	0.23	0.27	0.15	0.21
Age (Last Year Prevalence) (%)						
15 years of age	0.09	0.14	0.12	0.28	0.18	0.23
16 years of age	0.43	0.30	0.36	0.34	0.46	0.40
17 years of age	0.48	0.29	0.39	0.39	0.14	0.27
18 years of age	0.49	0.19	0.34	0.60	0.31	0.46
19 years of age	0.46	0.24	0.35	0.62	0.21	0.42
	2012			**2013**		
Frequency of use (Last Year) (% of total LYP users)						
1-9 times	75.00	83.33	78.07	75.31	82.61	77.95
10-19 times	4.17	4.76	4.39	6.17	2.17	4.72
20 times or more	20.83	11.90	17.54	18.52	15.22	17.32

Source: SPS-DAP 2012 and SPS-DAP 2013 Surveys – The Department for Anti-drug Policies

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

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

A comparison of 2013 data from different geographical areas (the northwest, the northeast, Central Italy, Southern Italy/the Islands) reveals largely stable figures for heroin use in Northwestern Italy and in Southern Italy / the Islands, while we see a slight decrease in numbers of users in Northeastern and Central Italy. These trends resulted in consistent heroin use prevalence figures throughout the country.

In 2013, this type of heroin use among male students remained stable overall, despite a certain amount of variation, with increases among 15-year-olds and among the 18-19-year-old age group but decreases among the 16- to 17-year-olds. The same sort of variation was found among female students, as had already been seen in 2012 (Table 2.6).
Of those students who had used heroin during the course of the year leading up to the survey, 17.3% had used the drug 20 or more times (a level of frequency more common among male students), while 80% reported less frequent use (1-9 times). Frequent use of heroin, although it applies to a smaller number of users, has nonetheless increased among female students, contrary to the trend observed among males. (Table 2.6).

Increase in number of users more significant among 15-year-olds, especially among male students

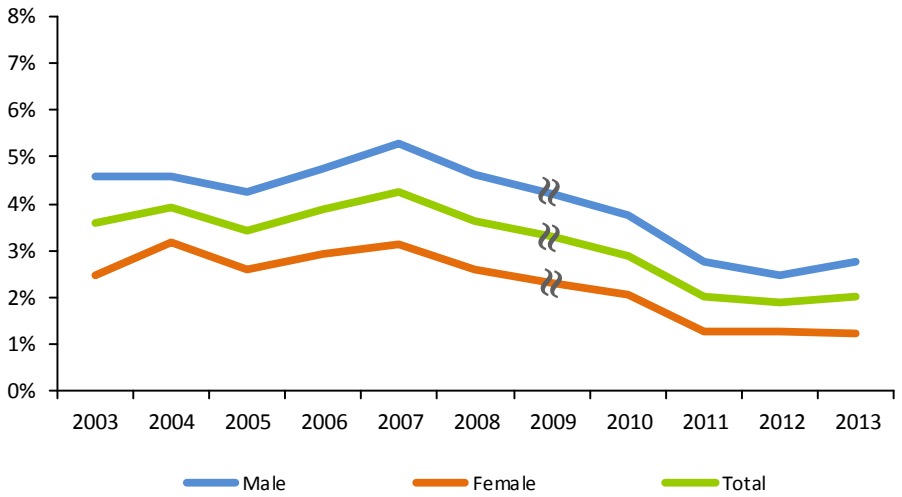
Cocaine use

According to information reported by students involved in the surveys conducted over the last ten years, less than 5% of students participating in the surveys had used cocaine at least once in the 12 months leading up to those surveys. Cocaine use has fallen since 2007. Use levels, which remained largely stable until 2005, rose over the three-year period from 2005-2007, then fell from 2007 to 2011, levelling off over the last three-year period.

Cocaine use has been falling since 2007

Figure 2.16: Cocaine use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2013

Drop in (LYP) cocaine use beginning in 2007, later levelling off



Source: ESPAD Italy 2003-2008,; SPS-DAP Surveys 2010-2013 – Department for Anti-drug Policies

In 2013, 2.8% of students filling out the questionnaire had tried cocaine, a percentage which falls to 2% when considering only those who had used the drug in the year prior to the survey and to approximately 1% when considering only those who had used in the previous 30 days (at least once) (Table 2.7). None of the data for cocaine use (neither LTP, LYP, nor LMP) differs in any statistically significant way from the previous year's data.

Table 2.7: Cocaine use (% prevalence) in the student population aged 15-19. The years 2012-2013

	2012			2013		
Cocaine use (%)	**M**	**F**	**Tot**	**M**	**F**	**Tot**
At least once in their lifetimes (LTP)	3.36	1.90	2.61	3.80	1.72	2.77
At least once in the last 12 months (LYP)	2.48	1.25	1.86	2.85	1.24	2.05
At least once in the last 30 days (LMP)	1.39	0.72	1.06	1.39	0.71	1.05
Age (Last Year Prevalence) (%)						
15 years of age	0.80	0.78	0.79	1.06	0.85	0.95
16 years of age	1.60	1.13	1.36	1.94	1.33	1.64
17 years of age	2.45	1.40	1.93	2.28	1.09	1.70
18 years of age	3.36	1.54	2.46	3.75	1.29	2.54
19 years of age	4.06	1.40	2.75	5.15	1.67	3.45
Frequency of use (Last Year) (% of total LYP users)						
1-9 times	80.49	84.89	81.97	82.49	90.00	84.74
10-19 times	8.07	4.44	6.86	6.61	6.82	6.68
20 times or more	11.43	10.67	11.18	10.89	3.18	8.58

Source: SPS-DAP 2012 and SPS-DAP 2013 Surveys – The Department for Anti-drug Policies

97.2% of students have never tried cocaine, while 2.8% have used cocaine at least once in their lives

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

In 2013, the number of students who had used cocaine in the year prior to the survey seemed to be greater in Central Italy, followed by Northwestern Italy and Southern Italy/the Islands. The phenomenon seems to be less widespread among students in the northeast of Italy, among whom a slight rise in use was reported in 2013, in line with other non-significant variability in the other areas of the country.

Numbers of cocaine users are greater among the older students, in particular among male students, who have a higher prevalence of use (LYP) than their female peers (Table 2.13). Prevalence of use among

Higher prevalence of cocaine use among male students

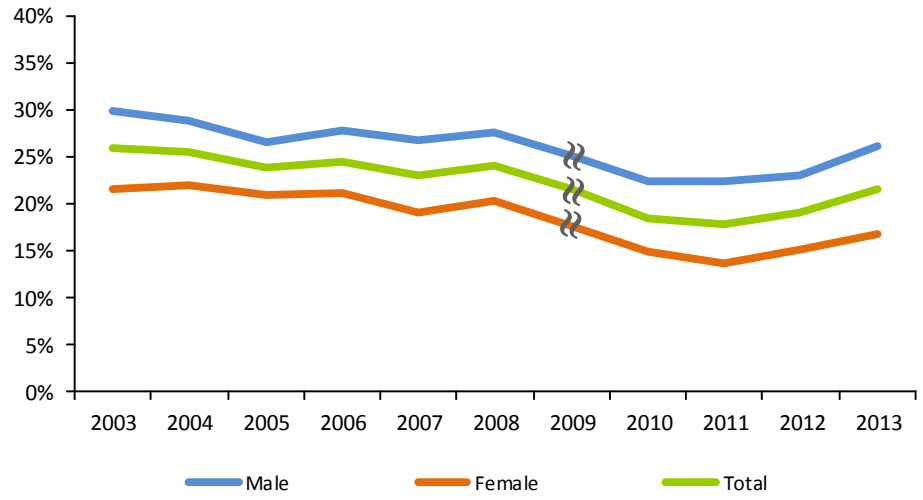
males rises from 1.1% of 15-year-olds, to 1.9% of 16-year-olds, 2.3% of 17-year-olds, 3.8% of 18-year-olds and 5.2% of 19-year-olds. Among female students, we can see an increase among the younger ages, but use prevalence remains stable among 17- to 19-year-olds.
Of those students who reported having used cocaine in the year leading up to the 2013 survey, 10.9% of male students and 3.2% of females used the drug 20 times or more, while 90.0% of the girls and 82.5% of the boys had used it occasionally (once or twice). Students who reported using cocaine frequently were fewer than in 2012 (Table 2.7).

Cannabis use

Cannabis is the illicit drug most used by students

The illicit drug most widely used by students over the last decade was found to be cannabis. From 2003 to 2010, the percentage of students who had used cannabis at least once in the 12 months leading up to the various surveys was in steady decline, but this was followed by an increase over the most recent three-year period. 2013 figures showed an increase of 2.3 percentage points, rising from 19.1% in 2012 to 21.6% in 2013. Since 2007, trends among male and female students have mirrored each other.

Figure 2.17: Cannabis use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2013



Source: ESPAD Italy 2003-2008,; SPS-DAP Surveys 2010-2013 – Department for Anti-drug Policies

24.6% of Italian students who filled out the questionnaire had tried cannabis at least once in their lives, while 21.6% reported having used it at least once during the year leading up to the survey. 15.2% of Italian students reported having used cannabis in the 30 days prior to filling out the questionnaire (Table 2.8).

Table 2.8: Cannabis use (prevalence %) in the student population aged 15-19. The years 2012-2013

	2012			2013		
Cannabis use (%)	**M**	**F**	**Tot**	**M**	**F**	**Tot**
At least once in their lifetimes (LTP)	26.95	18.40	22.63	29.63	19.39	24.56
At least once in the last 12 months (LYP)	23.10	15.18	19.14	26.25	16.77	21.56
At least once in the last 30 days (LMP)	15.95	9.93	12.95	18.96	11.37	15.20
Age (Last Year Prevalence) (%)						
15 years of age	7.99	5.70	6.80	10.65	6.97	8.75
16 years of age	17.98	12.03	14.99	18.50	15.80	17.17
17 years of age	24.87	16.86	20.94	26.91	18.03	22.56
18 years of age	30.70	20.03	25.41	34.88	20.88	28.00
19 years of age	32.52	21.36	27.02	39.02	22.12	30.79
Frequency of use (Last Year) (% of total LYP users)						
1-9 times	58.54	69.93	63.05	55.28	69.39	60.71
10-19 times	10.32	10.95	10.57	10.65	10.79	10.70
20 times or more	31.14	19.12	26.38	34.07	19.82	28.58

Source: SPS-DAP 2012 and SPS-DAP 2013 Surveys – The Department for Anti-drug Policies

75.4% of students have never tried cannabis, while 24.6% have used it at least once in their lives

15.2% had used it in the 30 days prior to the survey

The number of cannabis users in Central Italy remained more or less unchanged in comparison with 2012, and lower (23.3%) than the geographical area “northwest” (25.4%).

In 2013, as had already been seen in 2012, the number of cannabis users increased with age for both genders: among male students, prevalence of use increased from 10.7% of 15-year-olds to 39.0% of 19-year-olds, while it rose from 6.9% to 22.1% of the same age groups among female students (Table 2.8). The prevalence of users increases progressively with age among both male and female students, especially in the span of time between 15 and 17 years of age.

Use is highest among 19-year-old students: 30.8%

10.7% of cannabis users report having used cannabis 10 to 19 times over the 12 months prior to the survey. More intense cannabis use (20 times or more in a year) was reported by 34.1% of male students and 19.8% of female students who participated in the survey, an increase over the 2012 figures (Table 2.8).

28.6% of students use cannabis with more intense frequency

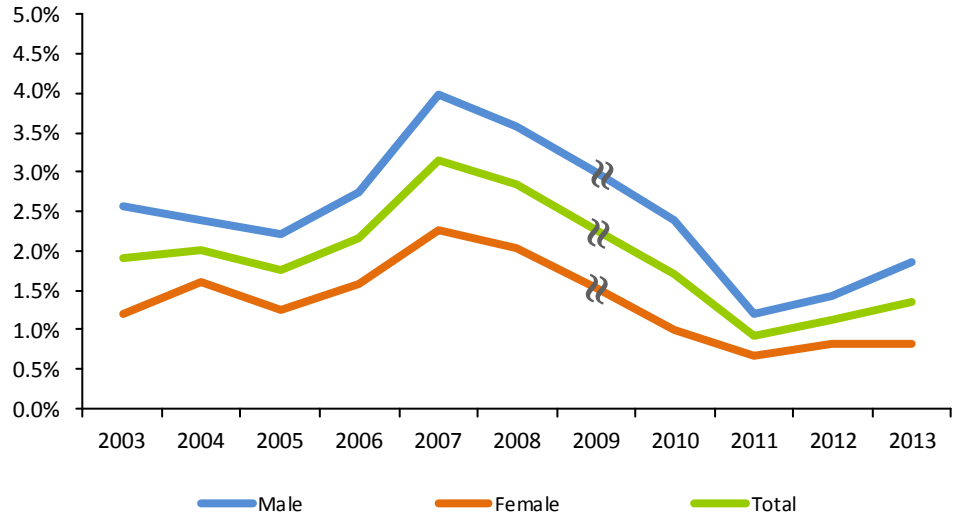
Stimulant use

Over the last ten years, the trend in the number of students who had used stimulant drugs (ecstasy and amphetamines) at least once in the 12 months prior to participating in surveys remained largely stable until 2006, followed by an upturn in 2007. Over the following five years there was a steady decline in the number of users until 2011. Then, in 2012 and 2013, figures began to rise.

Rising trend in stimulant use in 2013

2.0% of Italian students reported having used stimulant drugs at least once in their lives and 1.4% reported having used them during the course of the year leading up to their survey (Table 2.9). A remarkably low percentage (0.7%) of Italian students aged 15-19 reported having used stimulants recently, in the 30 days prior to participating in the survey. If we differentiate between different types of psychoactive stimulant drugs, we find equal percentages of users of ecstasy and amphetamines.

Figure 2.18: Stimulant use (% prevalence) in the student population aged 15-19 in the 12 months prior to the survey. The years 2003-2013



Source: ESPAD Italy 2003-2008; SPS-DAP Surveys 2010-2013 – Department for Anti-drug Policies

Table 2.9: Stimulant use (% prevalence) in the student population aged 15-19. The years 2011-2013

	2012			2013		
Stimulant use (%)	**M**	**F**	**Tot**	**M**	**F**	**Tot**
At least once in their lifetimes (LTP)	2.21	1.40	1.78	2.61	1.29	2.0
At least once in the last 12 months (LYP)	1.43	0.81	1.12	1.87	0.83	1.4
At least once in the last 30 days (LMP)	0.72	0.42	0.57	0.96	0.48	0.7
Age (Last Year Prevalence) (%)						
15 years of age	0.59	0.58	0.58	0.78	0.53	0.65
16 years of age	0.92	0.72	0.82	0.90	0.73	0.82
17 years of age	1.15	0.71	0.93	1.57	0.76	1.17
18 years of age	2.00	0.91	1.46	2.36	0.93	1.66
19 years of age	2.45	1.16	1.82	3.70	1.19	2.48
Frequency of use (Last Year) (% of total LYP users)						
1-9 times	88.33	91.10	89.33	88.72	94.52	90.48
10-19 times	20.62	23.29	21.59	5.34	1.37	4.14
20 times or more	11.67	8.90	10.67	5.93	4.11	5.38

Source: The SPS-DAP 2012 and SPS-DAP 2013 Surveys – The Department for Anti-drug Policies

98% of students have never tried stimulants, while 2% have used them at least once in their lives
0.7% had used them in the 30 days prior to the survey

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

Stimulant users, like the users of other drugs, become more numerous in older age brackets: 0.8% of 15-year-olds, slightly fewer than 1% of 16- to 17-year-olds, 1.6% of 18-year-olds and up to 2.4% of 19-year-olds reported having used stimulants in the 12 months prior to the survey (Table 2.9). If we separate data on stimulant use over the 12 months prior to the survey by age and gender, we can see a marked difference between male and female students, especially among 18-year-olds (2.4% and 0.9% respectively) and among 19-year-olds (3.7% and 1.2% respectively).

Highest student use among 19-year-old males: 3.7%

More male students reported frequent stimulant use (over 10 times over the 12 months prior to the survey) than their female peers (11.3% and 5.5% respectively).

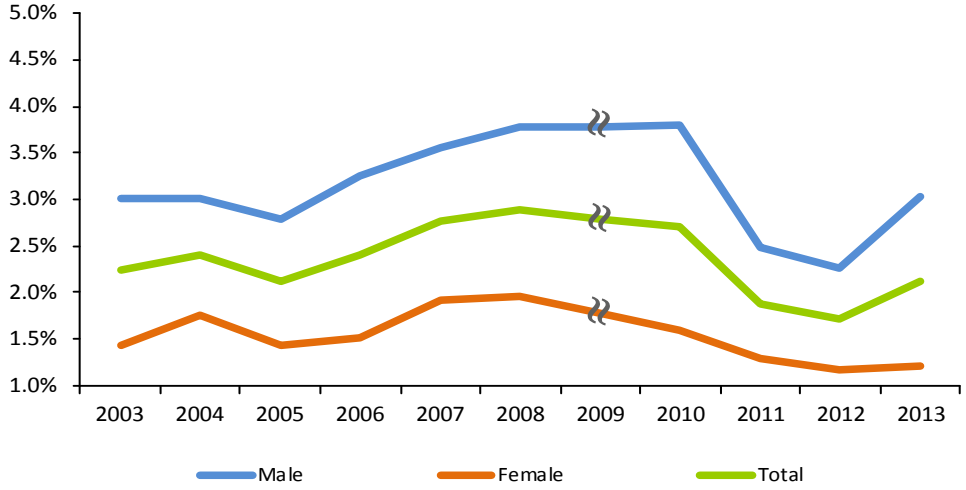
11.3% of male students use frequently

Hallucinogen use

Numbers of hallucinogen users on the rise

The use of hallucinogenic drugs (including LSD, ketamine, hallucinogenic mushrooms and other hallucinogens) in the 12 months prior to the survey declined among students from 2007 to 2012, contrary to 2013, when the trend took an upturn. Over the last year, in fact, there has been a considerable increase in use reported by the students selected to participate in the study, equal to 0.41 percentage points (from 1.72% in 2012 to 2.13% in 2013).

Figure 2.19: Hallucinogen use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2013



Source: ESPAD Italy 2003-2008; SPS-DAP Surveys 2010-2013 – Department for Anti-drug Policies

In 2013, 3.1% of Italian students reported having tried hallucinogens at least once in their lives and 2.1% reported having used these types of drugs in the 12 months prior to participating in the survey. 1.1% of students who participated in the survey reported having used hallucinogens recently, in the month leading up to the survey (Table 2.16).

This rising trend in hallucinogen use affected all areas of the country, with 2013 use prevalence levels similar to those observed in 2011, with the exception of Northwestern Italy, where the figures have been climbing steeply and continuously.

Highest student use among 19-year-old males: 4.7%

Among male students, hallucinogen use was found to be directly linked to subjects' age. Prevalence of use rose from 1.3% among 15-year-olds to 2.3% among 16-year-olds, 2.9% among 17-year-olds, 3.8% among 18-year-olds and up to 4.7% among 19-year-olds. Among female students, however, prevalence of use rose most during the span of time between 15 years of age (0.7%) and 18 years of age (1.4%), but then fell among 19-year-olds (Table 2.10).

With respect to frequency of use, there was increase in the number of male students who reported having used hallucinogens 10 or more times during the 12 months prior to the survey, while the number of female students who reported having used these types of drugs 20 times or more during the same time span decreased.

Table 2.10: Hallucinogen use (% prevalence) in the student population aged 15-19. The years 2012-2013

	2012			2013		
Hallucinogen use (%)	**M**	**F**	**Tot**	**M**	**F**	**Tot**
At least once in their lifetimes (LTP)	3.47	1.70	2.58	4.19	1.88	3.05
At least once in the last 12 months (LYP)	2.26	1.17	1.72	3.03	1.22	2.13
At least once in the last 30 days (LMP)	1.10	0.61	0.86	1.53	0.69	1.11
Age (Last Year Prevalence) (%)						
15 years of age	0.80	0.58	0.69	1.34	0.67	0.99
16 years of age	1.65	1.10	1.38	2.28	1.36	1.83
17 years of age	2.52	1.37	1.96	2.93	1.34	2.15
18 years of age	2.82	1.40	2.12	3.75	1.43	2.61
19 years of age	3.37	1.40	2.40	4.72	1.25	3.03
Frequency of use (Last Year) (% of total LYP users)						
1-9 times	92.87	93.84	93.20	87.91	91.16	88.83
10-19 times	3.19	2.37	2.91	4.6	6.0	5.0
20 times or more	3.93	3.79	3.88	7.51	2.79	6.18

Source: The SPS-DAP 2012 and SPS-DAP 2013 Surveys – The Department for Anti-drug Policies

96.9% of students have never used hallucinogens, while 3.1% have tried hallucinogens at least once in their lives

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

Polydrug use among 15- to 19-year-olds

The concomitant or consecutive use of different licit and illicit psychoactive drugs is the most characteristic and widespread pattern of drug use among adolescents and young adults.
Table 2.17 shows the distribution of conditional prevalence of licit and illicit drug use among those who reported having used illegal drugs during the 30 days prior to the survey.
15.2% of students reported having use cannabis during the month prior to the survey and, of these, 90.2% had consumed alcoholic beverage during the same period, 88.0% had smoked at least one cigarette per day, 5.8% had used cocaine and 1.1% had used heroin.
Of the students surveyed, 1.1% reported having used cocaine in the 30 days prior to the survey. 92.3% of cocaine users had consumed alcohol during the month prior to the survey, while 89.9% of cocaine users reported smoking cigarettes daily, 84.3% had also used cannabis and 16.8% had used heroin.
0.21% reported having used heroin at least once during the 30 days prior to the survey. 86.7% of heroin users had consumed alcohol during the same time period, 78.7% had smoked cigarettes on a daily basis, 81.3% had used cannabis and 84.0% had used cocaine. These results make it evident that a high percentage of subjects who use heroin as their primary drug also use cocaine, in contrast with subjects whose primary drug is cocaine, of whom a smaller percentage use heroin concomitantly or consecutively.

Strong trend towards polydrug use:

- Strong trend toward the concomitant or consecutive use of alcohol and tobacco with all of the other drugs
- Cannabis users:
  5.8% also use cocaine
  1.1% also use heroin
- Cocaine users:
  84.3% also use cannabis
  16.8% also use heroin
- Heroin users:
  81.3% also use cannabis
  84.0% also use cocaine

Table 2.11: Distribution of conditional prevalence of polydrug users in the student population aged 15-19 in the 30 days prior to the survey. The year 2013

Drug type	**Alcohol**	**Tobacco**	**Cannabis**	**Cocaine**	**Heroin**
Cannabis (LMP 15.20%)	90.19%	88.01%	-	5.82%	1.12%
Cocaine (LMP 1.05%)	92.27%	89.87%	84.27%	-	16.80%
Heroin (LMP 0.21%)	86.67%	78.67%	81.33%	84.00%	-

Source: SPS-DAP Survey 2013 – The Department for Anti-drug Policies

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

2.3. New drugs recorded in Italy by the National Early Warning System

The new synthetic drugs

Recent years have witnessed the rise of a never-before-seen phenomenon which has revolutionized drug use trends among, but not limited to, young people. The traditional drugs (cannabis, cocaine, heroin, etc.) have been joined by synthetic molecules, or, in other words, molecules which have been artificially produced in laboratories.
A number of these molecules are the products of research into the design of new products with potential therapeutic applications; nonetheless, none of these have ever advanced to the pharmaceutical development phase. Others were created specifically for use as recreational drugs. In addition, there is often no published toxicity data available regarding the use of these drugs. There is therefore a risk that their use may produce unknown and unexpected effects, including toxic effects. There have, in fact, been numerous cases of poisoning resulting from the use of these drugs. The evolution of this phenomenon has led international organizations which routinely monitor drug supply to take action to identify so-called synthetic cannabinoids and cathinones, as well as other drugs which have proven to be particularly hazardous to the health of users, as they appear on the market. Since 2009, the National Early Warning System has also been monitoring the appearance of these drugs on the Italian market.

Availability in smart shops and on the internet

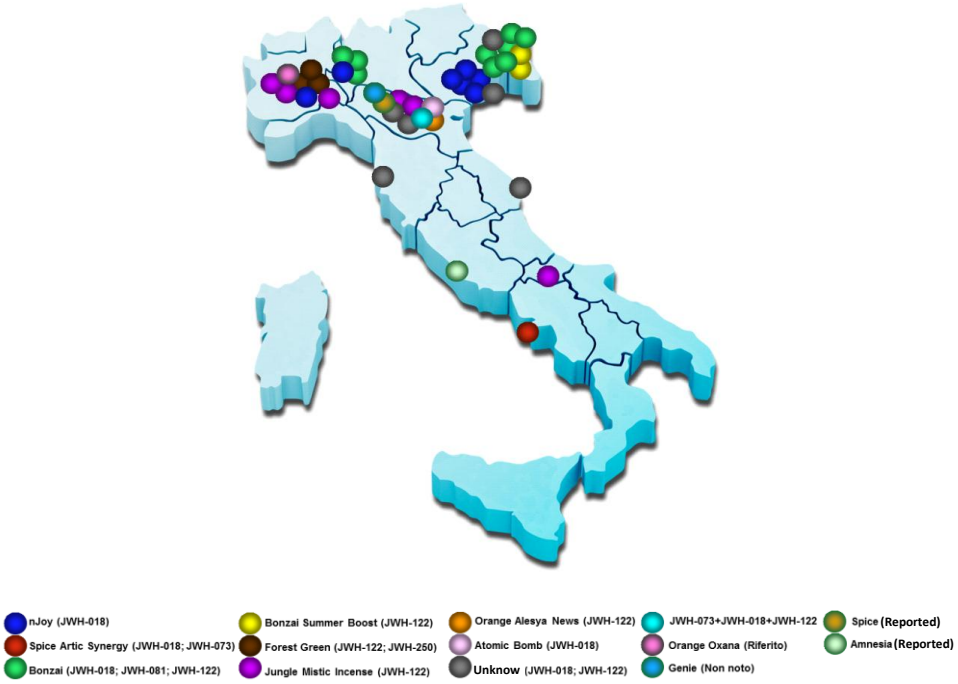
Until 2011, almost all of the new synthetic drugs were found to be available in smart shops located in various Italian cities. Rapid updating of drug tables made these substances illegal, and diligent effort on the part of Law Enforcement has now significantly reduced the availability of these drugs in smart shops.
Nonetheless, these new drugs are still widely available online, where they can be sold easily and quickly due to the difficulty inherent in monitoring and patrolling an environment in such constant fluctuation as the internet. To combat this phenomenon, the Department for Anti-drug Policies, by means of its National Early Warning System, has put into operation an internet monitoring unit to identify websites selling these new drugs.
What follows is a description of the main characteristics of the new drugs identified by the National Early Warning System in 2012 and the cases of poisoning which have been linked to them.

Synthetic cannabinoids

What they are

The first synthetic cannabinoids appeared in Europe as early as 2008 in different plant blends known as “herbal mixtures” or “herbal blends”, which were sold as incense or air fresheners. The first cannabinoids to be identified were JWH-018 and JWH-073. In 2010, the synthetic cannabinoid phenomenon began to affect Italy.
Analyses conducted on different “herbal mixture” products, carried out by a number of different international laboratories, brought to light the existence of numerous other synthetic cannabinoids besides those mentioned above, including JWH-122, JWH-200, JWH-250, JWH-251, JWH-081, JWH-398, JWH-019, HU-210 and CP 47,497 and its alkyl chain analogues CG, C8 and C9.

Figure 2.20: Geo-referencing of cases of acute synthetic cannabinoid intoxication requiring emergency-room admittance recorded by the National Early Warning System beginning in 2010, names of the drugs patients had used and the types of synthetic cannabinoids they corresponded to, as detected in patient samples analysed.



Source: National Early Warning System – Department for Anti-drug Policies

Acute intoxications in Italy since 2010: 41 cases from synthetic cannabinoids; 8 from cathinones; 10 from methoxetamine

Since 2010, the National Early Warning System has recorded, by means of reports from its collaborative centres, 41 cases of acute intoxication requiring emergency-room admittance linked to the use of synthetic cannabinoids in Italy (2 of which were in 2012) Figure 2.20 shows the geo-referencing of cases of acute synthetic cannabinoid intoxication, the names of the products the patients had used and the types of synthetic cannabinoids they corresponded to, as detected in analyses. Most cases occurred in Northern Italy and involved individuals from 15 to 55 years of age in 2012.

Synthetic cathinones

What they are

Another new type of drug recorded by the National Early Warning System in 2010 were synthetic cathinones.
Those recorded by the National Early Warning System since 2010 are: (among those most frequently recorded) mephedrone (14 reports); 4-Methylethcathinone (4-MEC) (11 reports); Butylone (5 reports); Methylone (5 reports); methylenedioxypyrovalerone (MDPV) (4 reports), pentedrone (4 reports); 3-Fluoromethcathinone (3 reports); buphedrone (2 reports).

Acute intoxications in Italy – 8 from cathinones

Since 2010, 8 cases (patients 18-38 years of age) of acute synthetic cathinone intoxication have been recorded in Italy. Patients presented the following symptoms: mydriasis; anxiety; panic; visual and auditory hallucinations, psychomotor agitation; violent behaviour. In one case, the use (ingestion/sniffing) of a product purchased in a smart-shop as plant fertilizer also caused, in addition to systemic effects, hyperaemia of the oral cavity and oedema of the glottis and of the uvula. All the patients received symptomatic treatment and were discharged after 24-48 hours in observation. These cases were recorded in the regions of Lombardy,

Veneto and Tuscany. The drugs responsible for causing the cases of acute intoxication were the synthetic cathinones Butylone, mephedrone, Methylethcathinone and MDPV.

Figure 2.21: Geo-referencing of cases of synthetic cathinone intoxication requiring emergency-room admittance recorded by the National Early Warning System since 2010 and types of synthetic cathinones detected in the samples analysed.

Source: National Early Warning System – Department for Anti-drug Policies

Methoxetamine

What it is

Methoxetamine is a ketamine analogue which differs from ketamine due to the presence of 3-methoxy group, which replaces the 2-chloro group on the phenyl ring, and of 2-ethylamine, which replaces methylamine. Methoxetamine is believed to act, like ketamine, as a non-competitive NMDA receptor antagonist and a dopamine reuptake inhibitor. It should also act as an agonist at dopamine D2, serotonin 5HT2, muscarinic cholinergic, sigma-1 and opioid mu and k receptors.

Acute intoxication cases in Italy: 10 from methoxetamine

Numerous cases of methoxetamine intoxication were reported in 2012. There have been a total of 10 cases of methoxetamine intoxication recorded by the National Early Warning System (one of which was in 2011), most of which (6) were identified in Northern Italy. The remaining 4 were identified in Central Italy, specifically in the regions of Tuscany, Lazio and Emilia Romagna. Figure I.1.57 shows the geo-referencing of cases of acute intoxication resulting from methoxetamine use which required emergency-room admittance.

Figure 2.22: Geo-referencing of cases of methoxetamine intoxication which required emergency-room admittance, as recorded by the National Early Warning System in 2011-2012.

Source: National Early Warning System – Department for Anti-drug Policies

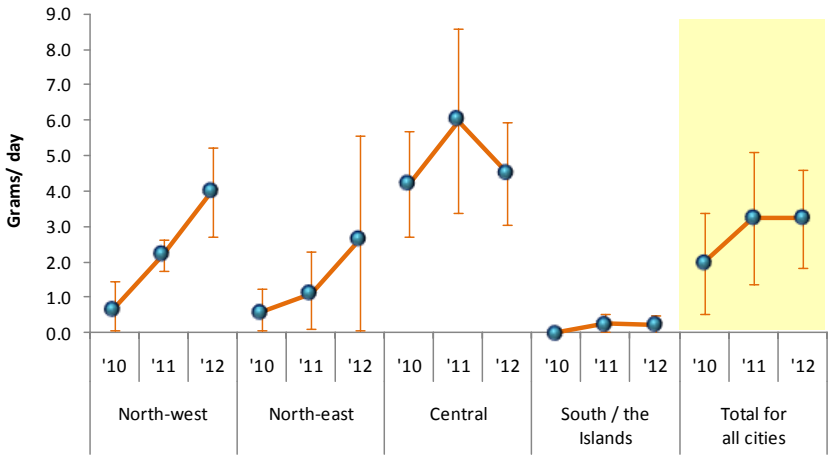
Use of new drugs in the general population 15-64 years of age

The 2012 GPS-DAP Survey examined, in addition to traditional drugs, trends in the use of a number of new drugs in the general population, differentiated by frequency (once in their lives, during the year prior to the survey or the thirty days prior to the survey). The following drugs, in particular, were subject to investigation: Smart Drugs (all compounds of natural or synthetic origin which may contain active ingredients with presumed or proven psychoactive properties), Salvia Divinorum (a psychoactive plant which can produce dissociative effects and induce visions and hallucinations), LSA – Hawaiian seeds (a psychedelic hallucinogen closely related to LSD) and Kobret (a form of heroin).
Initiation to and use of these new drugs seems most common among the younger age-groups, and especially among adolescents. It is largely for this reason that the GPS-DAP Survey, conducted over older age-groups, did not detect significant use of these psychotropic substances.

Significant increase in ketamine use, confined to Northern Italy, in 2011-2012,

Simultaneously, the AquaDrugs studies conducted over the last three years have detected, by means of wastewater analyses, concentrations of drugs used by the population 15-64 years of age. In addition to the traditional drugs (cannabis, cocaine, etc.), the study also analysed concentrations of ketamine, whose standardization was carried out using grams per day as the unit of measure. Levels of use for this drug, following a general increase recorded in 2011 (1.96 gr/day in 2010 vs. 3.24 gr/day in 2011), saw use levels remain largely stable, at 3.22 gr/day, during the last year (cf. 2.1).

Figure 2.23: Distribution of gr/day of KETAMINE detected over the three-year period 2010-2012 and corresponding confidence intervals, by geographical area

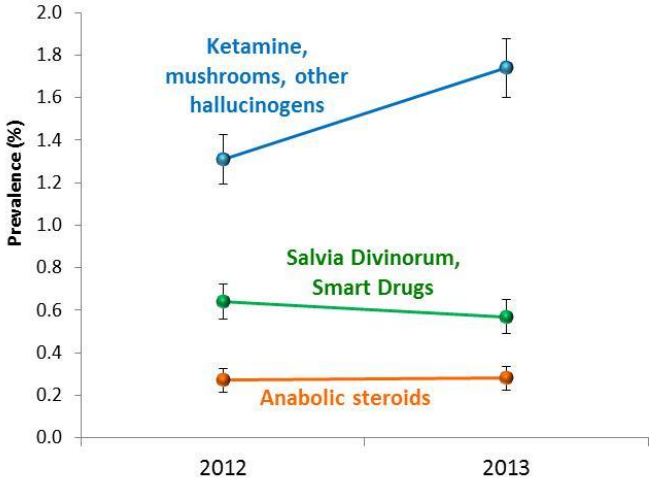


Source: AquaDrugs Studies 2010-2012 – Mario Negri Pharmacological Research Institute

Use of new drugs among students 15-19 years of age: slight increase in ketamine use among students

Unlike the General Population Survey, the SPS-DAP Survey, conducted among a sample group of students 15-19 years of age, revealed that these new drugs had been used during the year prior to the survey. A comparison of estimated use levels in 2013 with levels in the previous year (Figure 2.24), reveals a significant increase in the use of ketamine, of hallucinogenic mushrooms and of other hallucinogens (1.3% in 2012 vs. 1.7% in 2013); while use levels remain largely unchanged for Salvia Divinorum, Smart Drugs and anabolic steroids.

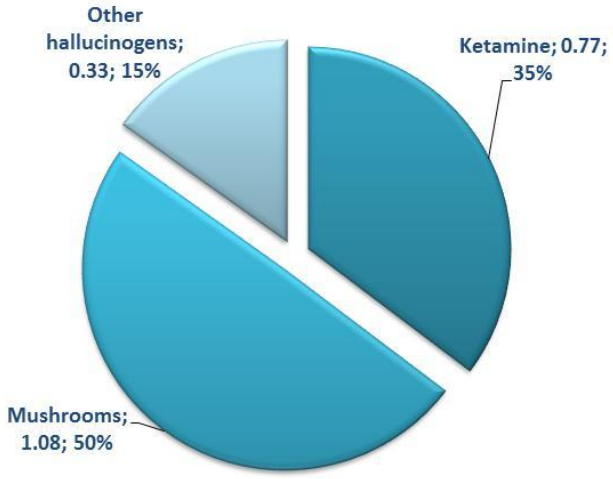
Figure 2.24: Users (prevalence %) of new drugs in the student population 15-19 years of age during the 12 months prior to the survey. The years 2012-2013



Source: SPS-DAP Studies 2012-2013 – The Department for Anti-drug Policies

Focusing our attention on the 2013 SPS-DAP Survey (Figure 2.25), we find that the use prevalence for all hallucinogens stood at 1.7%, with a greater use of hallucinogenic mushrooms (1.08%) than of ketamine or other hallucinogens (0.77% and 0.33% respectively).

Figure 2.25: Users (prevalence %) of new drugs in the student population 15-19 years of age, at least once in the 12 months prior to the survey. The year 2013



Source: the 2013 SPS-DAP Study – the Department for Anti-drug Policies

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

Preface

Over the course of 2012, the DPA continued its planned activities in the context of the DTLP (Drug Testing for Workers in High-Risk Professions) Project), improving and expanding its database and exchanging views with all institutional representatives in the interests of developing proposals for revision to the State-Regional Accord currently in force.

2.4.1. Preliminary results

91,953 subjects screened: 4.4% more than were screened in 2011

The data available to the Department for Anti-drug Policies, gathered through the DTLR project, were provided by the *RFI* (Italian State Railway System) – *Gruppo Ferrovie dello Stato* (The Italian State Railways Group), by the Italian Association of Public Transport (ASSTRA), the *A.N.M.A.* (National Association of Company Doctors), the *S.I.M.L.I.I.* (The Italian Society for Occupational Health and Industrial Hygiene), TRENORD S.r.l. (*t.n.* the regional train operator servicing Lombardy), ANAV (the National Association of Passenger Road Transport) and ENAV S.p.A. (*t.n.* the National Agency for Flight Assistance). 2012 data contains information on 91,953 individuals subjected to 1st level testing (+4.4% more than were tested in 2011, when 88,058 subjects were tested), of whom little more than 5% were women.
Approximately one-hundred collaborative centres of the groups listed above participated in the collection of data for the study, promoted by the DAP.
An analysis of the data by geographic provenance shows a clear majority of tests (66.1%) being performed in Northern Italy, followed by 18.2% in Central Italy and 15.7% in Southern Italy / the Islands. The number of subjects screened in Northern Italy rose in comparison with 2011 after new organizations joined the initiative. Workers in the public transportation sector are, by a large margin, those most often screened, followed by forklift / fork truck operators

Table 2.12: Provenance and number of subjects on whom data was provided. The year 2012

Data Provenance	Subjects
RFI (Italian State Railway System) – *Gruppo Ferrovie dello Stato* – Health Management Department	42,866
The Italian Association of Public Transport (ASSTRA)	22,644
A.N.M.A. (National Association of Company Doctors)	12,734
S.I.M.L.I.I. (The Italian Society for Occupational Health and Industrial Hygiene)	8,138
TRENORD S.r.l.(*t.n.* Lombardy's regional train operator)	1,945
ANAV – The National Association of Passenger Road Transport	1,819
ENAV S.p.A. (*t.n.* The National Agency for Flight Assistance)	1,807
Total number of individuals subjected to 1st level testing	**91,953**

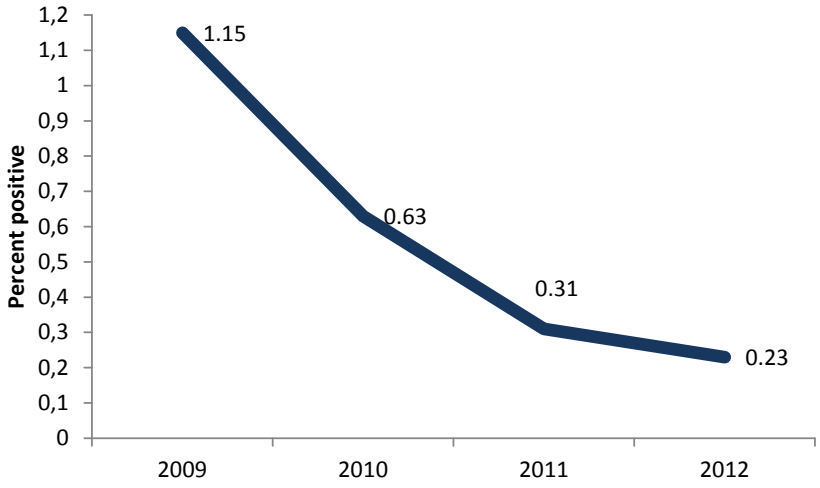
Source: Department for Anti-drug Policies

In 2012, 0.23% of subjects tested positive in first-level testing: 25.8% less than in 2011.

Findings which emerged from first-level testing (confirmed by laboratory testing of the samples collected) revealed that 0.23% of subjects had tested positive, to which we can add the group of subjects who "opted out" and who were held to be temporarily unfit for their duties, which raises the number of positive test results to 0.24%.

There was found to be a decrease of 25.8% in comparison with the year 2011, when the number of subjects testing positive was 0.31%. In comparison with the previous year, the type of subjects tested remained largely the same, and this confirms the on-going, positive trend which has seen the percentage of subjects testing positive in first-level testing fall by 80% from 2009 to 2012, from 1.15% in 2009 to the current figure of 0.23%. In comparison with 2010, when 0.63% of subjects tested positive, there has been a 50.8% reduction (Figure 2.26).

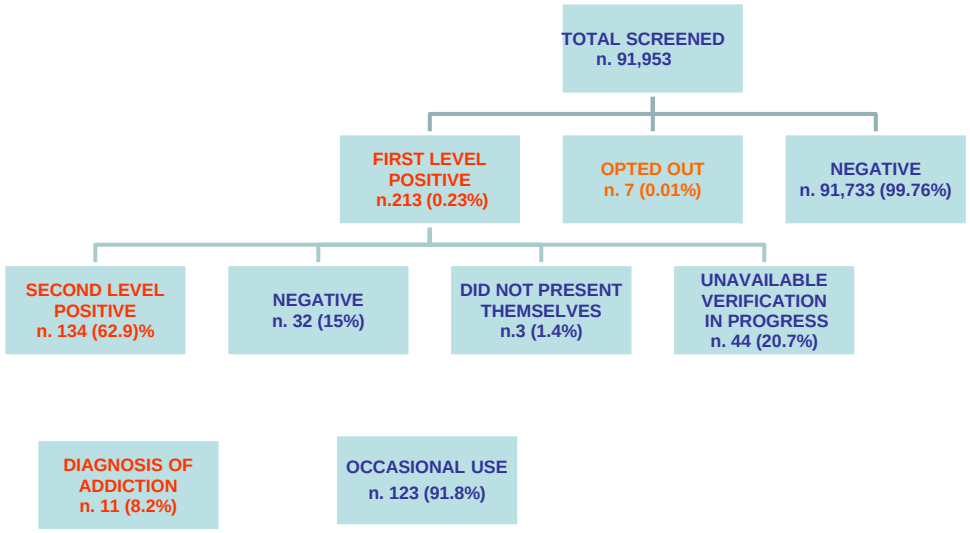
Figure 2.26: 1st-level Drug testing, positive results comparison 2009-2012



Source: Department for Anti-drug Policies

The 2012 data flow is represented in Figure 2.27 where numbers of subjects are reported.

Figure 2.27: Flow of subjects subjected to testing and verification – The year 2012



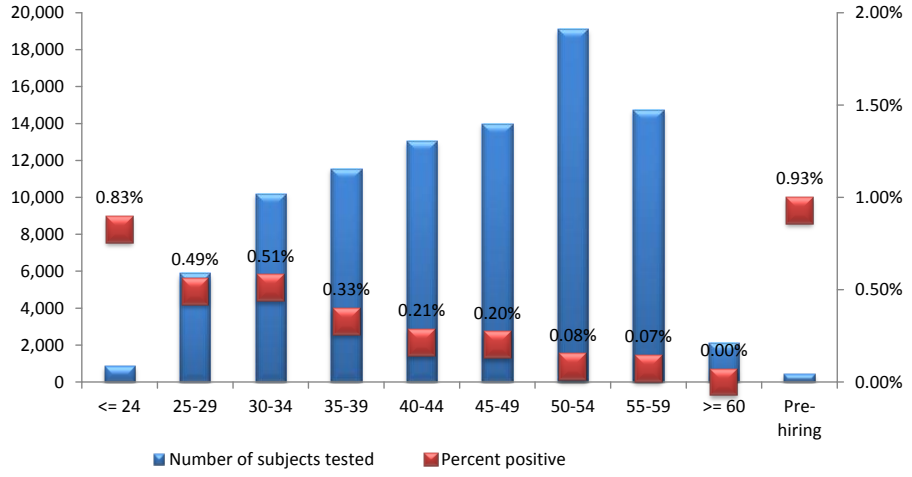
Source: Department for Anti-drug Policies

0.93% of subjects test positive in pre-hiring testing

An analysis by age group shows that most of the subjects in the sample assessed are between 45-59 years of age. Among age groups, it is the younger ones which present higher prevalences of positive test results, especially those under the age of 35. In comparison with 2011, an overall decrease in positive results was recorded for all age groups with the exception of those under 24 years of age (0.59% in 2011 vs. 0.83% in 2012) and those between the ages of 30-34 (0.40% in 2011 vs. 0.51% in 2012) .

The figure for the number of subjects who tested positive during pre-hiring testing, 0.93%, is very interesting. This phenomenon can most likely be attributed to partial ignorance on the part of some aspiring workers who do not realize they will also be subjected to this type of screening even if, in comparison with 2011 (1.66%), it appears there is decidedly greater awareness of it, resulting in a percentage of positives that is not too much higher than that found among workers up to the age of 35.

Figure 2.28: 1st-level Drug Testing by age group and result. The year 2012



Source: Department for Anti-drug Policies

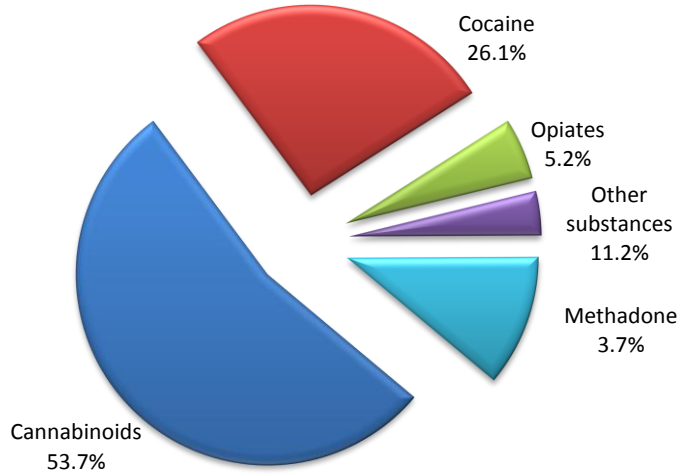
61.5% of subjects tested positive for cannabinoids, 19.7% for cocaine and 5.2% for opiates. Positive test results for cannabinoids rose in comparison with 2011 (52% in 2011 vs. 61.5% in 2012), while those for cocaine fell but positive test results for opiates and other drugs remained stable.

2nd-level verification data for the year 2012 includes information on 166 subjects (77.9% of the 1st-level positive tests). The remainder of the second-level verification data is still undergoing verification, either as a consequence of the amount of time which, for technical purposes, must pass between the finding of a 1st-level positive result and the pronouncement of a final diagnosis or because the subjects in question did not present themselves for verification.

More than 5% of the sample in question were diagnosed as having drug addictions, a decrease in comparison with 2011 (12%). Most of these were addictions to cannabinoids, followed by cocaine, then opiates, then methadone (Figure 2.29). The most common diagnosis remains that of occasional use, at 57.7% this year.

Figure 2.29: 2nd-level clinical verification – analysis by drug type – the year 2012

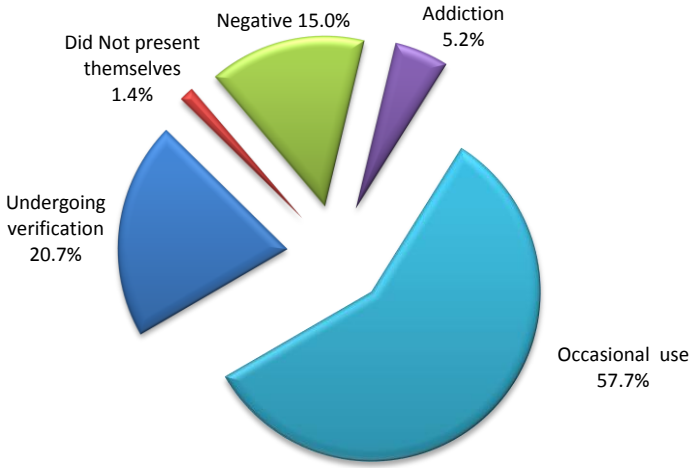
Cannabinoids were the drug most commonly detected (over 50% of cases)



Source: Based on DAP data

Figure 2.30: 2nd-level clinical verification – analysis by diagnosis – the year 2012

Nearly 58% were diagnosed as occasional users



Source: Based on DAP data

2.4.2. Testing in the Armed Forces

The General Directorate of Military Health (DIFESAN) of the Ministry of Defence oversees numerous activities, including the collection, processing and assessment of statistical data relating to drug addiction and the principal health conditions associated with it.
The data for the number of tests[1] performed were made available by the Italian Army, the Navy and the Air Force (Table 2.13.), while the Carabinieri Corp provided the figures for the number of subjects who underwent testing (Table 2.14).

Table 2.13: Drug tests performed on Armed Forces personnel. The years 2008 - 2012

	2008	2009	2010	2011	2012
Italian Army					
Tests performed	48,306	42,417	57,034	23,376	11,680
Positive tests	54	446	204	68	35
% Positive	0.11	1.05	0.36	0.29	0.30
Navy					
Tests performed	41,476	43,958	43,752	17,998	3,503
Positive tests	15	7	4	2	0
% Positive	0.04	0.02	0.01	0.01	0.00
Air Force					
Tests performed	64,108	70,258	82,805	77,963	23,579
Positive tests	41	27	0	29	7
% Positive	0.06	0.04	0.00	0.04	0.03
Total (Italian Army, Navy, Air Force)					
Tests performed	153,890	156,633	183,591	119,337	38,762
Positive tests	110	480	208	99	42
% Positive	0.07	0.31	0.11	0.08	0.11

Source: Based on data from the Ministry of Defence

Italian Army: a decrease in the number of tests; the number of positive results remains stable

Testing using the urine sample drug-testing method was carried out on sample groups of active duty personnel serving abroad and on active duty personnel serving within Italy; moreover, individuals seeking to enrol voluntarily are also subjected to testing.
More detail regarding activities conducted and on the DIFESAN programme can be found in the special section located in the "Administrations Data Sheet".
A total of 11,680 tests were performed on Italian Army personnel in 2012, of which 35 tests came back positive (0.30%). After the peak recorded in 2009, positive tests results have shown a consistent and significant decrease.

Navy: a decrease in the number of tests; no positive results

An unequivocal prerequisite to qualify for enrolment in the Navy is a negative result for tests for all the most commonly used drugs (opiates, cannabinoids, cocaine and amphetamines) which is an obligatory part of every competitive entrance examination. In 2012, 3,503 tests were performed, of which none came back positive.

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

The Air Force conducts periodic urinary catabolite drug testing of all its personnel assigned to drive automobiles, and as part of medical selection during enrolment, the latter being the phase in which most positive results

[1] A subject undergoes an average of 4 to 7 tests

are found. Occasional testing is also performed on personnel who have declared of their own free well that they have taken drugs or who have been reported to their Unit's health services for behaviour presumably attributable to drug abuse. Testing is also performed during the competitive entrance examinations for this branch of the Armed Forces.
In 2012, 23,579 tests were performed, of which 7 came back positive, a figure which is similar to the one obtained in 2011 and in line with results obtained in previous years.
In all three branches of the Armed Forces, despite a significant reduction in the number of tests being performed in 2012 in comparison with 2011 (80,575 less, equal to a reduction of 67.5%), the percentage of tests returning positive results was comparable to the percentage of positive results obtained in 2010, when nearly five times as many tests were performed.

-67.5% tests performed in all 3 branches of the Armed Forces

Table 2.14: Subjects tested within the Carabinieri Corp. The years 2008 - 2012

	2008	2009	2010	2011	2012
Carabinieri Corp					
Subjects tested	1,632	638	810	4,113	476
Subjects testing positive	14	6	2	5	1
% positive	0.86	0.94	0.25	0.12	0.21

Source: Based on data from the Ministry of Defence

In accordance with drug addiction prevention activities in the Armed Forces as set forth in Article 1, Paragraph 9 of the Consolidation Act of the Drug Addiction Laws as provided for under the requirements of Presidential Decree (DPR) 309/90, 476 Carabinieri were subjected to drug testing in 2012, of whom only one tested positive (0.21%). The number of tests carried out dropped steeply following the dramatic increase of the previous year.

88.4% less subjects tested by the Carabinieri Corp

3. PREVENTION

3.1. Introduction

The National Action Plan on Drugs is logically subdivided into 5 principal action areas. The first of these, in order of importance, is Prevention, and it focuses on providing information, starting as early as elementary school, as well as support to families and schools. The NAPD anticipates that universal prevention work be on-going; nonetheless, its initiatives largely target individuals with behavioural disorders (selective prevention). Other actions focus on launching initiatives for the early detection of drug use and alcohol abuse (Non è mai troppo presto) and fostering an educational approach to the issue.
A multitude of specific projects intended to put into effect the various actions anticipated under the NAPD 2010-2013 accompanied the plan's launch at both national and regional levels. This chapter will present the universal prevention initiatives which have been launched at the national level, as well as other initiatives in support of selective and targeted prevention actions. The initiative launched by the Department for Anti-drug Policies to assess the degree to which the NAPD has been adopted at a regional level, as well as which specific actions have been put into effect at the local level, will also be discussed herein.
Furthermore, primary prevention was the subject of a survey conducted by the Department for Anti-drug Policies of the Presidency of the Council of Ministers throughout the Regions and Autonomous Provinces. The survey was conducted using Structured Questionnaires (SQ) 25 and 26 provided by the European Monitoring Centre for Drugs and Drug Addiction in Lisbon regarding new or on-going prevention projects, evaluating them based on the following prevention aspects: universal, selective for at-risk groups or targeting nuclear family groups.
Based on the results which emerged from the use of the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) questionnaires, distributed and submitted online for the first time this year, this section provides a profile on the state of prevention initiatives according to the three areas defined by the Monitoring Centre in Lisbon.
An initial evaluation shows a notable increase in investments in the area of prevention (approximately +60%), with resources equal to approximately 48 million Euros being committed in 2011, particularly in the area of universal prevention. On the other hand, the number of activities, centres, courses and active plans and projects, such as communication campaigns, has fallen.

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

3.2. Environmental prevention

At the national level, universal prevention of drug use, as well as prevention aimed at specific target groups in the population, are both part of a broader context. Thanks to the cooperative collaboration of numerous Organizations and Central Institutions with specific competencies in the sphere of prevention, they have become part of the same multidisciplinary sphere that encompasses the prevention of alcohol and drug use. This field has been bolstered by updating and by the introduction of new regulatory acts which place stronger emphasis on combatting alcohol consumption in specific contexts and among the youngest age groups, as well as on tobacco use in public places, and especially in places where

large numbers of minors tend to gather.

3.2.1. Tobacco

The need for a coordinated global effort in the fight against tobacco consumption is highlighted in the *WHO FCTC (Framework Convention on Tobacco Control).* This treaty on tobacco control is the first treaty negotiated under the auspices of the WHO and 170 countries have become party to the convention.
To combat the phenomenon of tobacco consumption, we must not only promote preventative actions focusing on risk factors and protection, but also on treatment, facilitating access to information and services to assist in quitting smoking.

Regulations

Tobacco and minors

Tobacco and minors: Ever since 1934, Art. 25 of the Royal Decree No. 2316, "Consolidated Law on the protection and assistance of motherhood and childhood", has prohibited the sale or distribution of tobacco products to persons under the age of 16, who were also banned from smoking in public places. Law No. 189 of 8 November 2012, amending the Decree-Law of 13 September 2012, signalled another step forward in the fight against tobacco consumption by prohibiting the sale of cigarettes to persons under the age of 18, raising the upper age limit of 16 provided for in Art. 25 of the Royal Decree of 1934. Penalties for sellers who violate regulations governing sales to minors have also been made harsher: a fine of 250 to 1000 euros can be levied, and these amounts increase to 500 to 2000 euros for a second offense; finally, the seller's license may be suspended for up to three months. Automatic vending machines had to be equipped with automatic systems for age verification by 1 January 2013. Moreover, the decree of the Ministry of Health raising the legal age for buying electronic cigarettes containing nicotine from 16 to 18 came into force on 1 May 2013.

Framework Convention on Tobacco Control

The Framework Convention on Tobacco Control: The World Health Organization's Framework Convention on Tobacco Control (WHO FCTC) establishes a series of goals and principles whose aim is to protect present and future generations from the devastating health, social, economic and environmental consequences of tobacco consumption and the exposure to tobacco smoke. Italy signed the FCTC on 16 June 2003 and ratified it on 2 July 2008; it was published in Ordinary Supplement No. 97 to Official Gazette No. 91 of 17 April 2008.

Protecting the health of non-smokers

Protecting the health of non-smokers: **Law No. 3 of 16 January 2003 (Art. 51), "Protecting the health of non-smokers"**, extended the smoking ban to cover all closed locations (including private workplaces or those not open to the public, shops and food service establishments, recreational venues, gyms and sports centres), the only exception being locations reserved for smokers and premises which are strictly private (residential buildings). The Law makes it possible, but not obligatory, to create establishments for smokers. The structural characteristics and ventilation parameters of such establishments were identified in The Decree of the Presidency of the Council of Ministers on 23 December 2003, which also establishes measures for enforcement and penalties for violations.

Regulations governing tobacco smoking on public premises and on transport

Regulations governing tobacco smoking on public premises and on transport: Italy's first law on smoking dates from the 1970s. **Law No. 584 of 11 November 1975, "Prohibiting smoking in specified premises and on public transport"**, banned smoking in certain locations (Art. 1), including hospital wards, classrooms in schools, waiting-rooms in stations, closed premises intended for public meetings, cinemas and closed dance halls. The **Directive of the President of the Council of Ministers of 14 December 1995, "Prohibiting smoking on certain premises of the public administration and of public services",** extended the ban to include a prohibition on smoking in premises open to the public, by reasons of the functions involved, and in premises used by public administration and public bodies as well as by persons in the private sector providing public services.
Another important source of regulations having to do with the prohibition of smoking is **Circular No. 4 of 28 March 2001** of the Ministry of Health, which provides a very detailed exemplificative list of locations where smoking is banned, specifying that which was already contained in Law 584/75.

Advertising for tobacco products

Advertising for tobacco products: **Law No. 52 of 22 February 1983** regulates tobacco advertising and is a powerful tool in the fight against tobacco consumption. Art. 8 of this Law thus substitutes Art. 1 of Law 165 of 10 April 1962": "Advertising of any tobacco product, whether domestic or foreign, is forbidden", with no distinction made between direct and indirect advertising. In addition, **Ministerial Decree No. 425 of 30 November 1991**, implementing Directive 89/552/EEC, states that, "Television advertising for cigarettes and other tobacco products is prohibited even if it is indirectly performed by using names, trademarks, symbols or other elements proper to tobacco products or companies whose main activities consist of the production or sales of such products..." **Art. 8 of Legislative Decree No. 581 of 9 December 1993, "Regulations relating to sponsorships of radio and television programs and offers to the public",** forbids "natural or legal persons whose principal activity is the manufacture or sale of cigarettes or other tobacco products..." from sponsoring radio or television programs. **Legislative Decree No. 300 of 16 December 2004** implemented **Directive 2003/33/EC, "On the approximation of laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products"**, regulating advertising of tobacco products and related sponsorship with a cross-border character as well as the free distribution of tobacco products for promotional purposes. This legislation made it possible to ban the use tobacco brand logos during the Formula 1 Gran Prix races in Italy and in San Marino, as well as in MotoGP racing.

Prevention

At a national level, actions and initiatives for the prevention of tobacco consumption are proposed and implemented by the Higher Institute for Health in collaboration with the Ministry of Health, the Ministry of Education, Universities and Research and the Department for Anti-drug Policies of the Presidency of the Council of Ministers.
The principal initiatives targeting primary and secondary schools are:

A multimedia kit for primary schools

The* Fumotto *Multimedia Kit for Elementary Schools: Intended for elementary school students and their teachers, its purpose is to provide a simple and fun tool to teach children about tobacco smoke and how harmful it is to health.

The kit contains:

Fumotto A book containing all the information on tobacco and smoking that elementary-school children can easily absorb.
Stickers Depicting all the illustrations from the book, they can be used to create a personalized anti-smoking campaign.
CD Containing the whole book in an electronic format, its contents are simple to navigate. It also allows children to use their mouse and keyboard to play a series of educational games. In addition, they can print any of the pages, including the book's rich illustrations.
The *Fumotto* kit is an educational tool for teachers, who can use the materials contained therein as they deem suitable, based on their own professional experience and on their students' level of knowledge.

A multimedia kit for secondary schools

The* Venditori di Fumo *Multimedia Kit for Schools: The *Venditore di fumo* kit addresses the issue by starting with the responsibility of the tobacco industry. It places an emphasis on the dynamics that drive the tobacco market, the mechanisms used to induce the consumer to buy tobacco products and the harm to health which can result from addiction. The film *Insider*, which is included on a cassette inside the kit, is meant to provide inspiration for a group research project that addresses every aspect of the smoking 'habit'. To this end, the kit provides addresses of websites where it is possible to find useful informational materials. The kit also contains a CD on which the information from the sites listed has been recorded. The kits already produced and those in production, along with the tools they contain, aim to provide support for teachers, offering a small but concrete contribution to the important work they do, which often goes unacknowledged by society at large.

The PASSI monitoring project

In 2006, the Higher Institute for Health launched the "Progress by Local Health Units towards a Healthier Italy" (PASSI: *Progressi delle Aziende Sanitarie per la Salute in Italia*) project. Its aim is to conduct 360-degree monitoring of the health of the Italian adult population, for which it uses sample surveys conducted on the Italian adult population 18-69 years of age.
The study is intended as a means of monitoring public health, which it does by collecting information on non-communicable chronic diseases and on the degree of awareness of and participation in programmes the State is creating for their prevention.
The study focuses on the topics of smoking, physical inactivity, the condition of being overweight, alcohol consumption and vegetable- and fruit-poor diets. It also deals with monitoring risk of cardiovascular disease, screening for tumours and adopting safety measures to help prevent traffic accidents. Other subjects have to do with life in the workplace, flu-vaccine coverage, physical and psychological well-being, as well as other aspects of quality of life which are linked to health.
PASSI was born of the need to monitor the extent to which the health goals set by national and regional Health Plans were being achieved. Its other purpose is to contribute to forming assessments of the National Prevention Plan, since it is necessary to be aware of the health profiles of

the population and the risk factors affecting them in order to create specific prevention activities targeting vulnerable population groups and assess the effectiveness of past programmes and initiatives.

3.2.2. Alcohol

Harmful alcohol consumption is one of the greatest risk factors for human health and, together with smoking, represents one of the principal causes of death and disease. Alcohol consumption is highly influenced by cultural, social, economic and political contexts. The harm caused by alcohol extends beyond the drinker to his or her family and community at large, and its impact is felt by society as a whole.
The most recent European action plan on alcohol restates the need to formulate or, where necessary, reformulate national policies and intensify international collaboration in the face of growing common challenges in this field. In order to limit harmful alcohol consumption and prevent or reduce the harm it causes, the Action Plan strongly emphasizes the importance of promoting and supporting policies and programmes based on scientific evidence and the need to involve all levels of Government, as well as all of the spheres affected (the community, civil society and the private sector).

Regulations

Art. 689 of the Penal Code: It is forbidden to serve alcohol to minors under 16 years of age, but it is not forbidden to sell it to them.

Art. 689 of the Penal Code, Law No. 45 of 18 February 1999 and Law No. 125 of 30 March 2001

Law No. 45 of 18 February 1999: "Regulations regarding the national Fund for combating drug abuse and the personnel of addiction and drug-abuse services."

Law No. 125 of 30 March 2001: "Outline law on alcohol and alcohol-related problems ".

This last law was the first in Italy to deal with alcohol-related problems using an inter-institutional and integrated approach. It provided regulations in line with stances adopted by the EU and WHO for dealing not only with aspects of the problem that fall within the social-healthcare sphere, such as prevention, treatment and the social reintegration of alcoholics, but also with those aspects in the social-sociocultural sphere, such as traffic safety, workplace safety, advertising, methods of sale, university education of professionals working in the field and the availability of medications.

Law 125/2001 also lowered the legal blood alcohol level from 0.8 to 0.5 per thousand, thus bringing Italy into line with the legal BAC levels adopted by most other European nations. As part of this law's implementation, the State-Regional Accord Act of 16 March 2006 was adopted (in Official Gazette no. 75 of 30 March 2006), establishing the types of professions where there is a high risk of workplace accidents and a risk to the safety of third parties and for which the consumption or serving of alcoholic beverages of any sort is therefore forbidden. The Law also encourages the Ministry to create national information and prevention campaigns. It provides for the institution of a National Committee on Alcohol which will include experts in the treatment of alcoholism and members of research institutes as well as professionals from the industrial and production spheres and from self-help/mutual aid groups.

Law No. 160 of 2 October 2007

Law No. 160 of 2 October 2007: contains "Urgent provisions amending the Traffic Code in order to increase traffic safety levels". Art. 6 of this law introduces new legislation intended to promote awareness of the risk of having an accident when driving under the influence of alcohol. Specifically, it dictates that alcohol can no longer be served after 2 a.m. in venues where there are performances or other forms of entertainment taking place in conjunction with the sale and serving of alcoholic beverages. In addition, such venues must make a voluntary alcohol test available to patrons when they are leaving the premises. Law 160/2007, by means of a special decree, also assigned the Ministry the task of preparing purpose-made tables to help patrons of such venues to make an estimate of their blood alcohol level and be aware of the symptoms that accompany different levels of blood alcohol concentration. The Ministerial Decree implementing the law also contains a number of non-binding suggestions for owners and managers of venues where alcohol is served for promoting the proper understanding and the concrete use of the information contained in those tables by as large a number of their patrons as possible.

Decree of 30 July 2008 and Law No. 120 of 29 July 2010

Decree of 30 July 2008: Urgent provisions amending the traffic code in order to increase traffic safety levels.
Law No. 120 of 29 July 2010: Provisions concerning road safety. Tables to be displayed in public venues: A special Commission (formed under D.D. of 19 October 2007) provided the Ministry with assistance to ensure the scientific correctness and ease of comprehension of the information to be inserted into the tables. The same Commission was also in charge of conducting a test specifically designed to assess the tables in the field, testing the actual extent to which they were easy to understand, appropriate, intuitive, easy to use and were perceived as being useful by a sample group of 100 volunteer subjects of different ages and with different drinking habits. Annex 1 of the 30 July 2008 Decree contains the Tables describing the major symptoms linked to different blood alcohol concentration levels. Eight different groupings of BAC levels are listed, and the relative principal symptoms and physical and psychological effects associated with each of these groupings are described in language which is easy to understand. In order to place sufficient emphasis on the fact that even a BAC that is considered to be low (from 0.1 to 0.3 grams per litre) can have a real effect on driving, especially for certain subjects, the tables start from a blood alcohol concentration of zero, the only BAC that can truly be considered safe for driving. Annex 2 contains the Table that helps to estimate the quantity of alcoholic beverages which raise BAC above the legal level for driving under the influence (DUI level = 0.5 g per litre). The base unit of measure is the blood alcohol concentration resulting from the consumption of one standard unit of alcohol. This standard unit refers to the glasses, cans or bottles of beverages most commonly served in the venues which fall under Law 160/2007. Blood alcohol concentration was calculated based on the Widmark formula, corrected. In order to be able to make as close an estimate of BAC as possible, calculations had to include not only the subject's weight, as laid down in Law 160/2007, but also the subject's gender and whether or not he or she had a full or empty stomach, in accordance with instructions provided by the experts on the Ministerial Commission. The possible influence of other variables was pointed out to the Table's users in a list of specific warnings meant to assist them in making accurate use of the table.

Prevention

At a national level, actions and initiatives for the prevention of alcohol abuse are proposed and implemented by the Higher Institute for Health in collaboration with the Ministry of Health, the Ministry of Education, Universities and Research and the Department for Anti-drug Policies of the Presidency of the Council of Ministers.

A multimedia kit for schools: "If you know how to drive, know how to drink"

"If you know how to drive, know how to drink" (original name: "Se sai navigare sai come bere") - Multimedia kit for schools: an informative booklet on alcohol and its effects. The project, called "Lifestyles for the prevention of addictions", is financed by the National Fund for the Fight Against Drugs. It falls under the umbrella of activities by the Higher Institute for Health and was realized by the Monitoring Centre for Tobacco, Alcohol and Drugs (*OssFAD*). The multimedia educational programme, entitled, "If you know how to drive, know how to drink", deals with the issues that arise when drinking is combined with driving any sort of vehicle. Its goal is to promote prevention among secondary school students between 15 and 19 years of age. The choice of tools and methods are the result of experience that the Monitoring Centre for Tobacco, Alcohol and Drugs has accumulated while working with young people to prevent alcoholism.

Drinking and driving: According to the traffic code (Art. 186 and subsequent amendments) the legal blood alcohol limit (blood alcohol concentration [BAC]) cannot be above 0.5 when driving. Under the new Decree Law, drivers can be subjected to tests measuring the amount of alcohol they have drunk by analysing the amount in the air they exhale (breathalyser test) by law enforcement officers. They will be found to be driving under the influence if the legal level of 0.5 is exceeded in two tests conducted within five minutes of each other.

The Department for Anti-drug Policies – Booklets on alcohol and drugs and Project Edustrada*: a culture of road safety*

Project *Edustrada:* a culture of road safety

"Project *Edustrada*: a culture of road safety" is a production of RAI Educational and was created as part of a joint project by the Ministry of Public Education and RAI (*Radio-Televisione Italiana*). It aims to promote safe driving and teach about correct and responsible behaviour on the road.

The EDU *Project – The Department for Anti-drug Policies of the Presidency of the Council of Ministers*

Project "Operation Red Nose"

Project "Operazione Naso Rosso": The "Operazione Naso Rosso" project is the result of a collaboration between the Department of Youth of the Presidency of the Council of Ministers and the Higher Institute of Health. Its goal is to raise awareness among youth of road safety issues linked to alcohol consumption. The Project has therefore promoted information/prevention actions targeting young people with the aim of discouraging them from using drugs and alcohol, with a particular emphasis on raising their awareness of how alcohol consumption affects road safety.

The "Net_GAD" Project

The "Net_GAD" Project: the aim of this project, result of a joint effort on the part of the Ministry of Education, University and Research and the Higher Institute of Health, is to raise awareness among youth concerning road safety and alcohol and drug use.

3.2.3. Drugs

The first of the 5 principal Action Areas which lie at the core of the National Action Plan on Drugs is Prevention, which also plays a crucial part within the Projects Plan launched by the Department for Anti-drug Policies in order to provide support for the actions anticipated in the NAPD. According to the strategy laid down in the NAPD, the main objective of prevention is to provide information as early as elementary school, enlisting the support of families and schools. Universal prevention work must continue, but initiatives must focus largely on individuals with behavioural disorders (selective prevention). Programmes must be activated for the early detention of drug use and alcohol abuse (the "It's never too early" project), and an educational approach to the problem must be fostered.

Monitoring regional best practices in the sphere of addictions

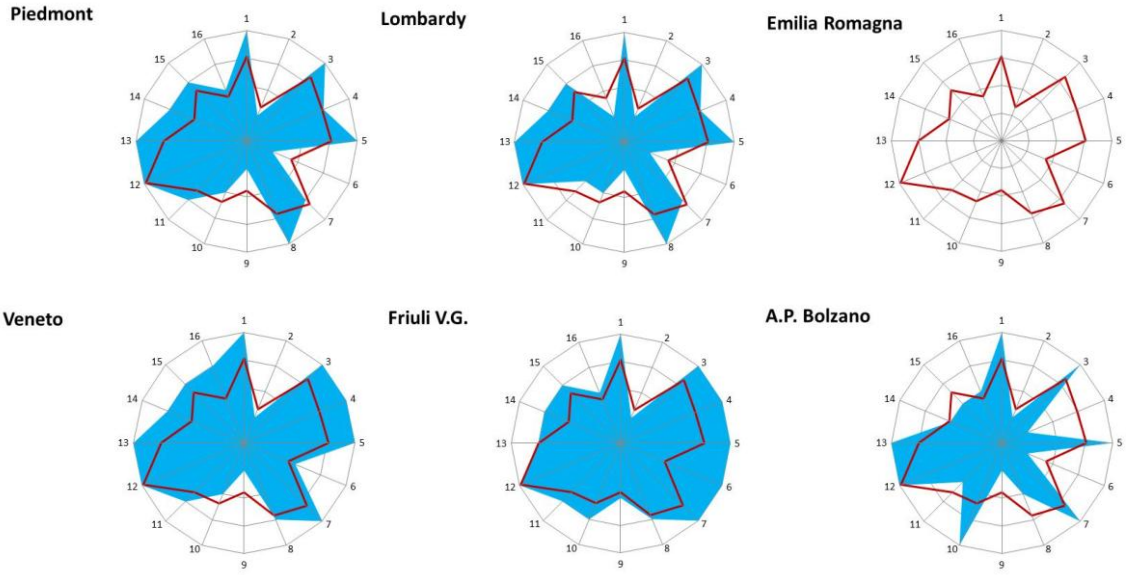
During the course of 2013, the Department for Anti-drug Policies conducted a study to monitor drug-use prevention actions launched at the regional level, divided according to objectives within the action area and evaluated in relation to the National Action Plan on Drugs 2010-2013.

The radar charts below show the points assigned to each goal in each Region, based on the following scale of "compliance":

1: no information (level close to radar chart origin)
2: goals are present in the Region
3: goals actualized through project activities
4: goals actualized through routine activities (level corresponds to most external circumference of radar chart)

The red lines represent the national average obtained by calculating the arithmetic mean of the points obtained for each of the goals in each Region and Autonomous Province being evaluated.

Figure 3.1: Regions/A.P.s and their scores for actualization of goals in the Prevention Action Area of the NAPD – the year 2012



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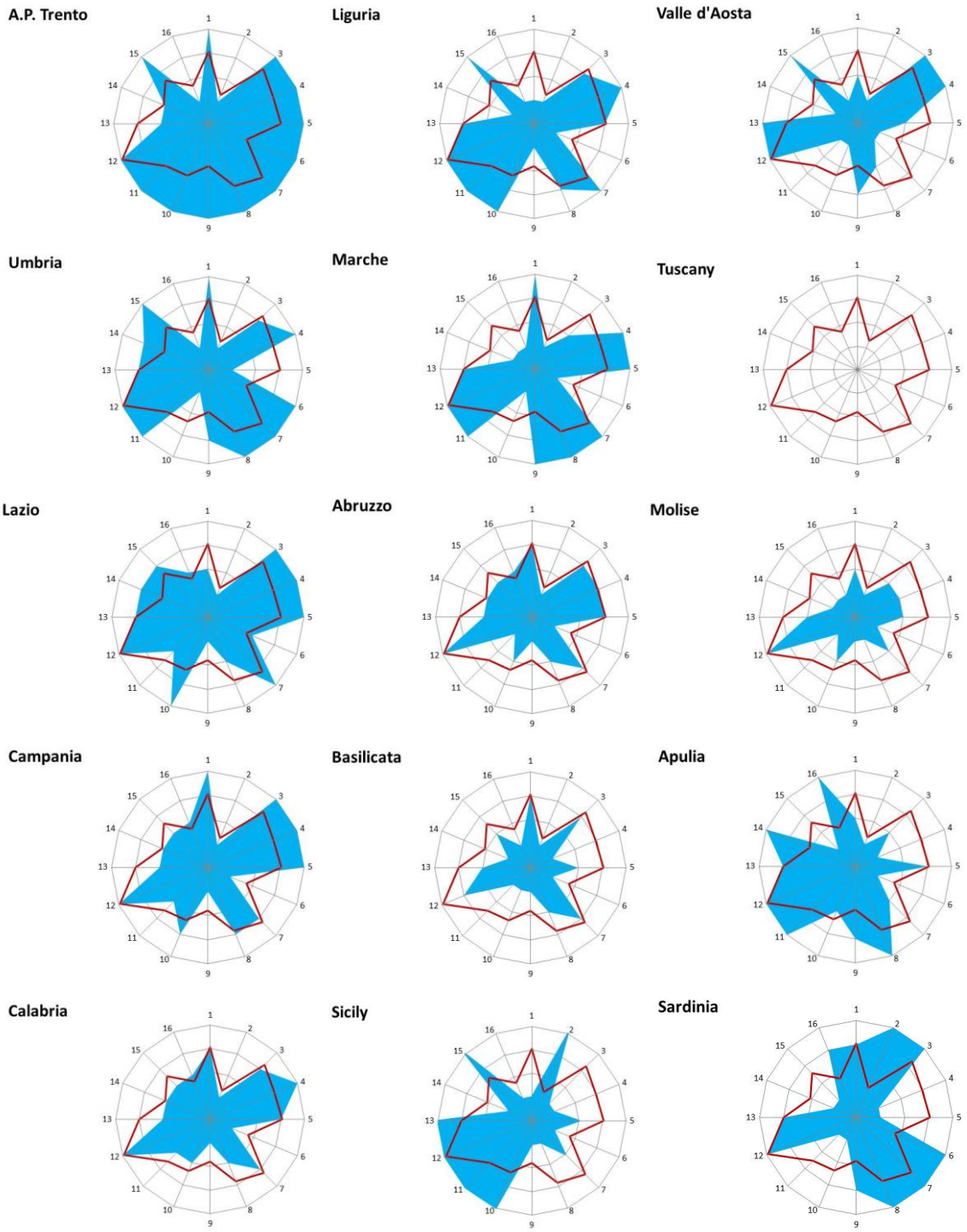


NAPD Goals – Chart Key:

1 Guaranteeing organisational conditions
2 Permanent national information campaign
3 Informing about risks and harm of drug use
4 Early detection
5 Early use prevention programmes
6 Gender-oriented prevention programmes
7 Programmes for parents and educators
8 Prevention of traffic accidents
9 Reducing workplace accidents
10 Prevention programmes for prison inmates
11 New prevention strategies
12 Prevention programmes with schools
13 Prevention in recreational and entertainment venues
14 Prevention in gyms
15 Gambling prevention
16 Keeping institutional websites up-to-date

As the radar charts show, prevention programmes in schools within the Regions and Autonomous Provinces tend to be fairly routine. These routine activities are bolstered by project activities focusing on other objectives, such as initiatives to inform students of the risks and harm associated with drug use, drug-use prevention activities and early detection activities, as well as programmes for parents and educators.
The Regions and APs with the best scores for NAPD goal actualisation include the Autonomous Province of Trento and the Regions of Piedmont, Lombardy, Veneto and Friuli Venezia Giulia, while the Regions with the least number of active prevention initiatives, whether routine or individual projects, were Molise, Basilicata and Abruzzo. On the other hand, no data at all were received from Emilia Romagna or Tuscany.

3.3. Universal prevention

3.3.1. School

As part of the survey on drug use conducted in upper secondary schools in 2013, school representatives were asked to fill out a questionnaire on universal and selective prevention activities conducted during the 2012/2013 academic year.
Of a sample group of 462 schools which had participated in the survey by 3 May 2013, 363 (78.6%) of these had filled out the aforementioned questionnaire, which was based on the questions contained in Structured Questionnaires 25 and 26.
During the 2012/2013 academic year, the types of drug-use prevention initiatives most commonly employed in secondary schools were ordinary lessons devoted to the topic of prevention (65.6%), followed by awareness days (62.8%) and by the distribution of informational materials (45.0%)

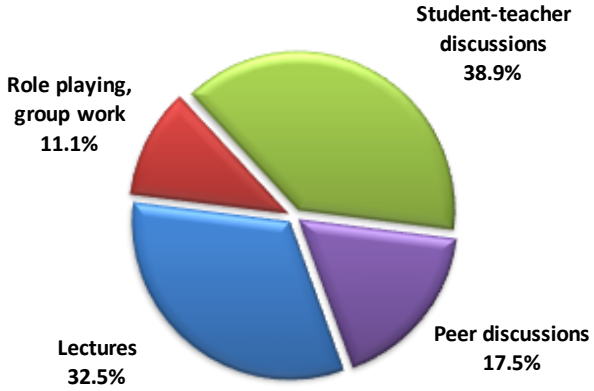
62.8% of the sample of schools participating in the survey conducted awareness days
49.4% of schools distributed informational materials

Among schools which reported having distributed *informational material* (49.4% distributed brochures and/or leaflets), art schools at the secondary level and art institutes devoted more attention to information on alcohol consumption (100%), followed by vocational schools (97.0%), while technical institutes focused largely on the prevention of tobacco use and the abuse of medications (86.2% and 25.9%, respectively).
With regard to the organisation of *awareness days* focusing on drug-use prevention, we find that art schools at the secondary level and art institutes focused mostly on the prevention of alcohol consumption and drug use (81.3%) and tobacco use (75.0%); in 71.6% of cases, they hosted informative events taught by educators from outside the school. 36.1% of schools involved *law enforcement* in their prevention days. Technical institutes, especially, sought the involvement of law enforcement in these types of initiatives (44.4%).

36.1% of the schools that organized awareness days involved Law Enforcement

Turning our attention to the didactic methodology employed in the ordinary lessons in which drug-use prevention topics were addressed, most of these took the form of *student-teacher discussions* (38.9%) and *lectures* (32.5%). Techniques involving more interaction between students were less common, although methods of this sort employed included, specifically, *peer discussions* (17.5%) and *role playing, group work* (11.1%).

Figure 3.2: Distribution of educational activities and didactic methodology employed in educational activities focusing on personal and/or social skills – the 2012/2013 academic year

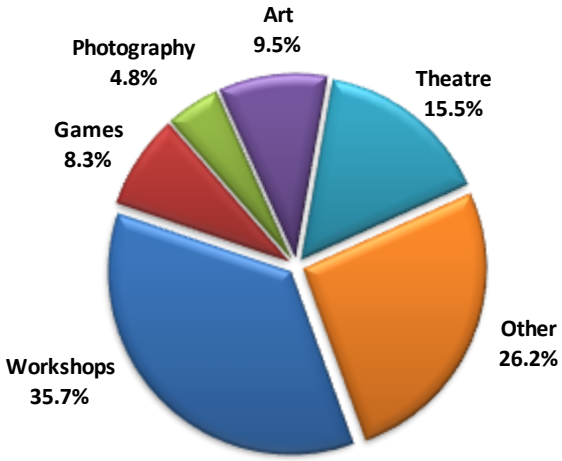


Source: SPS-DAP Survey 2013 – The Department for Anti-drug Policies

65.6% of schools dealt with the topic of prevention in ordinary lessons

During the 2012/2013 academic year, 65.6% of schools dealt with prevention topics during the course of ordinary lessons: vocational schools and secondary schools formerly specializing in teacher training devoted most of their attention to the topic of alcohol consumption (94.3% and 94.2%, respectively); these were followed by technical institutes, which focused more on the prevention of tobacco and drug use (92.5% and 98.1%, respectively).

Figure 3.3: Distribution of creative activities to promote prevention conducted in higher secondary schools – the 2012/2013 academic year



Source: SPS-DAP Survey 2013 – The Department for Anti-drug Policies

15.4% of schools organized creative activities to promote prevention

15.4% of the schools participating in the survey had organised creative activities focusing on drug-use prevention, with a fairly even distribution among the various types of schools. The types of creative activities most often offered by the different schools were *workshops* (35.7%), followed by *other types* (26.2%), *theatre* (15.5%) and *art* (9.5%).

3.3.2. Family

Projects and programmes based on self/reciprocal help among families

Prevention activities targeting the family, on the other hand, included projects/programmes based on self/reciprocal help among families (100%), projects/programmes for informational/educational meeting

events for families and/or parents (88.2%), and intensive educational courses on drug-use prevention for families (58.8%).

were given high priority

From an operational point of view, during the course of 2012 a full 76.5% of Regions and Autonomous Provinces launched or were preparing actions to develop plans which include a local-level drug-use prevention strategy.

Strong local commitment in the prevention field on the part of the Regions and Autonomous Provinces

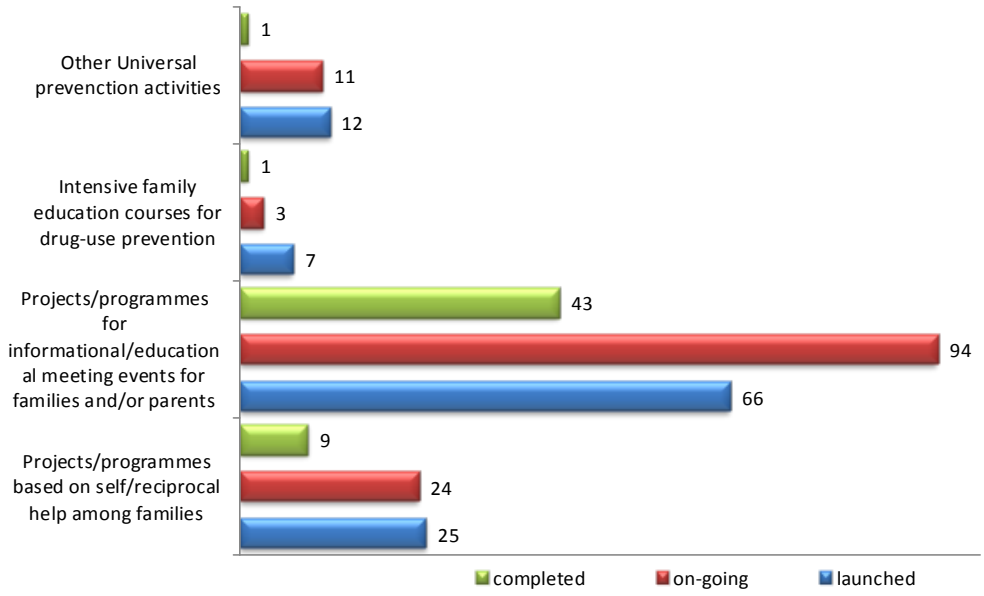
Projects to encourage the making available of recreational and/or cultural venues were launched or were already on-going in many Regions and Autonomous Provinces. Specifically, of local-level universal prevention projects, the most common were the making available of social clubs and counselling centres (381).

The Regions and Autonomous Provinces focused special attention on the drafting of official documents concerning actions to be undertaken in order to develop plans which include local-level drug prevention strategies. A full 106 were drawn up in 2012, as well as 118 documents for the launch of projects targeting family members, guardians, teachers and peers.

In 2012, turning our attention to plans for universal prevention projects targeting nuclear families which had already been launched, were on-going and/or were completed during the course of the year in the Regions and Autonomous Provinces, there was a significant amount of turnover for projects consisting of informative/educational meeting events for families and/or parents (66 launched and 43 concluded in 2012) (Figure 3.4).

Plans and programmes for families and parents

Figure 3.4: Number of universal prevention project plans targeting nuclear families: launched, on-going or concluded in 2012



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

3.3.3. Community

According to official documents on healthcare and/or social policies, universal prevention activities undertaken at the local-community level throughout the course of 2012 have consisted of the development of plans that include the following universal drug prevention strategies:

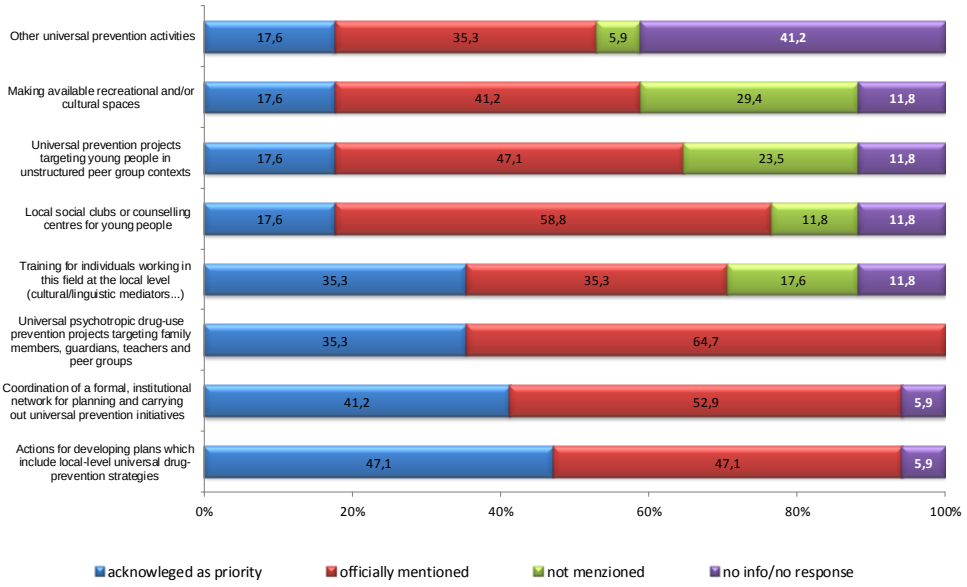
100% of Regions and Autonomous Provinces have universal prevention strategies targeting family members, guardians, teachers and peer groups

- universal drug prevention strategies targeting family members, guardians, teachers and peer groups (all of the Regions and Autonomous Provinces),
- local-level universal drug prevention strategies (94.2%),

- the coordination of a formal, institutional network for planning and carrying out universal prevention initiatives (94.1%), universal prevention projects targeting young people in unstructured peer group contexts (88.2%) and the making available of recreational and/or cultural venues (88.2%), training for individuals working in this field at the local level (88.2%), the use of social clubs and counselling centres for young people at the local level (88.2%).

In 2012, nearly half (47.1%) of the Regions and Autonomous Provinces considered drug-prevention plans to be a priority goal, and the same number made official mention of this goal, for a total of 94.2% (Figure 3.5).

Figure 3.5: Percentage distribution of different programmes at the **local-community** level explicitly referred to in official documents on healthcare and/or social policies in 2012



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

3.4. Selective prevention in at-risk groups and settings

In 2012, a total of over 13 million euros in funding was set aside for selective prevention projects for at-risk groups and other specific groups, a 33.1% decrease with respect to 2011, concentrated in the Regions of Tuscany (28.2%), Lombardy (25.1% of the total) and Lazio (19.6%).
In comparison with 2011, according to available data, a full five Regions reported no such funding whatsoever or had reduced it by 90%. Only Campania, Liguria and Piedmont reported having increased it.
In terms of comparison for the population 15-64 years of age, Tuscany and Basilicata were in the lead, with figures of over €1 per capita. Lazio, Lombardy, Campania and the Autonomous Province of Bolzano also had figures higher than the national average.

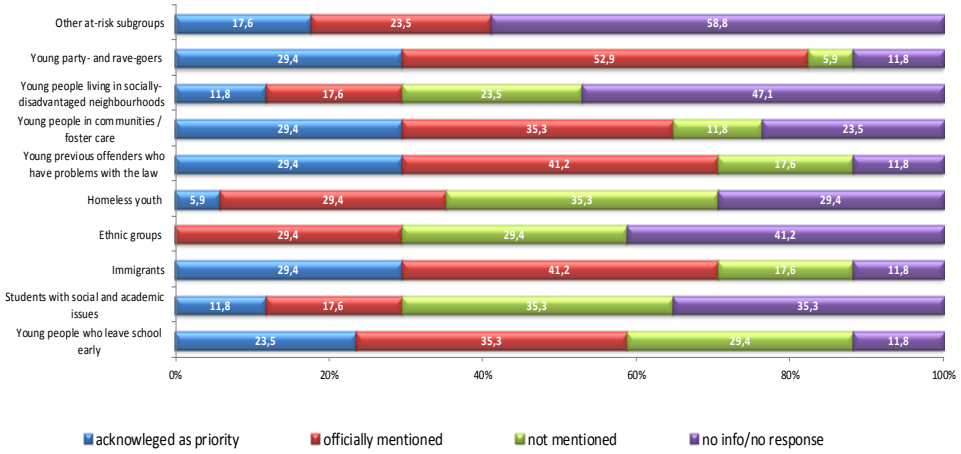
3.4.1. At-risk groups

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

Over the course of 2012, official healthcare policy and/or social policy documents made more frequent mention of young party-goers and rave-goers as well as of selective prevention activities targeting immigrants and young previous offenders who have problems with the law (explicit references by 88.2% of Regions and APs) (Figure 3.6).

There were very limited numbers of explicit references to the following categories: “other at-risk subgroups” (41.2%) and ethnic groups (58.8%).

Figure 3.6: Distribution of explicit references to prevention activities targeting **at-risk groups** in official documents on healthcare and/or social policies in 2012.



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

The total number of selective and targeted prevention initiatives which were either on-going or concluded by the Regions and Autonomous Provinces was high, 215 in all, but nonetheless there were fewer than in the previous year (254 in 2011).

Over 200 active prevention projects

The categories for which the largest numbers of projects were launched were those targeting young party-goers and rave-goers (50), followed by those targeting “young people living in socially disadvantaged neighbourhoods” (19).

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

The categories for which the largest number of projects were on-going in 2012 were those targeting “young party-goers and rave-goers” (57), followed by those for targeting immigrants (24), followed by those targeting young people who leave school early and those targeting young previous offenders who have problems with the law (22).

3.4.2. At-risk families

As far as regards selective prevention at a nuclear family level, explicit references were made to all of the at-risk categories in over 50% of official documents, with the exception of the “other at-risk nuclear families chosen for selective and/or targeted prevention” category (Figure 3.7).

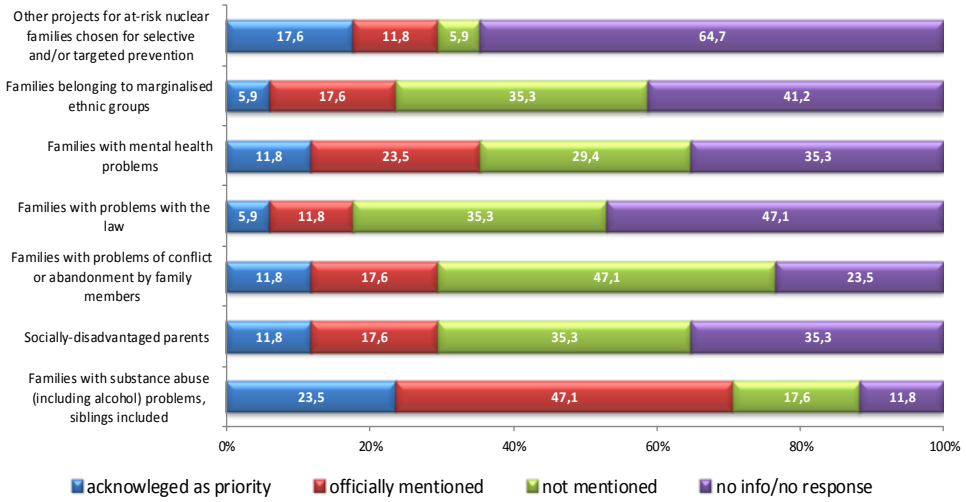
Projects launched for problem families, to whom special attention was reported as having been dedicated.

The Regions and Autonomous Provinces have a total of 212 on-going projects that fall under the category of selective prevention targeting families, more than twice the 2011 figure (98 in 2011). Nearly 80% of these are focused on “families with substance abuse (including alcohol) problems, siblings included”.

212 selective prevention projects targeting families: focused largely on families affected by substance-abuse issues

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

Figure 3.7: Distribution of explicit references to prevention activities targeting **families** in official documents on healthcare and/or social policies in 2012



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

3.4.3. At-risk students

Regarding selective drug-use prevention, approximately 5.1% of the sample group of schools participating in the survey about drug use in secondary schools reported having used standard protocols and/or criteria for the early identification of students exhibiting at-risk behaviours for drug use: 6.8% of vocational schools, 5.5% of secondary schools formerly specialising in teacher training, 4.8% of technical institutes and, finally, 0% of secondary art schools or art institutes conducted selective drug-use prevention.
47.1% of the schools used *counselling centres* in their selective prevention programmes, 29.4% employed *internal measures* implemented within the schools themselves and 17.6% had initiated *protocols of understanding with external organizations.* Moreover, *health education counsellors* to deal with these issues are present in 58.3% of the schools, while another 41.7% have *psychopedagogists* available.
Other selective drug-use prevention initiatives targeting students at a high risk of leaving school early were conducted by 36 of the sample schools (10.9% of schools which responded to the prevention questionnaire), with vocational schools conducting the highest number of such initiatives (15.1%), followed by technical institutes (10.5%), secondary schools formerly specialising in teacher training (9.2%) and secondary art schools and art institutes (8.0%).
86.1% of the sample schools offered *educational psychology services which students could access directly or to which they could be referred to discuss these issues* and 30.6% provided *training courses for teachers* and distributed *guidelines on ways of recognizing problem students, including those who use drugs*.

3.5. National and local media campaigns

In 2012, activities for the promotion and organization of information campaigns to raise awareness regarding drug-use prevention among the general population were conducted not only by the Regional

Administrations, but also by the Department for Anti-drug Policies, which organized and launched three important initiatives.

The "Elementare, ma non troppo….." Project

"*Elementare, ma non troppo...*" is a project promoted by the Department for Anti-drug Policies, the Higher Institute for Health and the Italian Parents Movement (a.k.a. MOIGE). Its goal is to raise awareness and provide information to minors, parents and Italian elementary school teachers about the risks linked to the use of cannabis and alcohol and the factors which increase the likelihood of young people beginning to use these substances.

This two-year project has involved 50 elementary schools throughout the country, with a total of 15,000 children, 30,000 parents and 2,000 teachers.

Each school held an "open day" which permitted children to learn more about the topic of the campaign through games overseen by experts from the Italian Parents Movement (MOIGE). Parents and teachers also had the chance to learn about the topic of the campaign during evening meeting events. Each child made a drawing about the topic and the 12 best were included in a calendar which was then sent to the schools.

During the course of these education days, targeted informational material was distributed to both children and adults containing useful advice to help prevent and fight drug and alcohol use and information about the factors which make the use of those substances more likely.

Information campaign entitled: "Liberi da tutte le droghe. Liberi da tutte le mafie. Chi compra droga finanzia le mafie, le loro violenze e il terrorismo"

The information campaign entitled *"Liberi da tutte le droghe, Liberi da tutte le mafie. Chi compra droga finanzia le mafie, le loro violenze e il terrorismo"* is an initiative of the Department for Anti-drug Policies, created on 26 June 2012 to celebrate the United Nations "International Day against Drug Abuse and Illicit Trafficking".

The campaign was based on a simple concept and a message that members of the younger generations should take to heart, especially when they are tempted to buy drugs: to live not only in respect of the law but, on a more fundamental level, to live in accordance with the principles of honesty and maintain personal integrity in one's actions.

The initiative was created under the High Patronage of the President of the Republic and under the aegis of the President of the Chamber and the President of the Senate, with the collaboration of the National Association of Italian Municipalities (ANCI).

On 25, 26 and 27 June, the anti-drug message, "*Liberi da tutte le droghe, Liberi da tutte le mafie. Chi compra droga finanzia le mafie, le loro violenze e il terrorismo*" was projected onto the Mole Antonelliana in Turin, in Piazza Maggiore in Bologna, on the Great Tower of the Carlo Felice Theatre in Genoa, on Palazzo Barbieri in Verona, on the Campanile of St. Mark's in Venice, on the San Niccolò Tower in Florence, on the Palazzo Priori in Perugia, on the Coliseum in Rome, on the Maschio Angioino Castle in Naples, on the façade of the municipal seat in Piazza Sant'Oronzo in Lecce, on the Torre dell'Elefante in Cagliari, on the Palazzo di Città in Palermo, on the Cavatore statue in Catanzaro and in Piazza Ferrarese in Bari.

Figure 3.8: Cities where the anti-drug message, "Free from all drugs, Free from all mafias. People who buy drugs finance the mafias, their violence and their terrorism" was projected.

All the Municipalities showed their full support of the project, and they worked to ensure that the projection went forward as smoothly as possibly, facilitating administrative procedures for requesting the necessary permits. In the same spirit, the Municipalities spread the word about the project throughout their territories, raising public awareness regarding the initiative.

Figure 3.9: Examples of the message, "Free from all drugs, Free from all mafias. People who buy drugs finance the mafias, their violence and their terrorism" being projected

The "Safe Beaches Summer Campaign"

A third initiative, the "*Safe Beaches Summer Campaign",* was created to fulfil the need to provide the young people who frequent Italian beaches during the summer with the prevention information they require regarding topics covered in campaigns launched by the Department for Anti-drug Policies:

- Drug-use prevention (providing information as early as possible, an educational approach ...)
- Prevention of traffic accidents resulting from driving under the influence of drugs and/or alcohol

The project was carried out during the months of August and September 2012, and included the following activities:

- 200 promotional posters, 70 x 100 cm in size and made from a weather-resistant plastic material were displayed on the sides of the SNS (*National Lifesaving Society*) lifeguard towers on the beaches of central-northern Italy and the Islands, and 70 more were displayed at 70 Auxiliary Beach Safety Points (known as PASS), for a total of 270 promotional posters.
- 20,000/40,000 flyers and/or leaflets were printed and distributed during the course of the "Papà ti Salvo Io" (*t.n. "Dad, I'll Save You")* information and education days held during beach-going season at different beach locations.

This activity took place during the month of August 2012 at beach locations made available by the National Lifesaving Society (SNS), consisting of 7,000 metres of Adriatic coastline between San Benedetto del Tronto and Porto d'Ascoli, identified and chosen for the purpose. "Hotpots" allowed users to surf the web for free once they had downloaded the app. The initiative involved 11 high-volume beach locations along the Tyrrhenian sea, 4 on the islands and 6 on the shores of Lake Garda.

Figure 3.10: Examples of the message, "Safe Beaches Summer Campaign" on display.

Of the initiatives launched by the Regions and Autonomous Provinces in 2012, most (55, or 83.3%) were universal prevention campaigns as opposed to selective, and only four Regions launched at least one campaign in both areas (three did so in 2011) (Table 3.1).

Table 3.1: Number of universal and selective prevention information campaigns conducted by the Regions and Autonomous Provinces during the course of 2012.

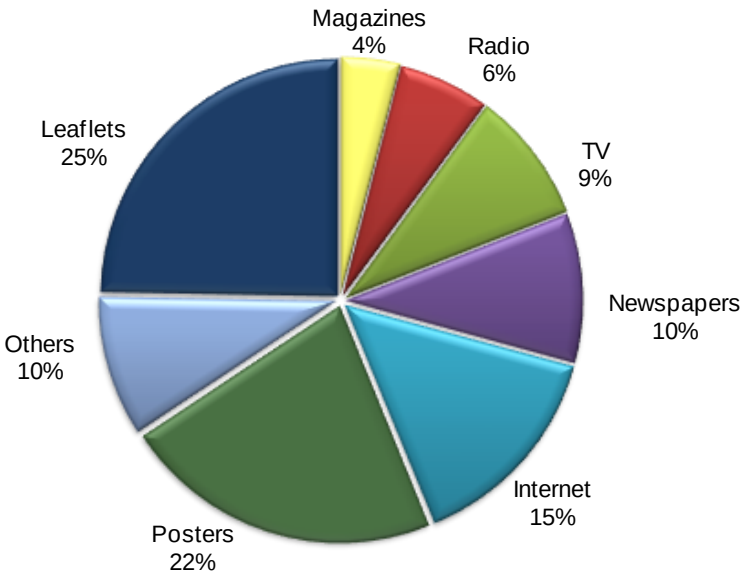
Regions	Universal Prevention	Selective Prevention	Total
Abruzzo	1	-	1
Bolzano	1	-	1
Calabria	3	3	6
Campania	2	-	2
Emilia Romagna	3	-	3
Friuli Venezia Giulia	5	2	7
Liguria	1	-	1
Lombardy	28	1	29
Piedmont	-	1	1
Apulia	7	3	10
Sardinia	3	-	3
Trento	1	-	1
Umbria	-	1	1
Total	55	11	66

A large number of universal prevention campaigns in Lombardy

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

The most commonly employed information tool was once again the leaflet (24.7%) followed by posters (21,9%); there was a large increase in the use of the internet, which rose from 5% to nearly 15%; the use of magazines and radio accounted for only 10% of campaigns. (Figure 3.11).

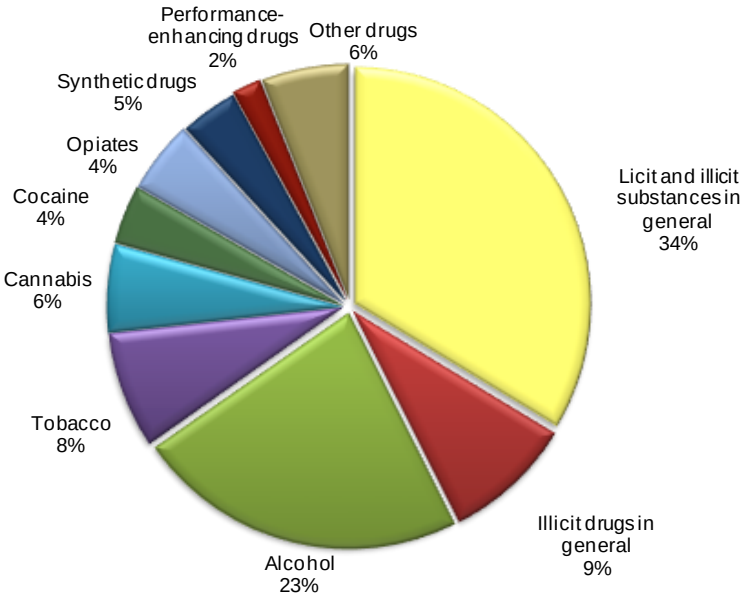
Figure 3.11: Percentage distribution of prevention campaigns conducted by the Regions and Autonomous Provinces in 2012, by type of mass media



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

The subject matter most frequently dealt with by prevention campaigns is clearly that of “licit and illicit substances in general”, which account for 33.7% of campaigns reported (Figure 3.12), followed by alcohol (22.8%). Campaigns dealing with illicit drugs in general and other drugs, each of which only accounted for 3% of campaigns in 2011, had tripled and doubled in number, respectively, in 2012.

Figure 3.12: Percentage distribution of prevention campaigns conducted by the Regions and Autonomous Provinces in 2012, by subject matter



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

4. PROBLEM DRUG USE

Foreword

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

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

4.1. Introduction

Over the years, panels of experts within the European Monitoring Centre in Lisbon have come to agree upon a definition for problem drug use[1], and they have also established methodologies for estimating the total fraction of the population who fit the PDU profile. The methods developed – which take full advantage of information gathered from the users who come into contact with treatment services or with other agencies responsible for the fight against drugs or for rehabilitation of users within a certain time frame – make it possible to calculate the numerical amount of problem drug users, both those already known or those still completely unknown who were never registered or counted during the period of time in question. All the methods which have been advanced for calculating these estimates attempt to take utmost advantage of the information available, and each adjusts itself to the level of detail of the information provided (aggregate or analytical data) and to whether it comes from multiple sources or from one source alone, mathematically modelling the data generation process of available data.[2]

New methods for estimating PDU

The methods for estimating PDU, in particular multiple-source information capture-recapture methods, which have provided excellent results when estimating the number of heroin and opiate users in need of treatment, are not reliable when estimating numbers of cocaine or stimulant users, let alone of cannabis. For these same reasons, the use of the multiple indicator method is also no longer adequate for calculating the use of drugs other than opiates. On an international level, it is with increasing frequency that we observe the application of single-source capture-recapture methods, such as the truncated Poisson model or models based upon an analysis of time elapsed between consecutive captures[3].

Information sources

The application of these methods to national information flows is particularly well-suited to data gathered by the Ministry of the Interior, and specifically by the Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources regarding reports filed under Art. 75 of Presidential Decree (DPR) 309/90 for possession of drugs for personal use, specifically cannabis and cocaine. In order to calculate prevalence estimates for subjects requiring assistance for opiate use, the

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

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

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

data was obtained from the information flow of the Ministry of Health, which provided information on clients receiving assistance from drug addiction services, as well as from Regional and Provincial Administrations which, via Regional monitoring centres, provided estimates – obtained from local-level application of the multiple-source information capture-recapture method – of the multiplier coefficient of clients in need of treatment for opiate use. Local sources included the flow of clients receiving treatment from Local Public Drug Addiction Service Units (*t.n.* abbreviated in Italian to *SerT*) and flows of hospital admissions for ordinary inpatient treatment or outpatient treatment (Hospital Discharge Records – HDR).

Summary of subjects in need of treatment

Table 4.1: Prevalence estimates of subjects in need of treatment, by drug type. The years 2011-2012.

Drug Type	The year 2011		The year 2012		Sources
	Subjects	Prevalence x 1,000 pop.	Subjects	Prevalence x 1,000 pop.	
Heroin	193,000	4.8	174,000	4.5	Ministry of Health
Cocaine	108,800(1)	2.7	105,500(2)	2.6	Ministry of the Interior
Cannabis	166,000(1)	4.2	159,000(2)	4.0	Ministry of the Interior
Total	467,800	11.7	438,500	11.0	

Source: Department for Anti-drug Policies, based on data from the Ministry of Health and the Ministry of the Interior
(1) Ministry of the Interior information flow, 2011 (2) Ministry of the Interior information flow, 2012

Table 4.1 provides a summary of figures – obtained using the different methods described above according to different drug types – for groups of subjects in need of treatment, described in more detail in the following sections. Overall, we can see a decline in drug use within the population, reflected in the estimate of subjects in need of treatment. It should be noted, however, that estimates calculated on data from the Ministry of the Interior, following delays in notification, are not updated to the year 2012, but to 2010. However, correction criteria have been introduced in order to improve accuracy of the estimates.

4.2. Prevalence and incidence estimates of PDU

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

Methodological guidelines

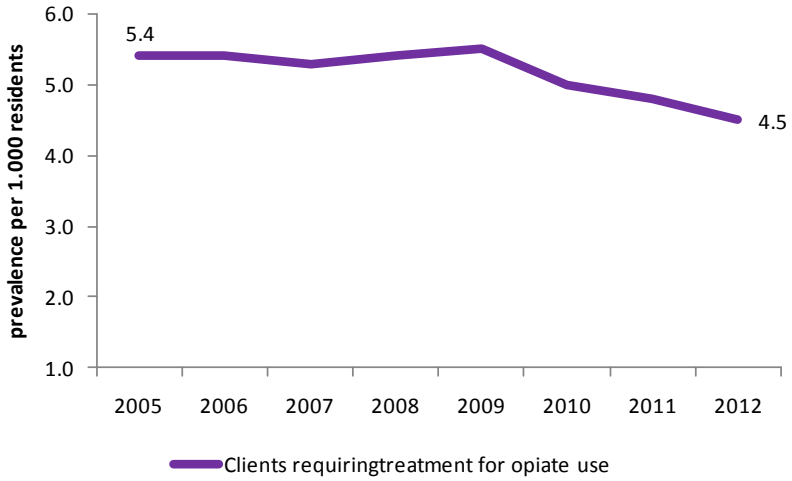
In view of the greater homogeneousness of the population of possible clients in treatment for the regular, long-term or injecting use of opiates (heroin and/or other opiates) in comparison with subjects who use other types of illegal drugs, the simple multiplier method listed in the EMCDDA guidelines was used to estimate this population's size.
The multiplier value for clients in need of treatment for opiate use was obtained by combining values at local levels, as estimated in 2012, for the Regions of Abruzzo, Basilicata, Calabria (LHA [Local Health Authority] of Cosenza and LHA of Reggio Calabria), Apulia (LHA of Bari), Sicily (LHA of Palermo, LHA of Syracuse, LHA of Enna and LHA of Ragusa), Veneto (LHA of Verona) and the Bologna metropolitan area; eleven local estimates available.

In 2012 (ST 7 opiates), it is estimated that there were approximately 174,000 subjects in need of treatment for primary use of opiates in Italy, equal to a prevalence of 4.5 per thousand residents between 15 and 64 years of age.

174,000 opiate addicts in Italy; in other words, 4.5 per thousand residents (15-64 years of age)

The trend in prevalence estimates over time for the group of subjects eligible for treatment for opiate use remained largely stable between 2005 and 2009, falling over the last two-year period, a decline owed to the greater number of subjects in need of assistance intercepted by national health service facilities (Figure 4.1), due in part to the introduction of the new information system.

Figure 4.1: Prevalence estimates per thousand residents aged 15-64. The years 2005-2012



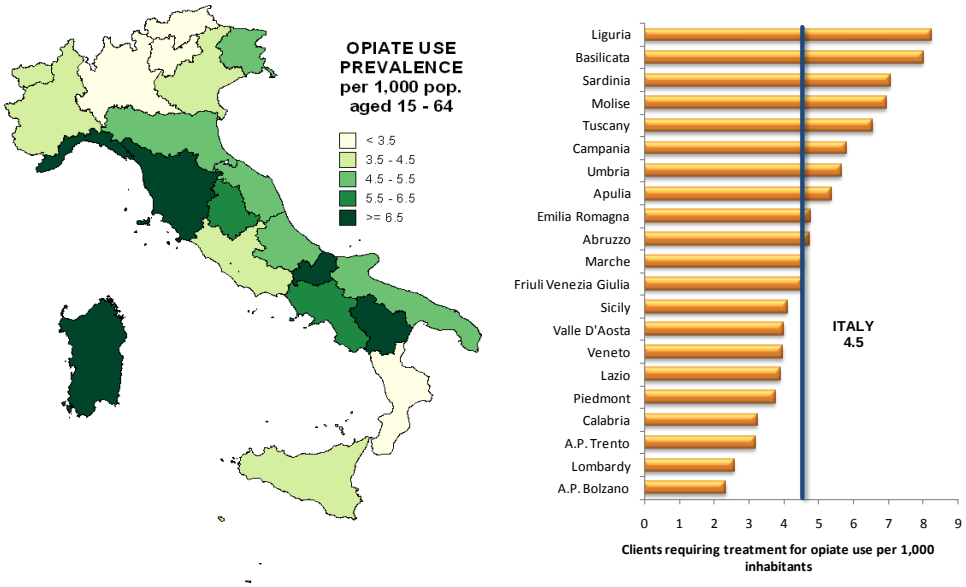
Source: Based on ministerial information flows

An analysis of regional estimates (Figure 4.2) shows the highest prevalence levels in Liguria (8.2 cases per 1000 residents), Basilicata (8.0 cases per 1000 residents) and Sardinia (7.1 cases per 1000 residents). The regions with the lowest prevalence levels were the Autonomous Province of Bolzano (2.3 cases per 1000 residents between the ages of 15 and 64), Lombardy (2.6 cases per 1000 residents) and the Autonomous Province of Trento (3.2 cases per 1000 residents).

Regional prevalence estimates vary widely

Regarding estimates of problem drug users in need of treatment for opiate use divided according to gender, we can see that levels are markedly higher for men in comparison with women (7.6 vs. 1.4 subjects per 1000 residents 15-64 years of age), while the regional prevalence distribution brings to light some differences between the two gender profiles.

Figure 4.2: Prevalence estimates (per thousand residents aged 15-64) of subjects requiring treatment for opiate use. The year 2012



Need of treatment for opiate use: Liguria, Basilicata and Sardinia are the regions hardest hit

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

Source: Based on ministerial information flows

In 2012, in order to harmonize the application of suitable methodologies for estimating the PDU indicator on the part of healthcare sources at the local/regional level by combining information from different data banks, the Department for Anti-drug Policies of the Presidency of the Council of Ministers set up a working group to launch a multicentric study on the indicator in question. The DAP included the Regions and Autonomous Provinces, all of which are involved with their Local Public Drug Addiction Service Units (Ser.T.), in the initiative.

As described earlier, the method used to estimate numbers of clients in need of treatment for the use of opiates is called capture-recapture; specifically, the two-source capture-recapture method was used. In accordance with the literature[4], the assumptions of this method are as follows: (a) the population which is the subject of the study is defined as "closed", in other words, it cannot undergo any changes during the period of the study; (b) each list must be homogeneous, meaning that the probability of capture must be identical for all members of the population; (c) the lists must be mutually independent.

Problems with the two-source capture-recapture method

When the two-source capture-recapture method is applied, assumption (c) is often violated, resulting in estimates of questionable validity[5]. Thus, if any dependence exists between the sources being analysed, then the PDU-indicator estimate obtained with this method may be imprecise. In order to remedy this issue, the capture-recapture method estimate can be applied to three or more information sources. In this way, the information provided by the additional source(s) can be employed to examine any possible relationships between data sources. If such relationships exist, the estimate of the overall size of the hidden population can be corrected accordingly.

The three-source capture-recapture

In order to assess the influence of the relationships between dependent data sources, the estimate of clients in need of treatment for opiate use

[4] Hartnoll R, Cohen P, Domingo-Salvany A, et al. *Estimating the Prevalence of Problem Drug Use in Europe*. EMCDDA Scientific Monograph Series, n°1, 1997

[5] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). *Methodological Guidelines to Estimate the Prevalence of Problem Drug Use on the Local Level*. Lisbon: EMCDDA, December 1999.

method

obtained using the two-source capture-recapture method was compared with an estimate obtained using the three-source capture-recapture method and based on data from a drug addiction services sample group participating in the multicentric study described above. This additional information flow was comprised of data on emergency room admissions not resulting in inpatient hospital stays for subjects with at least an ICD-9-CM code (2007 version) with the use of opiates in the principal or secondary diagnosis field (subjects between 15 and 64 years of age).
Using this method, the number of opiate users not known to the selected drug addiction service unit was estimated to be approximately 330 addicts, bringing the total estimated number of problem opiate users up to 1,070. The two-source capture-recapture method, on the other hand, provided an estimate of 380 hidden opiate users, for an estimated total of approximately 1,120 problem opiate users.

Scientific literature describes a number of different methods for estimating drug use prevalence. It is important to remember that there is no “best” method among those put forward. Which method is the most accurate varies based on what type of information is available and on the quality of the information flows used to obtain the estimate. It is clear that it is impossible to obtain an accurate estimate of drug use prevalence using a limited number of data sources or a single statistical methodology.

4.3. Data on PDUs from non-treatment sources

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

Estimate of problem cocaine use

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

Methodological criteria for estimating PDU

The Department for Anti-drug Policies used this latter method to estimate populations of cocaine users. It also used Ministry of the Interior records of subjects reported for drug possession for personal use, cocaine possession specifically, under Art. 75 of DPR 309/90.
Population estimates were obtained using the truncated Poisson model and by calculating Horvitz-Thompson, Chao and Zelterman estimators and their relative confidence intervals.
The population of reference is comprised of two subpopulations: subjects reported for the first time during the year in question, known as the “New” group, and those who had already been reported in previous years (recidivists), called “Already Known”. For each population, both subjects with a single “capture” during the year in question as well as subjects with “two or more captures” were taken into consideration. Using the method described above, it is possible to make estimates for the two populations, the new and the previously reported. We must recall that the population being estimated is not the total population of users of a particular drug, but only those at risk of being reported under Art. 75. However, taking into account the characteristics of the two subpopulations, new and previously

reported, they can be used as proxies for the estimation of drug users once they have been suitably corrected. Specifically, the estimated population of previously reported subjects can be used to estimate the population of subjects in need of treatment, while the population of new subjects being reported for the first time can be used, together with data on age at first use, to estimate incidence, although prevalence among younger age groups could already be considered an incidence estimate.

Parameters for correcting the estimate

Regarding parameters for correcting the estimate, based on previous evaluations of locations where reports were filed[6], it can be estimated that subjects who have already been reported and who are at risk of being reported again account for 38% of the total population of cannabis users and 30% of the total population of cocaine users.

Furthermore, it must be added that reports made under the requirements of Art. 75 (source data) suffer greatly from delays in notification. Reports filed during the period from 2011 to 2012 are incomplete, and we must therefore consider data from the year 2010 as the most reliable, assuming that, in that year, the total indicated must be increased by 5% to obtain the actual number of reports filed. It thus follows that the final estimates will also have to be increased by 5%.

Table 4.2: Zelterman estimates for cocaine user population sizes, for both New and Already Known users, and relative confidence intervals, by geographic area.
The year 2010.

Geographic area	Total reported	Cocaine users (Zelterman) Estimate	Min (CI 95%)	Max (CI 95%)
New reported subjects				
Northeastern Italy	582	15,398	6,129	24,668
Northwestern Italy	1,230	34,388	19,764	49,012
Central Italy	939	48,986	16,677	81,295
Southern Italy and the Islands	1,213	40,874	21,714	60,035
Total	3,964	139,647	64,284	215,009
Estimate without geographic area division	3,964	130,954	97,322	164,587
Already reported in previous years				
Northeastern Italy	225	2,303	878	3,728
Northwestern Italy	567	6,434	3,804	9,064
Central Italy	240	7,201	28	14,374
Southern Italy and the Islands	641	15,805	7,042	24,569
Total	1,673	31,743	11,751	51,735
Estimate without geographic area division	1,673	26,414	19,082	33,746

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

Estimate of cocaine users in need of treatment: 112,000 subjects between the ages of 15 and 64

Thus, once the population of already known cocaine users at risk of being reported again had been estimated, the estimates were corrected using a multiplier which, being constructed thus (risk of being reported 30%, notification delay 5%), was certainly cautious; the average value of estimates obtained was calculated using the Horvitz-Thompson, Zelterman and Chao methods. The estimate of cocaine users in need of

[6] The presentation can be viewed at: http://www.urbandrugpolicy.com/en/catalogue/detail/6/175/-

treatment thus obtained was of approximately 112,000 subjects between the ages of 15 and 64, with variance from confidence intervals found to range from 43,000 to 181,000 subjects.

Table 4.3: Horvitz-Thompson, Zelterman and Chao estimates for the size of the population of COCAINE users, both New and Already Known, and relative confidence intervals. The year 2010.

		Cocaine Users			
	Reported	**Estimate**	**Min (CI 95%)**	**Max (CI 95%)**	**Corrected estimate**
New reported					
Horvitz-Thompson	3,964	141,628	66,943	216,314	495,700
Zelterman	3,964	139,647	64,284	215,009	488,763
Chao	3,964	139,666	65,839	213,494	488,833
Already reported in previous years					
Horvitz-Thompson	1,673	32,579	12,900	52,258	114,028
Zelterman	1,673	31,743	11,751	51,735	111,101
Chao	1,673	31,761	12,482	51,039	111,162

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

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

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

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

Estimate of problem cannabis use

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

Methodological criteria for estimating PDU

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

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

Table 4.4: Horvitz-Thompson, Zelterman and Chao estimates for the size of the population of CANNABIS users, both New and Already Known, and relative confidence intervals. The year 2010.

	Cannabis Users				
	Reported	Estimate	Min (CI 95%)	Max (CI 95%)	Corrected estimate
New reported					
Horvitz-Thompson	21,922	481,244	390,043	572,445	1,329,754
Zelterman	21,922	470,287	377,839	562,734	1,299,476
Chao	21,922	470,486	380,876	560,096	1,300,027
Already reported in previous years					
Horvitz-Thompson	7,108	70,596	54,116	87,076	195,068
Zelterman	7,108	67,048	50,097	84,000	185,265
Chao	7,108	67,198	51,330	83,065	185,678

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

Estimate of number of cannabis users in need of treatment: 189,000 subjects between 15-64 years of age

If we correct estimates of cannabis users using the information on the size of the population at risk of being reported (38%) and the information on notification delay (5%), we obtain an estimate of the total number of users already reported in previous years on a national level. Taking the average value of the results obtained when applying the three proposed methodologies, we find that this total amounts to approximately 189,000 subjects, with variability of estimates ranging from a minimum of 143,000 users to a maximum of 234,000 users. If we consider that these subjects are the same ones who have been reported multiple times over the years, we can consider this population to correspond to the population of cannabis users in need of treatment. We must recall that a fair number of these subjects also use other drugs in addition to cannabis.

4.4.2 Estimate of problem cannabis use through use of the epidemiological studies

Methods of estimating the PDU indicator using other data sources

Records acquired during the course of the epidemiological studies conducted in 2012-2013 on the general population (the year 2012: approximately 20,000 questionnaires) and the student population (the year 2013: approximately 36,000 questionnaires) provided, in the form of the frequency of use reported by subjects surveyed, criteria for creating an estimate of the population in question for the purposes of this study (the PDU indicator).

Types of users: occasional, regular, problematic

Generally speaking, an analysis of the development of a problem drug user suggested that three groups of users should be defined: occasional, regular and problem users[7]. If we take the last 30 days as a time reference, then occasional users are those who have tried the drug in question and, if they do continue to use it, are able to limit their frequency of use to an average of twice per month. Regular users, on the other hand, are those subjects who use the drug weekly, and especially during the weekend. Lastly, problem users, the category which is the subject of this study, are those who use the drug every day or nearly every day, often even multiple times during the course of the day.
Using the aforementioned epidemiological studies, it is possible to estimate the distribution of the three types of drug users described above,

[7] Rey GM, Rossi C, Zuliani A. *Il mercato delle droghe. Dimensione, protagonisti, politiche*. Marsilio Editori, 2011

focusing our attention on the estimate of that part which is comprised of problem users.

Thus, using the information collected by means of the 2012 GPS-DAP general population survey and the 2013 SPS-DAP student population survey, it is possible to estimate the distribution of the three types of cannabis users (occasional, regular and problem).

Types of cannabis users in the student population

15.2% of the student population 15-19 years of age reported having used hashish or marijuana in the 30 days prior to the survey. Of these, approximately half appeared to be occasional users (46.0% of male students and 58.5% of female), and most of these were female (Table 4.5). The regular or problematic use of this drug was more common among male students, with a higher percentage of regular users being male (31.5% of male students vs. 28.7% of the female). It appears that, overall, of the 15- to 19-year-old students who reported having used cannabis in the 30 days prior to the survey, 18.9% of these were problem users who had taken the drug 20 times or more during the last 30 days.

Table 4.5: Students who had used cannabis in the 30 days prior to the survey, by type of user (prevalence %) in the student population 15-19 years of age, by gender. The year 2013.

Type of cannabis user (%)	Male	Female	Total
Occasional use	45.99	58.53	50.64
Regular use	31.49	28.74	30.47
Problem use	22.51	12.73	18.89

Source: 2013 SPS-DAP Survey – The Department for Anti-drug Policies

When analysing the types of cannabis users by age (Table 4.6), we find a greater amount of problem drug use in the older age groups (18-19 years of age), with percentages of problem users rising from 11.0% among 15-year-olds to 21.1% among 19-year-olds. On the contrary, the occasional use of hashish or marijuana can be more commonly observed among the youngest age group (15-year-olds), with a percentage of 61.2%.

Table 4.6: Students who had used cannabis in the 30 days prior to the survey, by type of user (prevalence %), in the student population 15-19 years of age, by age. The year 2013.

Type of cannabis user (%)	Age 15	Age 16	Age 17	Age 18	Age 19	Total
Occasional use	61.24	52.32	51.41	50.11	46.48	50.64
Regular use	27.75	31.13	29.73	29.43	32.45	30.47
Problem use	11.00	16.56	18.85	20.46	21.07	18.89

Source: 2013 SPS-DAP Survey – The Department for Anti-drug Policies

Types of cannabis users in the general population

Turning now to the general population18-64 years of age, we find that, among those who reported having used hashish or marijuana in the 30 days prior to the survey, occasional use was the most frequent type (65.2% of men and 83.2% of women), and more of these type of users were women (Table 4.7). Regular or problem use of the drug was more common among men, among whom there was a higher percentage of problem users (22.9% of male users vs. 8.5% of female users). Overall, of the Italian population sample who reported having used cannabis in the month prior to the survey, it appears that 17.9% engage in problem use of cannabis, using the drug every day or almost every day.

Table 4.7: Subjects who had used cannabis in the 30 days prior to the survey, by type of user (prevalence %) in the general population 18-64 years of age, by gender. The year 2012.

Type of cannabis user (%)	Male	Female	Total
Occasional use	65.22	83.02	71.48
Regular use	11.84	8.47	10.65
Problem use	22.94	8.51	17.87

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

When analysing the types of cannabis users by age (Table 4.8), we find a greater amount of problem drug use in the younger age group (18-24 years of age), with 23.8% of users in this age group being problem users. On the contrary, regular use of hashish or marijuana seems to be more common among the older age group (35-64 years of age), with a percentage of 21.3%.

Table 4.8: Subjects who had used cannabis in the 30 days prior to the survey, by type of user (prevalence %) in the general population 18-64 years of age, by age group. The year 2012.

Type of cannabis user (%)	18-24	25-34	35-64	Total
Occasional use	70.54	78.70	62.60	71.48
Regular use	5.66	10.07	21.33	10.65
Problem use	23.80	11.23	16.07	17.87

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

Estimates of the prevalence of problem cannabis users in the student and general populations

Using the percentage estimate of students who are problem cannabis users, it is also possible to estimate the prevalence of problem cannabis users in the resident population. On this topic, it appears that 18.9% of students who use cannabis are problem users, having taken the substance 20 or more times during the 30 days prior to the survey. This percentage of the Italian student population translates to 82,000 young people (reference: resident population 15-19 years of age on 01/01/2012, according to ISTAT [t.n. the National Institute of Statistics]), with a prevalence of 2.9%.
In the same manner, problem users of cannabis in the general population 15-64 years of age, estimated by means of the 2012 GPS-DAP epidemiological study (for the 18-64 age groups) and the 2012 SPS-DAP (for the 15-17 age groups) are shown to be approximately 127,000 residents, with a prevalence of 0.3% (reference: resident population 15-64 years of age on 01/01/2011, according to ISTAT).

The CAST Scale (Cannabis Abuse Screening Test)

In order to more accurately identify problem users of cannabis, the CAST scale (*Cannabis Abuse Screening Test*) was introduced into the SPS-DAP student population survey conducted during the first half of 2013.

The CAST scale

Designed mainly for adolescents and young adults, the CAST scale makes it possible to identify use patterns which lead to negative social or health consequences for the user or for others[8].
The CAST scale consists of 6 items which aim to identify subjects at risk

[8] Piontek D, Kraus L, Klempova D. *Short scales to assess cannabis-related problems: a review of psychometric properties*. Substance Abuse Treatment, Prevention and Policy, 2008, 3: 25

of problem cannabis use, with the previous year as a period of reference. Only students who reported having used cannabis in the year prior to the survey were asked to complete the CAST.

Codification in the CAST scale

The questions can be answered by choosing from the scale of "never", "rarely", "from time to time", "fairly often" and "very often", codified in a point system of either 0 (from "never" to "from time to time") or 1 ("fairly often" and "very often"). These last two answers indicate use patterns of a more problematic nature[9].

The score obtained in the CAST scale is the sum of the codified answers (0, 1), and can range from 0 to 6. A score of 0 indicates there is *no risk,* scores of 1 and 2 indicate a *low risk,* a score of 3 indicates *moderate risk,* while scores of 4 or higher indicate a *high risk* of problem cannabis use[10].

Overall, 68.4% of those who had used cannabis in the 12 months prior to the survey were found to be at no risk of problem use of this drug (score of 0) and 25.8% were at low risk (score of 1 or 2). Only 3.7% were at moderate risk (score of 3) and 2.1% were at a high risk of problem cannabis use (score of 4 or higher).

Male students are at higher risk of problem cannabis use

If we divide these results by gender, age and geographic area (Table 4.9), we find that males are at higher risk of problem cannabis use then females (moderate-to-high risk: 7% of males vs. 4% of females).

Table 4.9: CAST scale scores for students 15-19 years of age who had used cannabis (marijuana and hashish) in the 12 months prior to the survey, by gender, age and geographic area. The year 2013.

Gender	No risk	Low risk	Moderate risk	High risk
Male	65.61	27.42	4.52	2.45
Female	72.89	23.13	2.46	1.52
Age				
15	65.12	29.38	2.92	2.58
16	67.63	27.05	2.97	2.35
17	66.98	26.27	4.08	2.66
18	68.97	24.96	3.85	2.22
19	70.41	24.36	4.01	1.23
Geographic area				
Northwest	71.80	23.10	3.00	2.10
Northeast	74.69	21.64	2.44	1.22
Centre	66.62	27.09	4.47	1.82
South/Islands	64.77	28.38	4.32	2.53

Source: 2013 SPS-DAP Survey – The Department for Anti-drug Policies

When considering the results obtained by focusing on student age, we find that younger users, especially the 15- and 17-year-olds, are at a higher risk of problem cannabis use (2.6% and 2.7%, respectively), while 19-year-olds have the highest percentage of those at no risk of problem cannabis use (70.4%).

When considering geographic area of residence of the students who participated in the survey, it appears those in Southern Italy/the Islands who had used cannabis in the 12 months prior to the survey had a higher percentage of subjects at risk of problem use of this drug than in other areas (2.5%). On the other hand, 74.7% of cannabis users in Northeastern

[9] Hibell B, Guttormsson U, Ahlström S, et al. *The 2011 ESPAD Report. Substance Use Among Students in 36 European Countries*. Stockholm, May 2012

[10] Legleye S, Karila L, Beck F, Reynaud M. (2007) *Validation of the CAST, a general population Cannabis Abuse Screening Test*. The Journal of Substance Use, 12 (4), pp. 233-242

Italy appear to be at no risk of problem cannabis use.

Estimate of prevalence of moderate-to-high risk cannabis users in the student population

Just as was done when creating the estimates of problem cannabis users in the general and student populations, using the estimate of subjects with a moderate-to-high risk of problem cannabis use obtained using the CAST scale (5.8% of students reported having used cannabis in the 12 months prior to the survey), we can estimate the figure for the student population at approximately 36,000 individuals, with a prevalence of 1.3% (reference: resident population 15-19 years of age, according to ISTAT).

Comparison between prevalence figures obtained for problem cannabis users

Comparison between the results of the CAST scale and problem cannabis use figures

It has proved interesting to evaluate, firstly, the comparison between the estimated percentage of the student population with a moderate/high risk of problem cannabis use (CAST scale) and the estimated percentage of problem cannabis users (subjects who use the drug every day or nearly ever day, and often even multiple times during the day) obtained using the answers provided by students 15-19 years of age regarding their drug use in the 30 days prior to the survey during the course of the 2013 SPS-DAP epidemiological study.

The estimate of subjects with a moderate/high risk of problem cannabis use obtained using the CAST scale was calculated at 5.8% of those students who reported having used cannabis in the 12 months prior to the survey, which translates to 36,000 members of the student population (reference: resident population 15-19 years of age on 01/01/2012, according to ISTAT), with a prevalence of 1.3%.

On the contrary, it appears that 18.9% of students participating in the survey engaged in problem cannabis use, having taken the drug 20 or more times in the 30 days prior to the survey, which translates to 82,000 young people, with a prevalence of 2.9% (reference: resident population 15-19 years of age on 01/01/2012, according to ISTAT).

It is important to point out that when creating an estimate of problem cannabis users with the 30 days prior to the survey as a period of reference, the figures obtained come out slightly overestimated, since it could be more accurate to take into account use of the drug over the previous 12 months as well, in order to get a more precise estimate of cannabis users' characteristics.

Comparison between problem users as estimated based on records of subjects reported under the requirements of Art. 75 and estimates based on the epidemiological studies

Moreover, it is interesting to compare the prevalence of problem cannabis use in the general population 15-64 years of age (2012 data) with the prevalence of cannabis users in need of treatment as estimated based on Ministry of the Interior records of subjects reported for possession of cannabis for personal use under the requirements of Art. 75 of DPR 309/90.

Problem cannabis users in the general population 15-64 years of age, estimated based upon the 2012 GPS-DAP (for the 18-64 age groups) and the 2012 SPS-DAP (for the 15-17 age groups) epidemiological studies found there to be 127,000 problem cannabis users among the resident population, with a prevalence of 0.3% (reference: resident population 15-64 years of age on 01/01/2011, according to ISTAT).

The number of cannabis users in need of treatment, estimated using

Ministry of the Interior records of subjects reported for possession of cannabis for personal use under the requirements of Art. 75 of DPR 309/90, was found to be approximately 189,000, with a prevalence of 0.5% (reference: resident population 15-64 years of age on 01/01/2011, according to ISTAT). This result is comparable, in terms of the size of the amounts, to the prevalence figure obtained using the 2012 general population studies.

5. TREATMENT DEMAND AND TREATMENT AVAILABILITY

Information about treatment demand on the part of drug users, in accordance with European standards for the data organisation system, provides a profile which can be used to frame policies and strategies for the treatment of drug addicted subjects, as well as to determine organisation of the social and healthcare services throughout the country and provide useful information about the epidemiological characteristics of the population of Service network clients.
In Italy, this information comes from different information sources. Some of the information flows employed are created ad hoc, but most have been organised and put into use in accordance with regulations currently in force for monitoring the activities of the Services network.

Information flows and data sources

Specifically, information useful for developing both strategies and social and healthcare policies for the treatment of individuals who approach the Services for assistance, especially at a Regional level, is gathered through the use of the structured EMCDDA questionnaire (SQ 27 Part 1), while Part 2 of the same questionnaire is used to gather data about the monitoring of the quality of treatments provided. These questionnaires were distributed to all of the Regions and Autonomous Provinces for completion during the course of 2013 with the intention of gathering data regarding the situation in 2012. Information was requested from a sample group of local drug addiction service providers (approximately 50% of those which exist country-wide) regarding the adoption of protocols, guidelines and other standard instruments for the monitoring and assessment of the quality of treatments provided.
Information on the organisation of the network of local services and the treatments provided by them, as well as information regarding clients of those services, comes from the information flow of the Ministry of Health, in accordance with D.P.R. 309/90.

5.1 Strategy/policy

The National Action Plan on Drugs 2010 - 2013

As described in the last edition of this report, nationwide strategies and action policies for the treatment of drug addicts are contained within the National Action Plan on Drugs for 2010 – 2013, where they are organised according to 5 principal action areas, one of which is devoted to the treatment and diagnosis of drug addictions (early outreach, reception centres, appropriate diagnoses and treatment and the concomitant prevention of drug-related diseases).
For each action area, the Action Plan includes goals which must be actualized, as well as actions and assessment indicators for each of these.

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

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

Monitoring regional best practices in the field of addictions

A study was conducted during the course of 2013 to monitor regional best practices in the field of "addictions" under the various action areas and evaluate them in relation to the National Action Plan on Drugs 2010-2013.

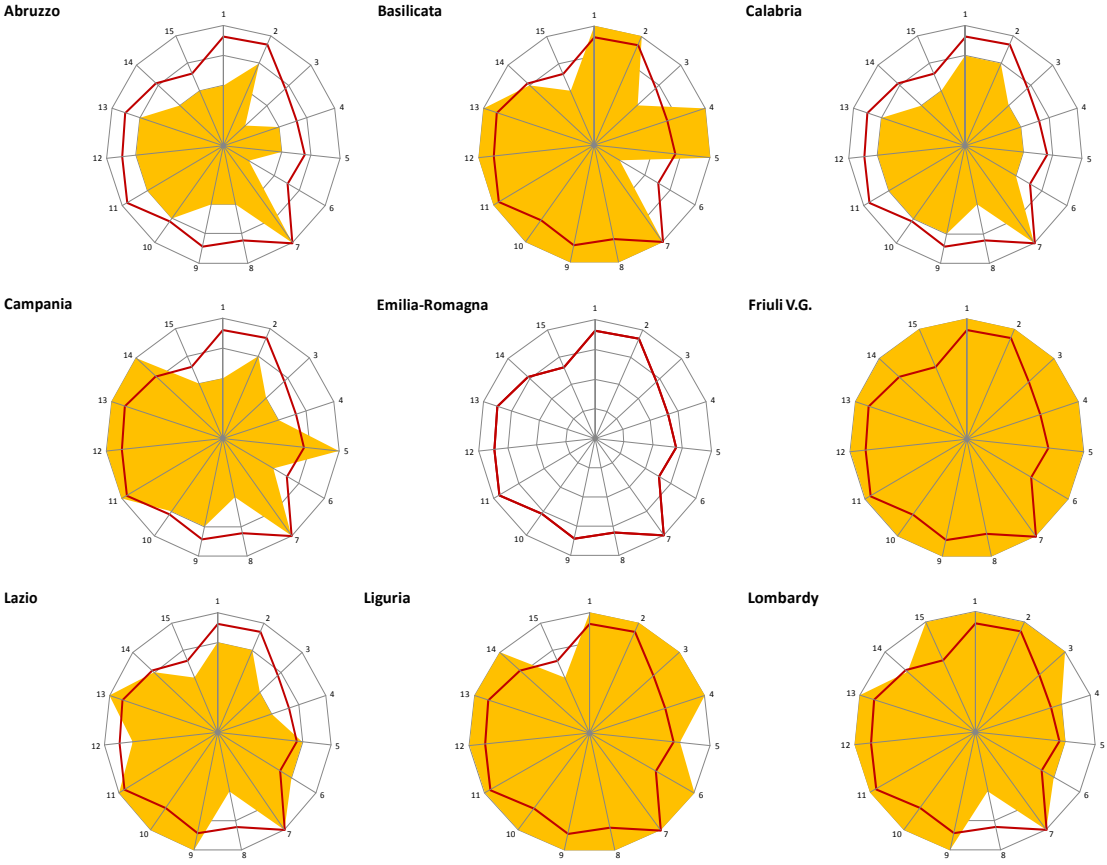
The radar charts below show the points assigned to each goal in each Region, based on the following scale of "compliance":

1: no information (level close to radar chart origin)
2: goals are present in the Region
3: goals actualized through project activities
4: goals actualized through routine activities (level corresponds to most external circumference of radar chart)

The red lines represent the national average obtained by calculating the arithmetic mean of the points obtained for each of the goals in each Region and Autonomous Province being evaluated.

As the radar charts show, a full ten Regions (Basilicata, Friuli Venezia Giulia, Liguria, Lombardy, Marche, A.P. of Trento, Sardinia, Umbria, Valle d'Aosta and Veneto) presented satisfactory results with regard to their degrees of actualization of the National Action Plan on Drugs (NAPD), with a score of 4 achieved for at least ten goals.
If we focus on the Action Area of Treatment and Rehabilitation, we find that the Regions of Molise, Calabria and Abruzzo each achieved a score of 4 for only one of the goals; these three regions also had the lowest average score for overall actualisation of goals (with scores of 2.3 for Abruzzo, 2.6 for Calabria and 2.4 for Molise). No data was received from Emilia-Romagna or Tuscany.

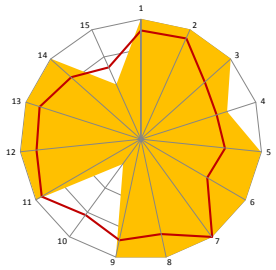
Figure 5.1: Regions/A.P.s and their scores for actualization of goals in the Treatment Area of the NAPD – the Year 2012



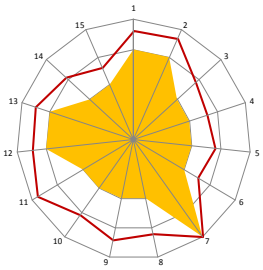
continue

continue

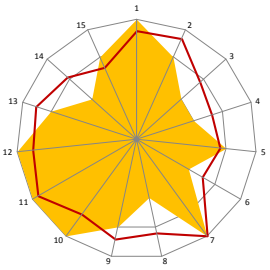
Marche



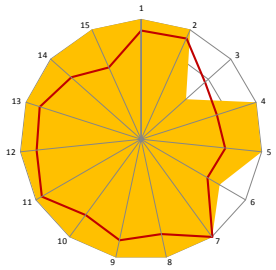
Molise



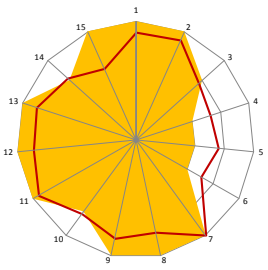
A.P. Bolzano



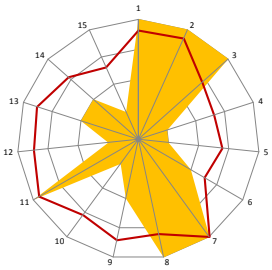
A.P. Trento



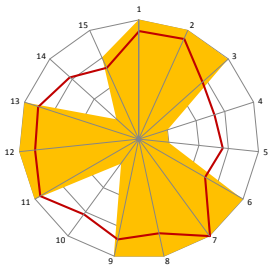
Piedmont



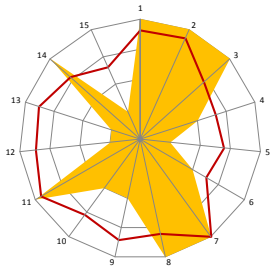
Apulia



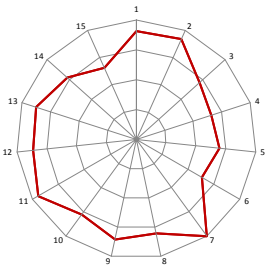
Sardinia



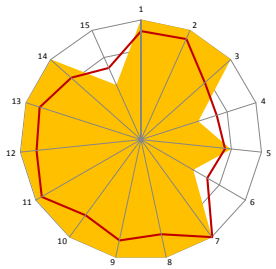
Siciliy



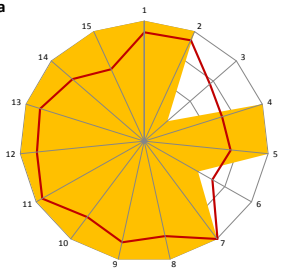
Tuscany



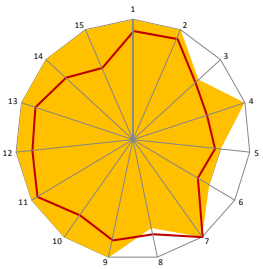
Umbria



Valle d'Aosta



Veneto



NAPD Goals – Chart Key:
1. Guarantee organisational conditions
2. Integration of public drug addiction services and non-profit organisations
3. Research to reform drug addiction services
4. Increase speed with which clients are taken into treatment
5. Establish contact with occasional users
6. Treatment environments for minors and for women
7. Establish free choice of the means of/place of treatment
8. Adopt standard diagnostic methods
9. Improve quality and effectiveness of treatments
10. Management of patients who are polydrug users
11. Management of patients with drug-related diseases and conditions
12. Reduction of drug-related mortality
13. Guarantee appropriate treatments in prison
14. Reduce potential for treatments to become chronic
15. Launch services for new types of addictions

5.2 Treatment system

5.2.1 Organisation and quality assurance

1,661 treatment facilities, of which:

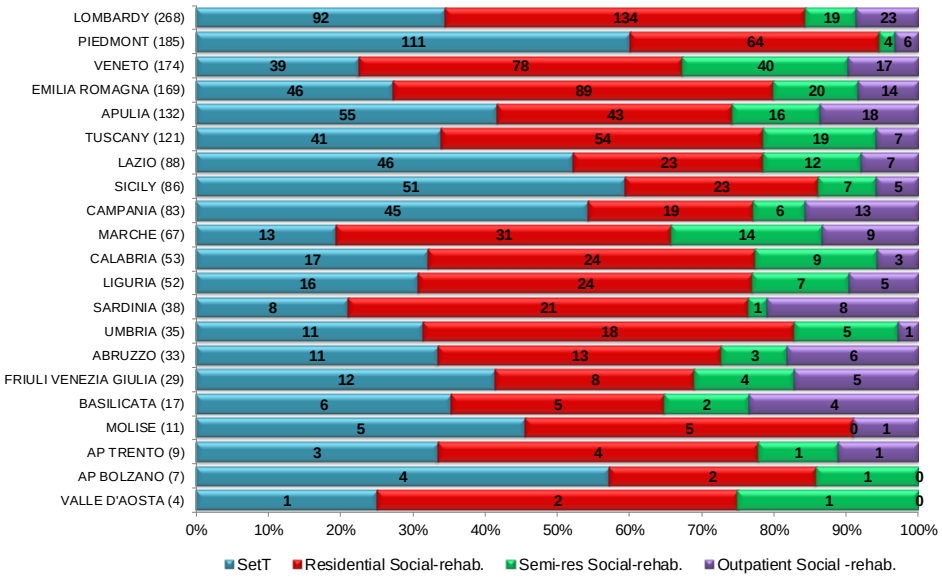
633 SerTs (Local Public Drug Addiction Service Units)

1,028 social-rehabilitative facilities, of which 66.5% residential therapeutic communities

On 31 December 2012, according to Ministry of Health and Interior Ministry Sources, a network of 1,661 social-healthcare facilities dedicated to the treatment and rehabilitation of individuals with treatment needs associated with drug use were active. Of these, 633 (38.1%) were Local Public Drug Addiction Service Units (SerT), while the remaining 1,028 were social-rehabilitative facilities, for the most part residential (66.5%), followed by semi-residential facilities (18.6%) and outpatient service units (14.9%). In comparison with 2011, there has been a 3.7% (39 facilities) decrease in the number of social-rehabilitative facilities. However, there has been a greater drop in the number of outpatient service units (down by 8.9%) and residential facilities (a 3.4% decrease).

As far as regards the distribution of public healthcare facilities and those belonging to private non-profit, we find that there are greater percentage distributions of Local Public Drug Addiction Service Units (SerT) in Piedmont, in Sicily, in the Autonomous Province of Bolzano and in Campania (Figure 5.2).

Figure 5.2: Distribution of health and social services facilities for drug addicts, by type and by region – the year 2012



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

The State-Regional Accord Act of 5 August 1999

A 16.7% decrease in residential facilities

During the first six months of 2012, as in 2011, a survey was conducted by Regional Authorities regarding the recognition of private non-profit facilities (Auxiliary Entities which have received accreditation or authorisation pursuant to Articles 115 and 166 of D.P.R. 309/90) and of public facilities. The facilities in question are those of a diagnostic-therapeutic-rehabilitative nature, as set forth in the State-Regional Accord Act of 5 August 1999. From information gathered from all the Regions and Autonomous Provinces (with the exception of Valle D'Aosta) by means of a specific online platform created by the Department for Anti-drug Policies, it was found that there were a total of 39 residential and semi-residential diagnostic-therapeutic-rehabilitative facilities which had not been or could not be entered into the records required by the State-Regional

Accord, 13 less than in the previous year (Table 5.1). The number of residential facilities fell, confirming the trend which had already been observed the previous year (16.7% fewer than in 2011) and the number of semi-residential facilities also decreased (12.5% fewer than in 2011). The number of services which fall under the category of "Reception" services in the Framework for the Accord Act increased (those categorized as residential by increased by 14.3% and those categorized as semi-residential facilities by 83.3%). Overall, it is impossible to make a direct comparison with 2011 figures, since in that year a significant number of the facilities listed were entered without their facility type having been specified.

"Reception" centres: residential facilities of this type increased by 14.3%

Table 5.1: Diagnostic-therapeutic-rehabilitative facilities in accordance with the Framework for State-Regional Accord Act of 5 August 1999, by type of facility and type of treatment provided. The years 2011 – 2012.

	Private diagnostic-therapeutic-rehabilitative facilities		
	2011	**2012**	**Δ %**
Collective pathological addictions (not included or impossible to include in the Framework for the Accord Act study)	52	39	-25.0
Reception services Art.11	48	35	-27.1
Therapeutic-rehabilitative services Art.12	38	384	-0.8
Specialised treatment services Art.13	153	158	3.3
13 a) Double diagnosis	40	50	n.c.
13 b) Mother with child	18	24	33.3
13 c) Alcoholics	31	29	-6.5
13 d) Cocaine addicts	2	5	150.0
13 e) Pathological gamblers	5	2	-60.0
13 f) Minors	16	6	-62.5
13 g) Couples	1	1	0.0
13 h) Crisis centres	6	14	133.3
13 i) AIDS assisted-living communities	25	17	-32.0
13 l) Other	9	10	11.1
Pedagogical-rehabilitative services Art. 14	139	146	5.0
Integrated multi-disciplinary services Art. 15	10	12	20.0
Other accredited programmes	0	103	n.c.
Total	789	877	11.2

n.c.= figure could not be calculated

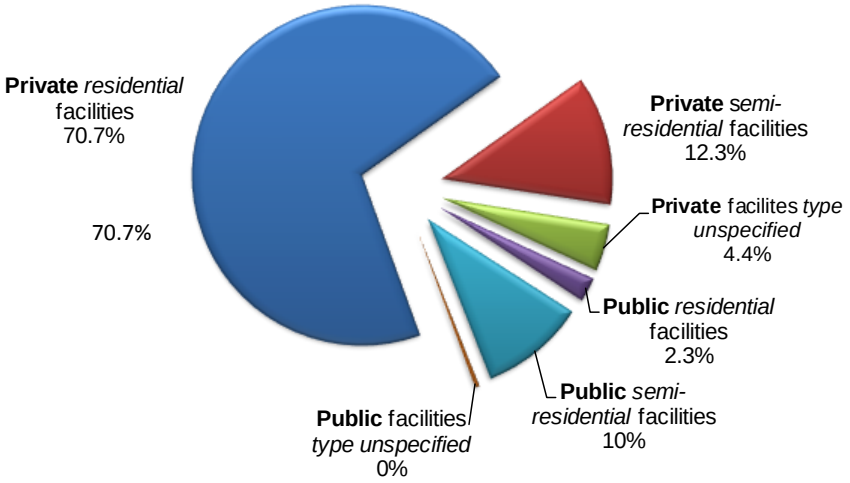
Source: Based on information from the Regions and Autonomous Provinces

In the Regions participating in the study there were a total of 127 public diagnostic-therapeutic-rehabilitative facilities (residential, semi-residential and type-unspecified). Principally, 48.8% are therapeutic-rehabilitative facilities and 44.8% are specialised treatment facilities. Of the specialized treatment facilities, 40.4% provide treatment for alcoholics, 24.5% to minors and 12.3% to dual-diagnosis patients.

With regard to quality control and monitoring of treatments provided, during the first half of 2013, the Regions and Autonomous Provinces were asked to complete the SQ 27 Structured Questionnaire, Parts 1 and 2, to which an additional section had been added devoted to ensuring the quality of treatment. The objective was to collect information on the existence – on a regional / individual-service-provider level – of protocols / procedures / guidelines for the

assessment of the quality of treatments provided by addiction services.
The survey was divided into three parts: Guidelines for evaluating the quality of treatment, Monitoring and assessment and, finally, the Development, sharing and implementation of "best practices".

Figure 5.3: Percentage distribution of diagnostic therapeutic and rehabilitative public and private facilities in accordance with the Framework for the State-Regional Accord Act of 5 August 1999. The year 2012



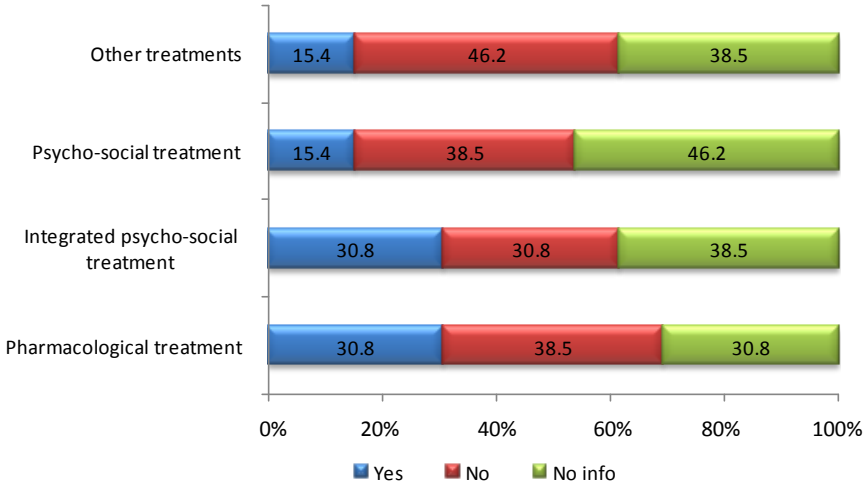
Source: Based on information from the Regions and Autonomous Provinces

Guidelines for assessing treatment quality

Guidelines not widely applied

Guidelines as a tool for assessing treatment quality are still not widely applied in all of the Regions and Autonomous Provinces. Only in 30.8% of Regions and APs do guidelines exist for pharmacological treatment and for integrated psycho-social treatment, while guidelines for psycho-social treatment and other types of treatment are rarer still (Figure 5.4).
The lack of available data is also significant. In at least 30% of cases (with a peak percentage of 46.2%) the data available was insufficient to formulate responses.

Figure 5.4: The existence of official documents for the assessment of treatment quality. The year 2012



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

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

Very low compliance with obligatory application of guidelines

The Regions and Autonomous Provinces were asked to provide further information about guidelines, concerning specifically: "the inclusion of aspects/criteria of treatment protocols in guidelines"; "description of required documentation for the assessment of treatment quality including admission/discharge information, outcome, client and personnel satisfaction"; "the manner in which guidelines for assessing treatment quality were created"; whether or not "reference regulations" existed. With regard to these topics, the amount of information available was scant and the response to requests for available data was, for the most part, nil.

Very little information made available by the Regions and Autonomous Provinces

Monitoring and assessment

There are still very few assessments of various treatment types, whether they be psycho-social, integrated psycho-social or pharmacological, which have comparable outcomes, and these are only conducted by a third of Regions and Autonomous Provinces, while a full 58.3% of Regions and APs declare such assessments to be inapplicable.

Assessments of treatment results not widely applicable

Development, sharing and implementation of "best practices"

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

Very little sharing of "best practices"

5.2.2 Availability and diversification of treatment

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

Preface on the types of treatment provided

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

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

Pharmacological treatment is further subdivided into two subcategories: treatments with substitution drugs (methadone and buprenorphine) and treatment with antagonists.
According to the EMCDDA, each of the above-mentioned types of treatments can be carried out in outpatient, inpatient or residential facilities or in the clinics of general practitioners.
Generally speaking, these classifications of treatment exist in Italy as well, although the places where they are provided differ. Pharmacological treatments are rarely provided by general practitioners and inpatient facilities generally assist clients in the event of acute episodes.

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

53% of Regions and Autonomous Provinces report having regional strategies aimed to promote social and healthcare activities to benefit persons in need of treatment for drug use. Of these, 89% declared that a document attesting to this was present and accessible on the internet (SQ 27, Part 1).
94.1% of Regions participating in the study had launched programs targeting children and adolescents and 82.4% had launched programs for problem drug users with a dual diagnosis.
On the other hand, specific treatment programs targeting ethnic groups in need of treatment existed in only 29.4% of Regions and only 11.8% had launched programs for other groups of people with problem drug use.

Positive results regarding the accessibility of treatment services

An assessment of the availability of services offered returned very positive results overall, with ratings of at least "good" in 100% of regions with reference to "specific ethnic groups with problem drug use", "other groups of people with problem drug use" and "immigrants with problem drug use".
Accessibility received a consistently positive rating from the Regions and Autonomous Provinces in seven out of ten cases, receiving a rating of excellent in at least 20% of cases. Only 10% ranked accessibility as being low (for subjects who abuse benzodiazepine).

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

The introduction of the SIND (National Information System on Addictions) information flow, which substituted the previous flow of data on treatments (ANN 03), profoundly changed the way in which data on the activities of drug addiction services were collected and organized. This is in line with the new health information system's inherent objective of focusing less on the type of treatment dispensed and more on the type of services provided to patients as a means to directly measure the 'product' dispensed by the operative units. This approach is part of a new assessment profile which aims to go beyond a mere tally of services dispensed. Rather, it links those services with the duration of treatment in order to obtain some indicators of the output provided per "equivalent" patient by use of the concept of the patient in "person years". This makes the indicator more homogeneous, and it is thus easier to compare the activities of different operative units.
This indicator, together with others used to monitor outcomes of pharmacological treatments, makes it possible to identify those output profiles which best represent effectiveness of treatments dispensed (measurement of outcomes in terms of effectiveness). Moreover, these can be used to assess how efficiently resources have been allocated in relation to, among other factors, the treatment outcomes obtained.

The macro service categories of the SIND information flow

Based on the data collected by addiction services and recorded in the "services provided" archive of the SIND information flow, it is possible to record sixteen

types of macro service categories for each client. Each of these macro categories can be further broken down into sub-categories by operative units in order to better describe activities conducted.
Different types of services dispensed to each patient during the period of reference can be recorded under the profile with which each patient is provided. An analysis of the distribution of patients by macro-category of services provided, where a patient can be counted once for each type of service he or she received, shows that, in 2012, each patient was provided with an average of 3 to 4 different types of macro-services (specifically, 3 for patients receiving psycho-social-rehabilitative treatment and 4 for patients receiving integrated pharmacological treatments.

When we draw a distinction between clients undergoing psycho-social-rehabilitative treatment and those in integrated pharmacological treatment, we find that 51.3% of patients were receiving integrated pharmacological treatment, in comparison with 66.2% in 2011. An analysis of the distribution of clients receiving integrated pharmacological treatment by region shows that a full ten regions have a higher figure than the Italian national percentage (51.3%); of these, three that stand out in particular are Campania (85.5%), Valle d'Aosta (82.4%) and Umbria (77.3%).
Low percentages, much lower than the national average, can be found in the Autonomous Province of Bolzano (25.8%), in Piedmont (19.2%) and in Sardinia (8.1%); these numbers appear not to reflect the actual number of pharmacological treatments being provided but, rather, the fact that only a part of these have been recorded.
Continuing with an analysis of services provided to these two separate groups of patients (those in psycho-social-rehabilitative treatment and those receiving integrated pharmacological treatment) the average number of services received was calculated for both. Patients in the first group each received an average of 21 services during the period of reference, a figure which deviates greatly from the average in other Regions. Indeed, in the Autonomous Province of Bolzano, each patient undergoing psycho-social or rehabilitative treatment received an average of over 165 services during the period of reference, in comparison with the second-highest average of 41.2 services (Veneto), followed by the Autonomous Province of Trento and by Piedmont (27.0 and 26.5 services received, respectively). These differences may be partially attributed to the incomplete recording of services provided on the part of some regions, and partially to different durations of treatment.

5.3 Characteristics of subjects undergoing treatment

The National Information System on Addictions (SIND)

The National Information System on Addictions (SIND) decree

On 11 June 2010 the "Institution of the National Information System on Addictions" was approved by decree of the Ministry of Health. This new information flow contains individual data on subjects receiving care from the addiction services of the Regions and Autonomous Provinces.
This new information flow substitutes the previous flow, which was based on aggregate data (Ministerial Decree 20 September 1997), and provides for the collection of data consisting of facility census information, information on personnel working in drug addiction services, information on activities conducted by services in order to assist drug addicts and, finally, anonymous HIV-monitoring data.

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

The SIND archives

- SUBJECTS' PERSONAL INFORMATION – This contains personal information and information on living situation, drug of use, age at first use and age at first treatment for the individual clients who are the objects of the SIND study.
- TESTS UNDERGONE – This contains information concerning tests the individual clients who are the objects of the SIND study have undergone which have been reported. What is meant by 'reported' is that there exists a report on the test in question, prepared by a testing laboratory, or the transcription of a report seen by a member of personnel.
- CONCOMITANT DISEASES – This contains information on diseases which the individual clients who are the objects of the SIND study were diagnosed with or objectively reported having, active during the period in question and concomitant with the principal diagnosis.
- DATES OF CONTACT – This contains the dates of contact when individual clients who are the objects of the SIND study were first taken into care of services and provided with a series of services grouped homogeneously.
- DRUGS OF USE – This contains information on the drugs of use or behaviours which caused the individual clients who are the objects of the SIND study to be taken into a treatment programme.
- HOMOGENEOUS SERVICES GROUP – This contains data on groups of homogeneous services offered by each service provider (Local Public Drug Addiction Service Units, prisons, therapeutic communities) to the open contact.

Table 5.2: Transmission of SIND archive data on the part of addiction services, in accordance with Ministerial Decree 11 June 2010. The years 2011-2012.

	SIND flow The year 2011	SIND flow The year 2012
Abruzzo	Complete transmission	Complete transmission
Basilicata	Data not received	Complete transmission
Calabria	Data not received	Partial transmission
Campania	Complete transmission	Complete transmission
Emilia Romagna	Complete transmission	Complete transmission
Friuli Venezia Giulia	Complete transmission	Complete transmission
Lazio	Partial transmission	Partial transmission
Liguria	Data not received	Complete transmission
Lombardy	Complete transmission	Complete transmission
Marche	Data not received	Partial transmission
Molise	Data not received	Partial transmission
AP Bolzano	Complete transmission	Complete transmission
AP Trento	Complete transmission	Complete transmission
Piedmont	Partial transmission	Complete transmission
Apulia	Complete transmission	Complete transmission
Sardinia	Data not received	Partial transmission
Sicily	Complete transmission	Complete transmission
Tuscany	Data not received	Complete transmission
Umbria	Complete transmission	Complete transmission
Valle d'Aosta	Complete transmission	Complete transmission
Veneto	Complete transmission	Complete transmission

Source: the Ministry of Health

In 2013, not all Regions had adopted the new information flow, and a number of Regions therefore did not provide all the information they were required to produce.
Table 5.2 provides a summary of the transmission of SIND flow information on the part of the Regions and Autonomous Provinces in 2012 (from data gathered in 2011) and up until 20 September 2013 (from data gathered in 2012).

Data transmission on the part of the Regions and Autonomous Provinces

The information received from the Ministry of Health containing data from information flows of the Regional Drug Addiction Services and from Regional Administrations, integrated with 2011 data for the Regions and Autonomous Provinces who did not send SIND flow information or sent only a part, covers 90% of the services active throughout Italy.

Coverage index of greater than 90%

Focus on TDI data

The TDI tables were compiled in accordance with TDI protocol 2.0 using data on clients receiving treatment provided by the Regions by means of the SIND individual-client record layout.
The data used to calculate the TDI refer to 85% of the overall total number of clients receiving care from the services which submitted the information.
The subjects taken into consideration for the TDI (based upon European guidelines) are comprised of: 26,745 new subjects and 27,875 returning subjects, meaning that the latter group is already known to services and that they began a new treatment during the course of 2012 (subjects already undergoing their treatments before 2012 were not considered). Thus, the overall total sample taken into consideration was comprised of 54,620 subjects, 85% of whom were male and 49% of whom were entering the care of a Local Public Drug Addiction Service Unit (SerT) for the first time.

Table 5.3: Subjects in treatment with Drug Addiction Services, by gender and type of subject (new or returning). The year 2012.

Subjects in treatment	New clients	%	Returning clients	%	Total
Male	22,446	83.9	23,952	85.9	46,398
Female	4,197	15.7	3,920	14.1	8,117
Unknown/missing	102	0.4	3	0.0	105
Total	26,745	100.0	27,875	100.0	54,620

TDI 2.0 data: 26,745 new 27,875 returning

Source: Based on data from the Ministry of Health

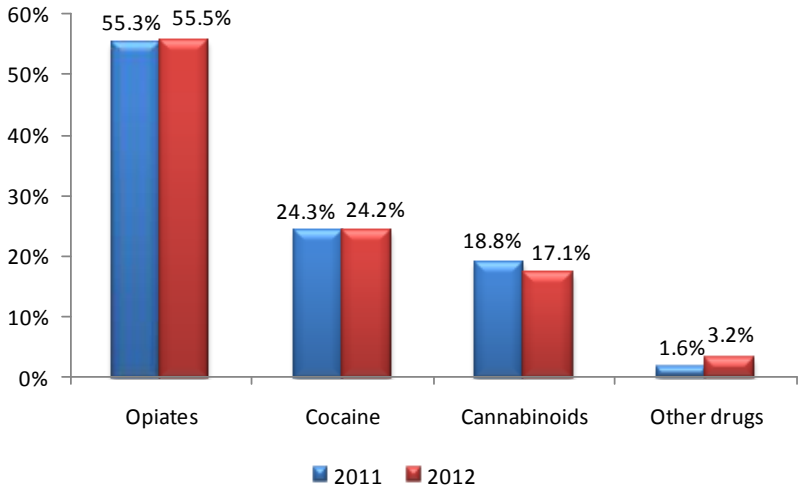
Data on the primary drug of use was not collected for nearly 45% (approximately half) of the total number of subjects in treatment with Addiction Services in 2012 who were selected for their suitability for the TDIs. Consequently, in order to be able to compare this data with that collected in 2011 and with the European profile of the phenomenon, the percentages are based solely upon those clients for whom the primary drug of use was known.

Of the individuals who specified a primary drug of use, 55.5% reported an opiate as their primary drug, followed by cocaine (24.2% of clients in treatment) and cannabis (17.1% of the total in treatment) (Figure 5.5).
2012 data are in line with data collected in 2011, with a slight decrease of nearly 2 percentage points for cannabis.

Most commonly used primary drugs: 55.5% heroin, 24.2% cocaine, 17.1% cannabis

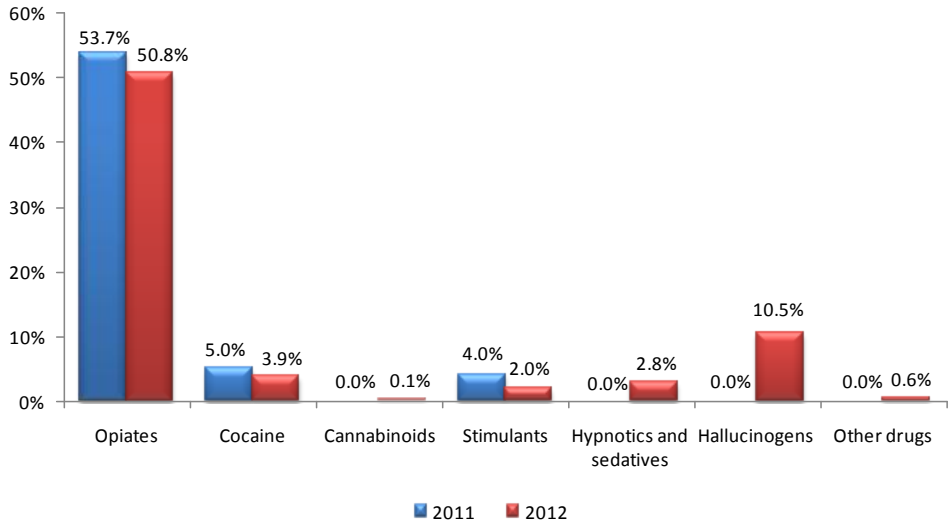
Cannabis and cocaine, while continuing to grow in appeal as primary drugs among service clients, are also the preferred secondary drugs of clients who use more than one type (35% of subjects for both cannabis and cocaine).

Figure 5.5: Percentage distribution of clients in treatment with Drug Addiction Services, by primary drug. The years 2011 – 2012



Source: Based on data from the Ministry of Health

Figure 5.6: Percentage distribution of clients in treatment with Drug Addiction Services, by injecting use of primary drug. The year 2011 – 2012

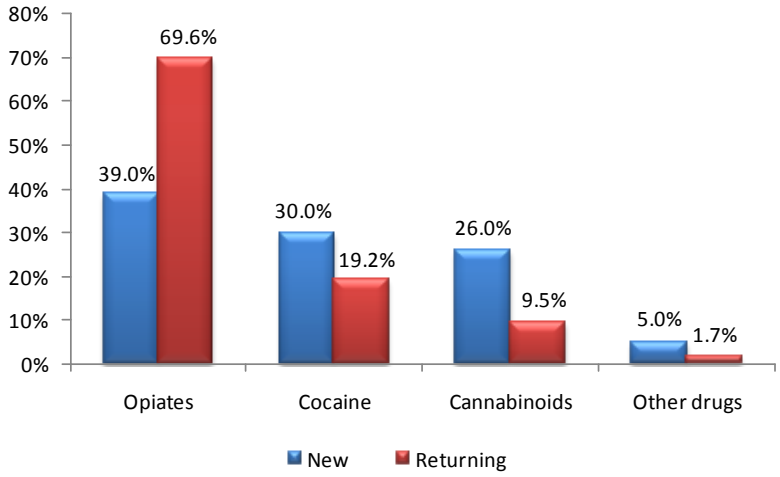


Source: Based on data from the Ministry of Health

Injecting drug use fell slightly among opiate users during the course of the last year (53.7% in 2011 vs. 50.8% in 2012).

The use profile which emerged from a study of primary drugs of use according to client type provided particularly interesting findings. 69.6% of subjects who had received care from Local Public Drug Addiction Service Units (SerT) in the past and then returned in 2012 were receiving treatment for opiate use, while the numbers of users of cocaine (19.2%) and cannabis (9.5%) were much lower. The percentage of problem opiate users is quite high among new service clients as well (39.0%), but is markedly lower than the percentage of opiate users among returning clients. On the other hand, percentages of cocaine and cannabis users are higher among new clients than among returning ones (10.8% higher for cocaine and 16.5% higher for cannabis) The percentages of new subjects in treatment for cocaine and cannabis use, unlike the percentages among returning clients, is higher (10.8 and 16.5 percentage points higher, respectively) (Figure 5.7).

Figure 5.7: Percentage distribution of clients in treatment with Addiction Services, by type (new or returning) and primary drug of use. The year 2012.



Source: Based on data from the Ministry of Health

Figures concerning primary-drug methods of use, and especially regarding injecting drug use, also show differences between new and returning clients. We can see that primary drug use via injection is more common among returning clients (39.9%), with percentages of injecting users standing at 56% of opiate users and 5% of cocaine users. Among new clients, on the other hand, 16.7% use the injection method (specifically, 40.1% of opiate users and 3.2% of cocaine users).

As revealed by studies conducted in previous years, average age at first use changes in relation to the type of drug in question: heroin and cocaine users began at average ages of 21 and 22, respectively, while cannabis users began at 17.

Ages at first use:
heroin: age 21
cocaine: age 22
cannabis: age 17

As far as age at first treatment is concerned, on the other hand, the following figures emerged in 2012: age 25 for heroin users, 31 for cocaine users and, finally, 23 for subjects who reported using cannabis as their primary drug.

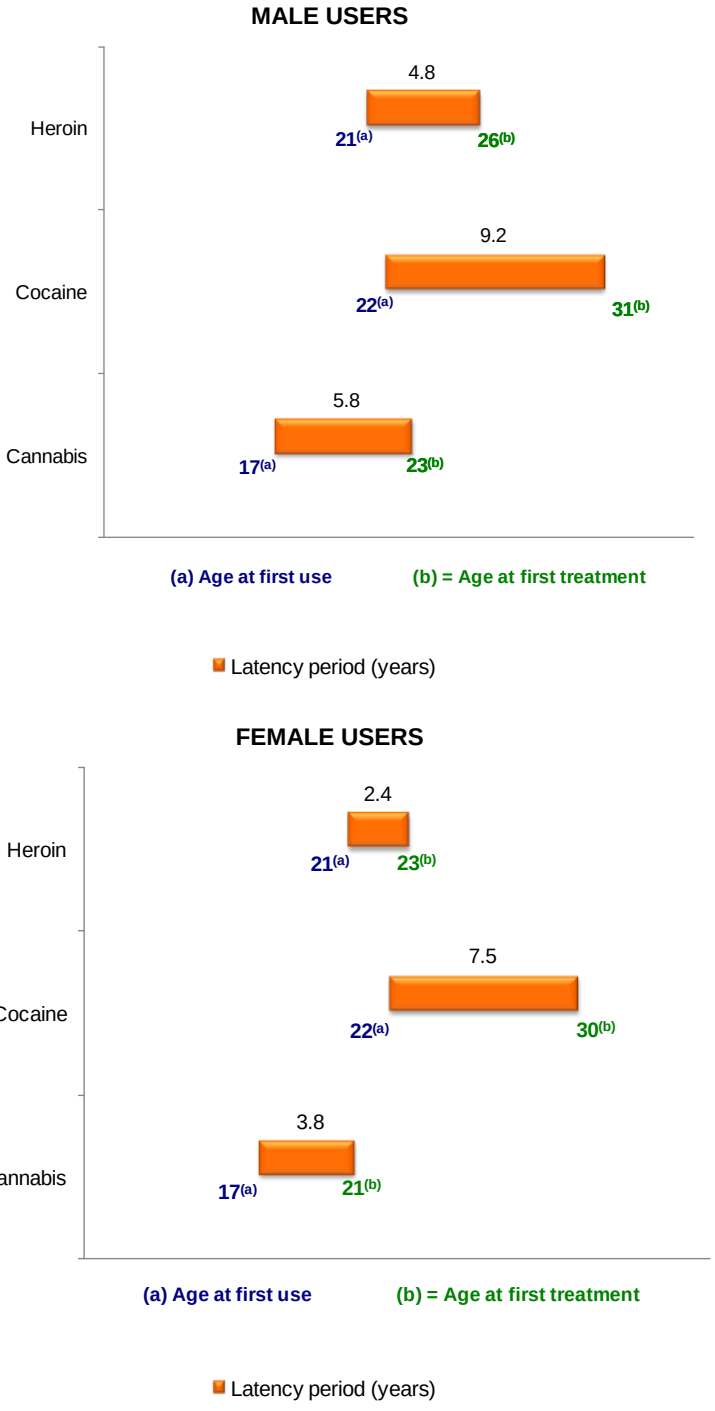
Age at first treatment: heroin: age 25
cocaine: age 31
cannabis: age 23

Age at first use and age at time of first treatment define the latency period, calculated as the period of time that passes between first drug use and first request for drug treatment (as a result of problems deriving from the use of the drug in question).

An analysis based on primary drug type reveals longer latency periods for cocaine users in comparison with heroin and cannabis users. Specifically, the latency period for opiate users was recorded at 4.4 years, while it stood at 9.1 years for cocaine users and 5.6 years for cannabis users. These figures vary slightly when findings are analysed by gender. However, overall, latency periods for women are shorter than those for men for all three types of drugs. This is confirmed by the fact that we can see that the age of first treatment is younger for female users, even though age at first use is the same for them as for their male counterparts (Figure 5.8).

Latency periods between first use and first contact with services:
heroin:4.4 years
cocaine 9.1 years
cannabis 5.6 years

Figure 5.8: Age at first use, age at first treatment and latency period, by gender. The year 2012



Source: Based on data from the Ministry of Health

Heroin and cocaine: most clients seek treatment voluntarily

Cannabis: most clients sent to treatment by the Prefectures

The manner in which clients enter into the care of drug addiction services differs according to drug type. Most opiate and cocaine users seek treatment voluntarily or are brought into contact with services by friends or family members (61% of opiate users and 47% of cocaine users). 28% of cannabis users, on the other hand, are sent to Public Drug Treatment Units by order of the Prefectures (under Articles 121 and 75), while 26% enter into treatment voluntarily. The low number of referrals for most drug types on the part of a number of important potential sources, such as social services and local health boards, should be noted.

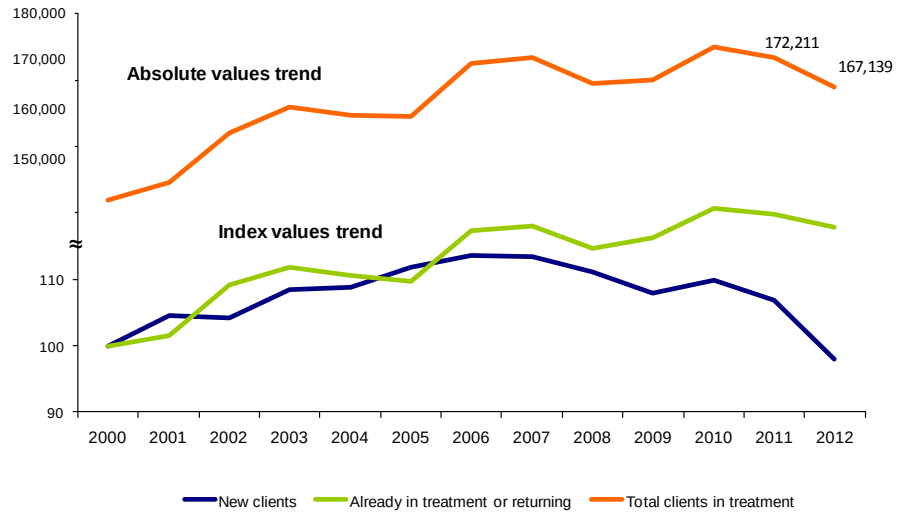
Finally, if we compare the ways in which different types of clients enter into

treatment, we find that the percentage of clients who were sent to Local Public Addiction Service Units by the Prefectures is much higher among new clients than among those returning (10.9% vs. 4.5%). On the contrary, the percentage of clients who entered into treatment voluntarily is higher among returning clients (63.7% of returning vs. 39.9% of new clients).

5.4 Trends among clients in treatment

Based on data obtained by means of the SIND information flow, the number of drug addicted persons who received treatment in 2012 (including new clients, returning clients and clients who were already undergoing treatment when the year began) was estimated at 167,139 subjects.
Data on approximately 90% of this number were gathered from the new SIND information flow, while information on the remaining 10% was estimated based on 2011 aggregate data.
The drop in the number of clients undergoing treatment can be blamed, in small part, on an actual decrease in the number of subjects receiving treatment from Services, and in part on the switch from an information system based on aggregate data to an information system that uses individual data (SIND) and thus reduces the problem of double counting.

Figure 5.9: Clients undergoing treatment with Drug Addiction Services, by type of contact: Absolute values and index values (Base year 2000 = 100) – the years 2000 – 2012



Source: based on data from the Ministry of Health

167,139 drug-addicted persons receiving treatment from Services in Italy

Over 18% of subjects in treatment are clients who began their first-ever treatment with addiction services during the course of the year in question, while the remainder are subjects already known to Services; this latter group is divided into subjects who began a new treatment in 2012 (returning) and those who were already in treatment when the year began (already receiving treatment). New clients are an average of 34 years of age (39 for returning subjects or those already receiving treatment), and are mainly male.
Between 2000 and 2006, there was a steady increase in the number of drug addicts requesting first-time treatment from the network of public services provided by the National Health System (new clients), which rose from 31,510 in 2000 to 35,766 in 2006; in the following three-year period (2007-2009) there was a phase of decline (35,731 in 2007 to 35,020 in 2008 and finally to 33,983 in 2009), followed by an increase in 2010, which brought the figure up to

34,625, matching levels seen in 2004 (Figura 5.9).

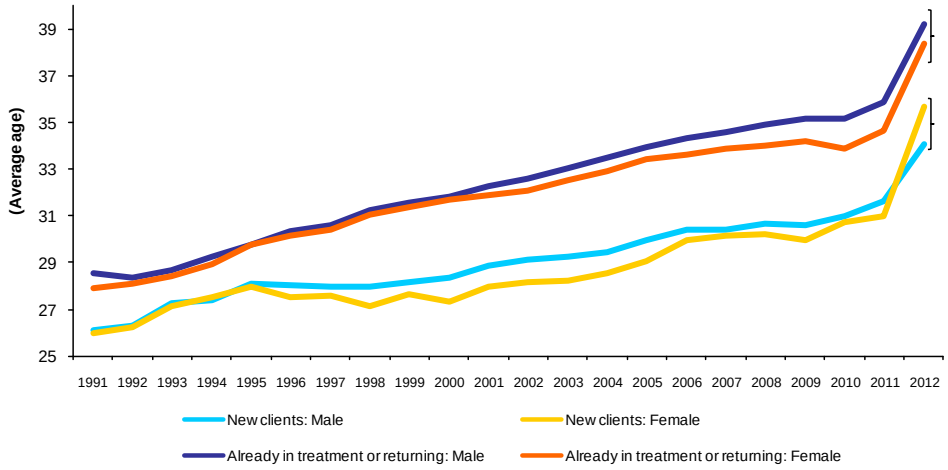
Number of new clients decreased over the last year

Over the most recent two-year period, there has been a decrease in the number of new clients entering treatment, with numbers falling from 34,625 clients in 2010 to 30,888 in 2012. This trend, which can also be seen among clients already known to services, can be justified in part by the criteria being used to calculate the estimates, in part by the different information flows being used and, finally, by the smaller degree of coverage provided by the information flow.

Over the last twenty years, the average client age progressively increased among both already-known and new clients, rising from 26 years of age for both genders among new clients to nearly 36 for women and 34 for men in 2012. Among clients already known to services, the average age continues to rise, although differently for each gender, with a more pronounced age increase for men than for women.

Figure 5.10: Average age of clients undergoing treatment with Drug Addiction Services, by type of contact and by gender – the years 1991 – 2012

Increase in average age at first contact with services



Source: Based on data from the Ministry of Health

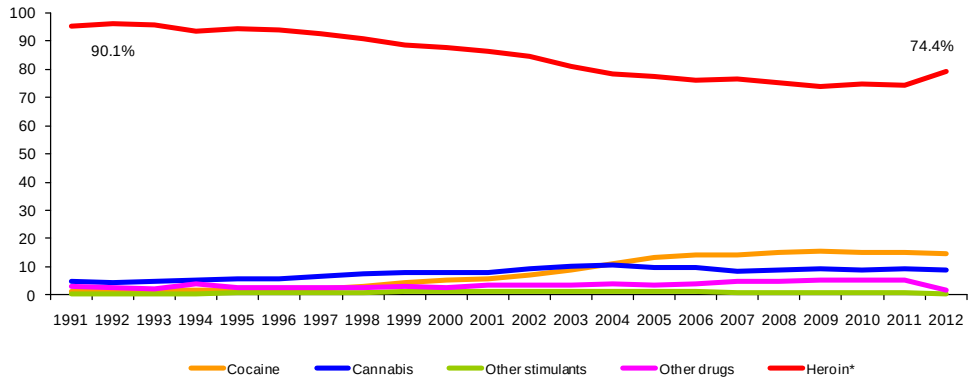
Over the last year, however, the trend shown in Figure 5.10 highlights a steep increase in average age for all clients in treatment with services (new, already known, male and female). This result is not to be attributed to factors that are part of the drug problem, but rather to the introduction of the new information flow. In comparison with the ministry charts of aggregate data (Ministerial Decree 20 September 1997), which call for the collection of data on clients by 5-year age brackets until the age of 39, and afterwards by separate age brackets (for those above 39 years of age), the SIND information flow makes it possible to collect exact data on age. Therefore, the criteria previously used to calculate estimates suffered from a factor of incorrect overestimation, unlike the data currently available, which now make it possible to calculate a more precise estimate of the average age of clients in treatment.

Clients undergoing treatment for heroin use: after remaining steady for five years, their numbers rose from approximately 70% to 74.4%

Although it remains high, the percentage of clients undergoing treatment for the use of opiates as their primary drug showed a progressive decrease between 1991 and 2005 (falling from approximately 90% to 68.9%). It levelled off at around 70% during the following five-year period and rose to 74.4% in 2012, as a consequence of the introduction of the SIND information system. While the number of clients who use opiates as their primary drug has increased, there

has been a slight fall in cocaine and cannabis use (as primary drugs) in comparison with 2011.

Figure 5.11: Percentage distribution of clients undergoing treatment with Drug Addiction Services, by primary drug. The years 1991 – 2012



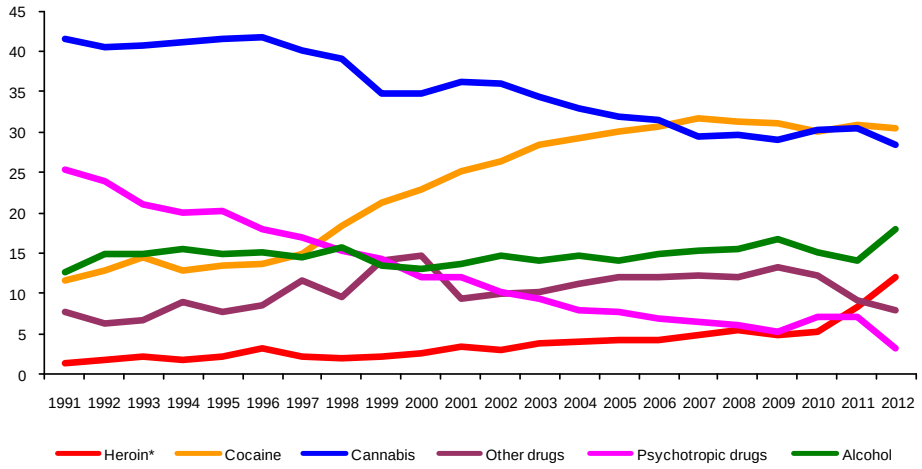
Decrease in the number of clients undergoing treatment for cocaine use

** Heroin until 2010, Opiates in 2011-2012*

Source: Based on data from the Ministry of Health

Turning our attention to secondary substances, we find that, from 1997 on, there has been a visible increase in the use of cocaine as a secondary drug, which rose from 15% to 32% in 2007. The percentage remained stable until 2009, but fell slightly during the following three-year period, dropping to 30.5% in 2012 (Figure 5.12).

Figure 5.12: Percentage distribution of clients undergoing treatment with Drug Addiction Services, by secondary substance. The years 1991 – 2012



Decrease in the concomitant or consecutive use of psychotropic and other drugs in addition to the primary drug

Ever since 2007, cocaine has been the most widely-used secondary drug

** Heroin until 2010, Opiates in 2011-2012*

Source: Based on data from the Ministry of Health

6. HEALTH CORRELATES AND CONSEQUENCES

Infectious diseases among drug addiction services clients

Drug- and alcohol-related traffic checks

Deaths caused by acute effects of drug use

One of the principal consequences directly correlated with drug use, and in particular with methods of drug use, not to mention the type of lifestyle the average individual who uses drugs leads, is the high risk of contracting infectious diseases, a topic to which a large part of this chapter is devoted.
One specific section will also be devoted to traffic checks carried out by Law Enforcement Agencies for drivers under the influence of psychoactive drugs.
The final part of the chapter will deal with acute drug-related mortality, the subject of a study by the Central Directorate for Anti-drug Services of the Ministry of the Interior, and with mortality among drug users in who have been admitted to hospitals.

6.1 Introduction

The National Information System on Addictions (SIND), established under the SIND Decree of 11 June 2010, took the place of the previous aggregate data flow which existed under the Ministerial Decree of 20/09/1997. Under the new system, there have been a series of problems and technical difficulties (typical when launching complex new information systems) with the flow of information on 2012 client test results for HIV, hepatitis B virus and hepatitis C virus from the Regions to the Ministry of Health, as well as with the subsequent transfer of data to the Department for Anti-drug Policies (DAP). This has led to a significant decrease in the amount of valid data available to be processed in the case of the majority of the Regions and Autonomous Provinces. As a result, an updated representation of the national situation which incorporated the new 2012 data on this aspect of the drug phenomenon would be unreliable. The Department for Anti-drug Policies has thus deemed it ill-advised to publish results obtained from processing the 2012 data on this topic collected by means of the SIND information flow, since it has not yet been properly consolidated, nor has it undergone necessary quality checks. Data regarding hepatitis B and C results are missing for approximately 80% of addiction-services clients, which renders data processing impossible.
Data on HIV testing presents a further problem, which is that of privacy. In order to protect clients' privacy, specific records were designated to be transferred which were not to contain any information which could be used to identify individual clients, even indirectly, or endanger their anonymity. This makes it impossible to identify those individuals who have been tested more than once during the year in question (and who thus appear more than once within the same set of records), leading to overcounting.
This aspect is especially important when counting the number of subjects who have been tested in comparison with the total number of subjects in the care of drug addiction services. Indeed, since a subject could be counted more than once, the end result could be that the number of subjects for whom testing information is available is higher than the total number of subjects in the care of addiction services.

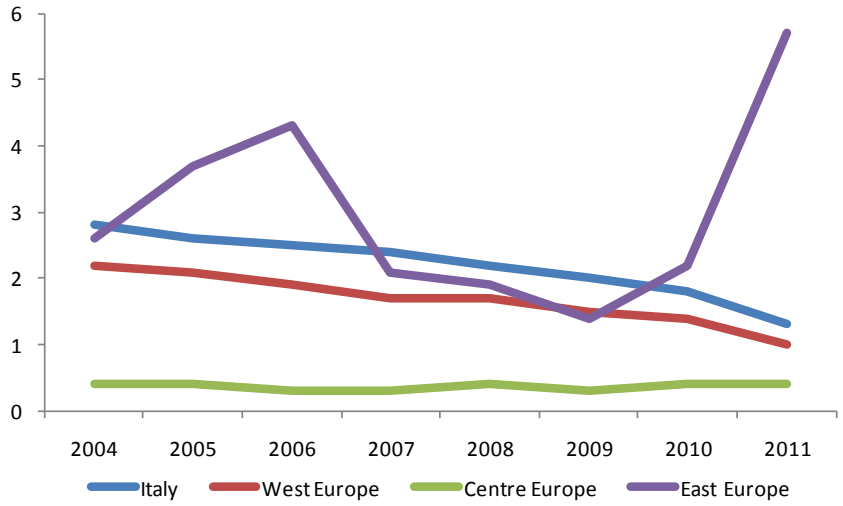
Prevalence of HIV and AIDS

The incidence of cases of HIV among Italian drug addicts is declining

The incidence of HIV infection diagnosed among injecting drug users (IDU) is on the decline in Central and Western Europe. It is on the rise, however, in the countries of Eastern Europe (with a significant increase between 2010 and 2011). If we put aside, for now, the special case of Eastern Europe, we see that the falling numbers are due, in part, to the greater availability of universal prevention measures and measures for the treatment and prevention of drug-related diseases, including substitution treatments and needle and syringe exchange programmes. A number of countries also cite other factors, such as the decline in injecting drug use, which has also been observed in Italy.

The number of drug addicts diagnosed as HIV-positive who are receiving care in hospitals (infectious disease wards) has been progressively declining. Italian numbers, while slightly higher than those for its home area (Western Europe) as a whole, are nonetheless perfectly in line with the broader Western European situation (Figure 6.1).

Figure 6.1: Incidence rate (cases per 100,000 pop.) of HIV diagnosis, in Italy and in the different areas of Europe. The years 2004 - 2011

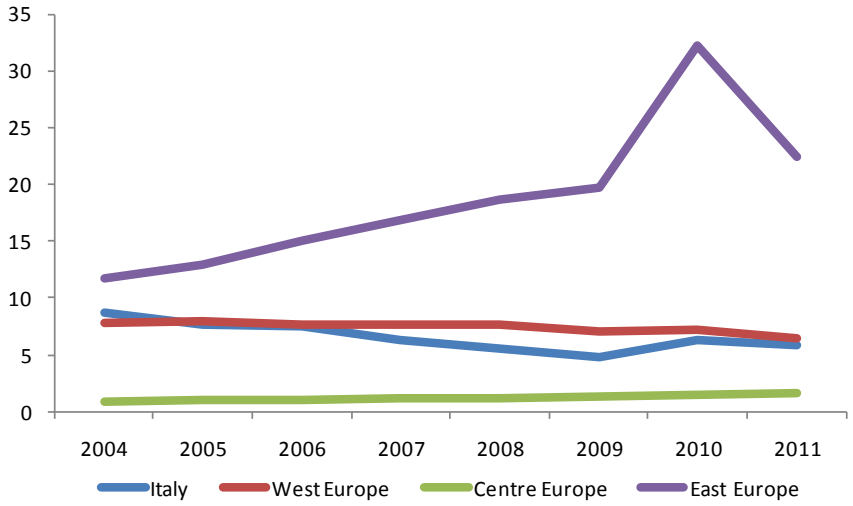


Source: European Centre for Disease Prevention and Control – Surveillance Report 2011

AIDS-incidence data is important for establishing new cases of symptomatic disease and for providing evidence of the spread and effectiveness of highly active antiretroviral therapy (HAART). High rates of AIDS incidence in some European countries make it appear that a large number of habitual injecting drug addicts infected with HIV may not be receiving HAART during the early stages of infection.

If we look at AIDS data, we find that the picture they delineate is similar to the situation regarding HIV, with numbers in Eastern Europe being considerably higher than those in the other two areas of the continent, especially during the last two-year period being considered.
In Italy, this trend (which is in decline) closely follows the trend in Western Europe as a whole, with a slight downturn between 2007 and 2009. (Figure 6.2).

Figure 6.2: Incidence rate (cases per 100,000 pop.) of AIDS, in Italy and in the different areas of Europe. The years 2004 - 2011



Source: European Centre for Disease Prevention and Control – Surveillance Report 2011

6.2 Drug-related infectious diseases

With the launch of the new SIND information flow, only the data provided by the Regions of Emilia-Romagna, Lombardy and Umbria regarding drug-related infectious disease testing conducted on subjects in the care of local addiction services covered an acceptable portion of the population (over 50% of clients in the care of addiction services). What follows is a summary of the results of the processing of this data. As pointed out earlier, HIV data are affected by the problem regarding privacy, which makes it impossible to identify subjects who have undergone testing more than once during the course of the year in question. The consequence of this issue is that one subject may have been counted more than once, leading to a situation where the number of subjects for whom there is testing data is larger than the total number of subjects receiving care. (Table 6.1).

Turning our attention to hepatitis B, we find that, of the 5,527 subjects in the Region of Emilia Romagna who were eligible for testing during the year of reference, over half were tested for HBV (59.6%). The number is similar in Lombardy (59.2%) but stands at approximately 39% in Umbria.

Regarding hepatitis C, testing for this disease was conducted on over half of clients in care of services in the Regions of Emilia-Romagna (55.8%) and of Lombardy (63.1%), while a much lower percentage were tested in the Region of Umbria (33.6%). We thus find that numbers for hepatitis C testing reflect the situation for testing for hepatitis B.

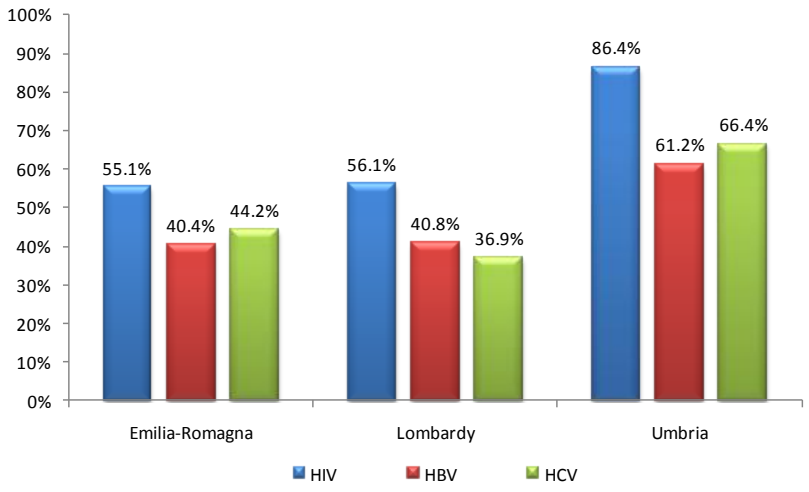
Table 6.1: Clients in the care of addiction Services: Subjects tested and subjects not tested for HBV, HCV and HIV. The year 2012.

Region	Tot. C.C.	No info	% no info of total C.C.	Not eligible for testing	Clients Tested this year				Clients NOT Tested this year			
					N.C.	R.C.	Total No.	Total % of clients eligible for testing who were tested this year	N.C.	R.C..	Total No.	Total % of clients eligible for testing who were NOT tested this year
HBV												
Emilia Romagna	13,035	4,460	34.2	3,048	571	2,721	3,292	59.6	2	2,233	2,235	40.4
Lombardy	18,355	7,492	40.8	885	724	5,184	5,908	59.2	297	3,773	4,070	40.8
Umbria	3,083	1,544	50.1	429	55	376	431	38.8	7	672	679	61.2
HCV												
Emilia Romagna	13,035	4,421	33.9	3,054	573	2,532	3,105	55.8	2	2,453	2,455	44.2
Lombardy	18,355	8,581	46.8	1,487	719	4,509	5,228	63.1	306	2,753	3,059	36.9
Umbria	3,083	1,632	52.9	472	50	279	329	33.6	6	644	650	66.4
HIV												
Emilia Romagna	13,035	-	-	458	41	3,731	3,772	44.9	29	4,608	4,637	55.1
Lombardy	18,355	-	-	1,138	2,512	6,665	9,177	43.9	2.374	9,345	11,719	56.1
Umbria	3,083	-	-	41	58	379	437	13.6	401	2,368	2,769	86.4

C.C. = Clients in Care
N.C. = New Clients
R.C. = Returning Clients
Not eligible for testing = tested positive previous to year of reference
Tested this year = tested positive this year + tested negative this year + results inconclusive this year
Not tested this year = last test before this year negative + last test before this year inconclusive + not tested this year
Eligible for testing = tested this year + not tested this year

Source: Based on data from the SIND information flow

Figure 6.3: Percentages of Local Public Drug Addiction Service Unit (SerT) clients eligible for testing who were NOT tested for HIV, HBV and HCV. The year 2012



Source: Based on data from the SIND information flow

The percentage of clients who received HIV testing from addiction services is smaller than percentages of clients tested for the two hepatitides. In fact, of subjects eligible for testing, only 44.9% were tested in Emilia Romagna, 43.9% in Lombardy and a mere 13.6% in Umbria.

6.2.1 The Prevalence of HIV

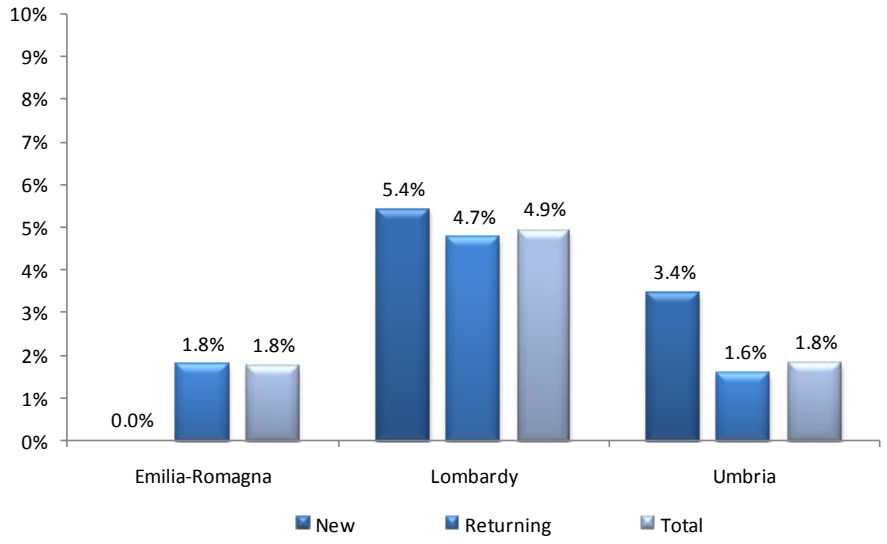
The following figures are based on data received, and take into account only those Regions for which a larger amount of testing data are available. The prevalence of HIV diagnosis among clients tested in Emilia-Romagna in 2012 was 1.8%, of whom all were returning clients. In Lombardy, on the other hand, there was a higher incidence of HIV diagnosis among new clients tested: 5.4%, in comparison with 4.7% of returning clients. In the Region of Umbria, as well, there was a higher incidence of HIV diagnosis among new clients (3.4%) in comparison with returning (1.6%).

Table 6.2: Prevalence of clients tested for HIV who were diagnosed HIV-Positive. The year 2012.

Region	Clients TESTING POSITIVE this year					
	New Clients		Returning Clients		Total	
	No.	% positive this year (unequivocal test results)	No.	% positive this year (unequivocal test results)	No.	% positive this year (unequivocal test results)
Emilia Romagna	0	0.0	65	1.8	65	1.8
Lombardy	58	5.4	131	4.7	189	4.9
Umbria	2	3.4	6	1.6	8	1.8

Source: Based on data from the SIND information flow

Figure 6.4: Prevalence of clients tested for HIV who were diagnosed HIV-Positive. The year 2012



Source: Based on data from the SIND information flow

6.2.2 Prevalence of the Hepatitis B virus (HBV)

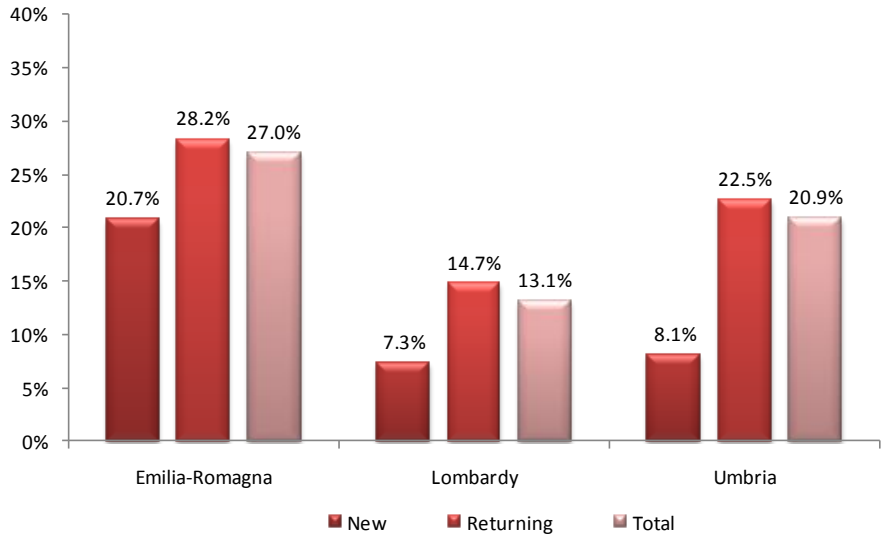
Among subjects tested for HBV in 2012 in Emilia Romagna, a higher number of returning clients than of new clients tested positive (28.2% of returning; 20.7% of new). In Lombardy, the overall prevalence was 13.1%, thus divided: 7.3% of new clients were diagnosed HBV-positive and 14.7% of returning. Figures are considerably higher in Umbria, where the overall prevalence of HBV-positive test results was 20.9%, and 8.1% of new clients and 22.5% of returning clients were diagnosed HBV-positive.

Table 6.3: Prevalence of clients tested for HBV who were diagnosed HBV-Positive. The year 2012.

Region	Clients TESTING POSITIVE this year					
	New Clients		Returning Clients		Total	
	No.	% positive this year (unequivocal test results)	No.	% positive this year (unequivocal test results)	No.	% positive this year (unequivocal test results)
Emilia Romagna	72	20.7	490	28.2	562	27.0
Lombardy	34	7.3	244	14.7	278	13.1
Umbria	3	8.1	66	22.5	69	20.9

Source: Based on data from the SIND information flow

Figure 6.5: Prevalence of clients tested for HBV who were diagnosed HBV-Positive. The year 2012



Source: Based on data from the SIND information flow

6.2.3 Prevalence of the Hepatitis C virus (HCV)

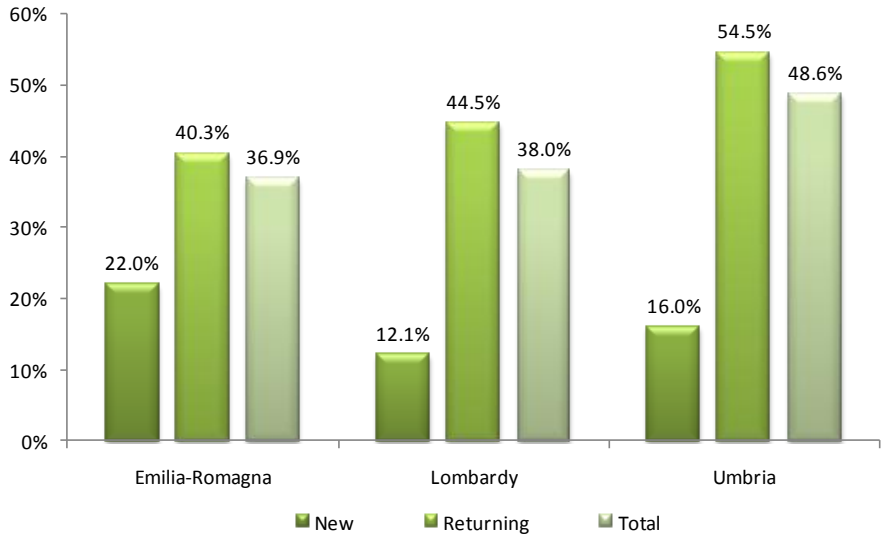
Among subjects tested for HCV in 2012 in Emilia-Romagna, a higher percentage of returning clients than of new clients tested positive (40.3% of returning; 22.0% of new). The overall prevalence was 38.0%, thus divided: 12.1% of new clients were diagnosed HCV-positive and 44.5% of returning. In Umbria, on the other hand, the overall prevalence of HCV-positive test results was 48.6% (16.0% of new clients and 54.5% of returning). As has already been found in studies from previous years, the Regions which conduct less testing are the same ones that have higher prevalences of positive results.

Table 6.4: Prevalence of clients tested for HCV who were diagnosed HCV-Positive. The year 2012.

Region	Clients TESTING POSITIVE this year					
	New Clients		Returning Clients		Total	
	No.	% positive this year (unequivocal test results)	No.	% positive this year (unequivocal test results)	No.	% positive this year (unequivocal test results)
Emilia Romagna	126	22.0	1,021	40.3	1,147	36.9
Lombardy	72	12.1	1,051	44.5	1,123	38.0
Umbria	8	16.0	152	54.5	160	48.6

Source: Based on data from the SIND information flow

Figure 6.6: Prevalence of clients tested for HCV who were diagnosed HCV-Positive. The year 2012



Source: Based on data from the SIND information flow

6.2.4 Focus on IDU data

With the launch of the SIND information flow, Standard Table 09 was prepared and completed with information on subjects who had engaged in injecting drug use (IDU) at least once in their lives.
The data presented here is only from those three regions which had already been found to have infectious-disease information flows with an adequate amount of coverage: Emilia-Romagna, Lombardy and Umbria.
The highest percentage of unequivocally positive test results during 2012 was for HCV (all Regions showed figures of higher than 60%), while HIV tests returned the lowest amount of positive test results, not only in absolute terms, but also in terms of percentages (2.7% Emilia-Romagna, 8.8% Lombardy, 0.6% Umbria).

Table 6.5: Addiction service clients testing positive for HBV, HCV or HIV who have engaged in injecting drug use (IDU) at least once in their lives. The year 2012.

Region	Total clients in care (IDU)	No information	% no info of total clients in care	Positive this year	Tested this year with unequivocal results	% testing positive this year of those with unequivocal results
HBV						
Emilia Romagna	7,165	1,613	22.5	446	1,256	35.5
Lombardy	5,017	1,456	29.0	152	593	25.6
Umbria	784	213	27.2	38	145	26.2
HCV						
Emilia Romagna	7,165	1,582	22.1	1,019	1,670	61.0
Lombardy	5,017	2,437	48.6	371	602	61.6
Umbria	784	238	30.4	83	128	64.8
HIV						
Emilia Romagna	7,165	-	-	60	2,234	2.7
Lombardy	5,017	-	-	106	1,206	8.8
Umbria	784	-	-	1	178	0.6

Unequivocal test results this year = positive this year + negative this year

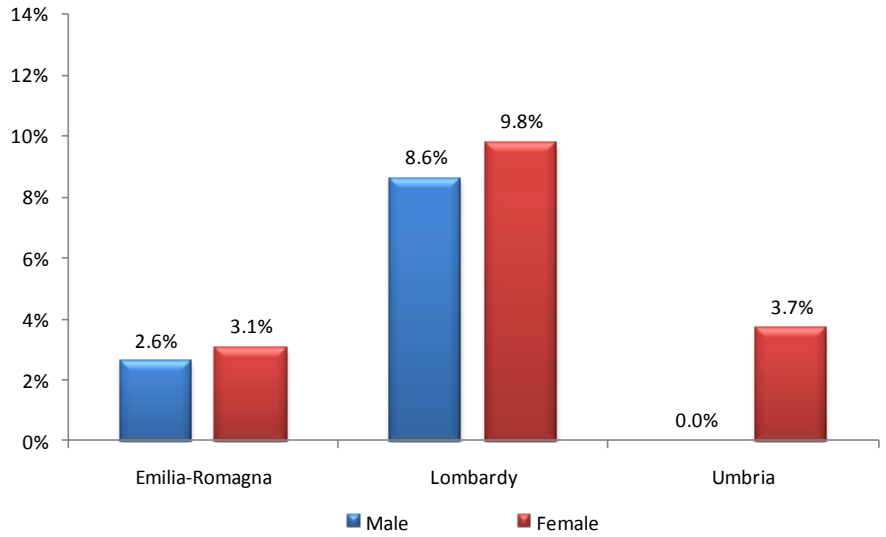
Source: Based on data from the SIND information flow

Subjects who have engaged in injecting drug use (IDU) at least once during their lives

HIV

Among subjects tested for HIV in 2012 who have engaged in injecting drug use, women had a higher prevalence of positive test results than men in all of the Regions whose data was analysed.

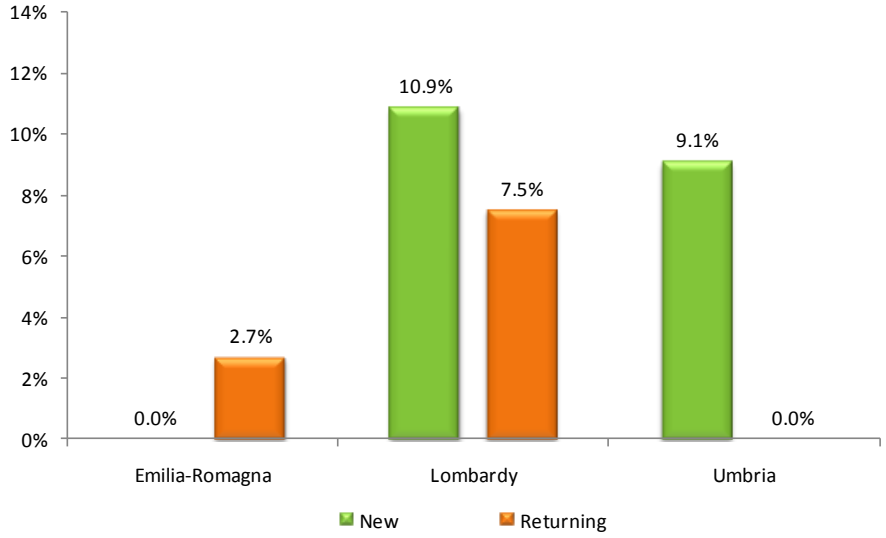
Figure 6.7: Prevalence of Injecting Drug Users (IDU) tested for HIV who tested Positive, by gender. The year 2012.



Source: Based on data from the SIND information flow

If we compare the prevalence of subjects testing positive by treatment type, we find that new clients have a higher prevalence of positive results than returning clients (10.9% in Lombardy and 9.1% in Umbria), except for in Emilia-Romagna (0% of new vs. 2.7% of returning).

Figure 6.8: Prevalence of injecting drug users tested for HIV who tested Positive, by treatment type. The year 2012

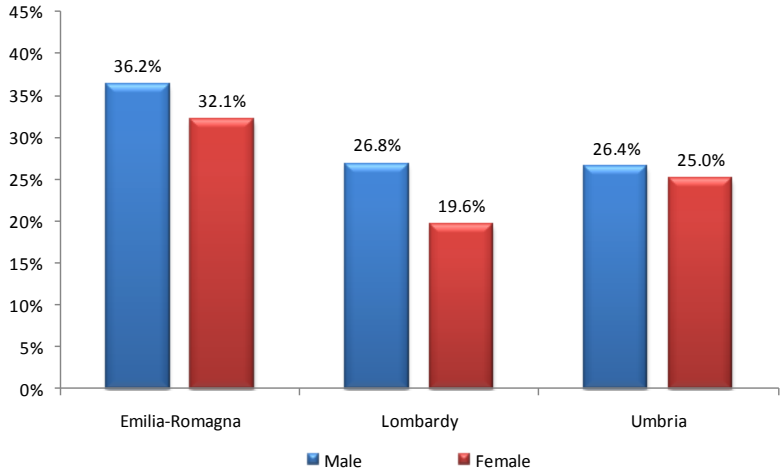


Source: Based on data from the SIND information flow

Hepatitis B Virus (HBV)

Data regarding testing for the hepatitis B virus (HBV) shows a higher prevalence of subjects with positive test results among males in comparison with females in all of the Regions whose data was being analysed. The difference between the genders is greatest in Lombardy, where 7.2 percentage points separate male from female (in comparison with 4.1 in Emilia Romagna and 1.4 in Umbria).

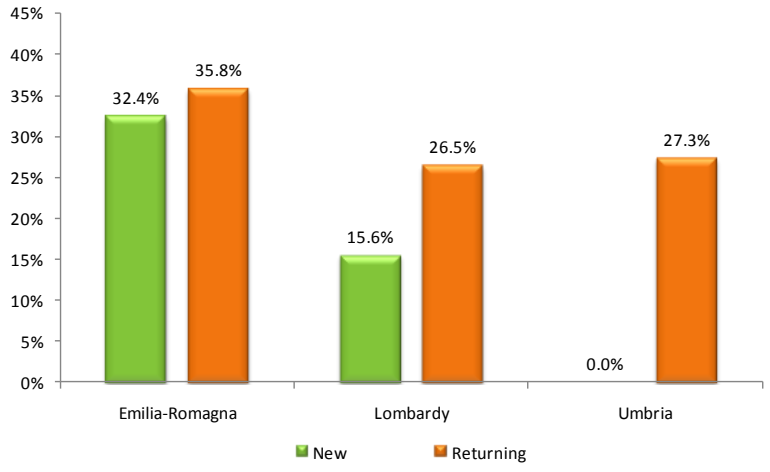
Figure 6.9: Prevalence of injecting drug users tested for HBV who tested Positive, by gender. The year 2012



Source: Based on data from the SIND information flow

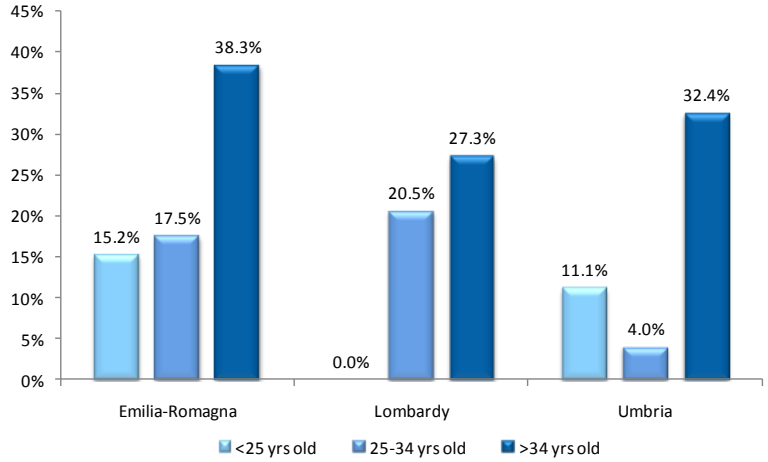
Unlike the situation for HIV, there was a higher prevalence of subjects tested for HBV who tested positive among returning clients than among new.
In Emilia Romagna, clients tested for HBV who tested positive were 35.8% of returning clients and 32.4% of new; in Lombardy, the figures stood at 26.5% of returning vs. 15.6% of new, while in Umbria the difference was greater: 27.3% of returning vs. 0.0% of new (Figure 6.10).

Figure 6.10: Prevalence of injecting drug users tested for HBV who tested Positive, by treatment type. The year 2012



Source: Based on data from the SIND information flow

Figure 6.11: Prevalence of injecting drug users tested for HBV who tested Positive, by age group. The year 2012



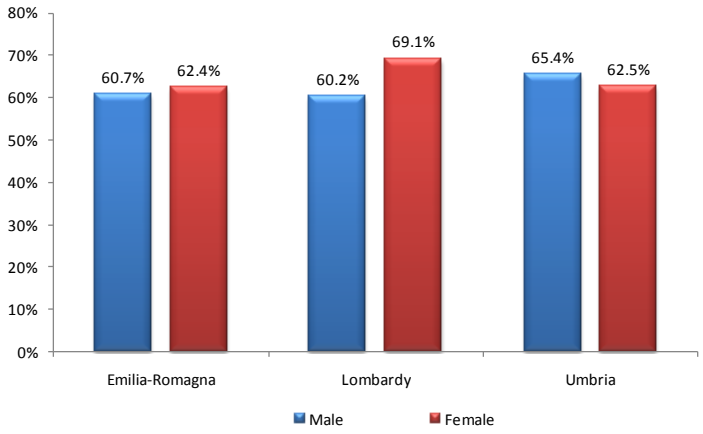
Source: Based on data from the SIND information flow

In addition to gender and type of treatment, we can also analyse prevalences of subjects tested for HBV by age group. Data shows the highest prevalence of positive test results among subjects greater than 34 years of age: 38.3% in Emilia-Romagna, 27.3% in Lombardy, 32.4% in Umbria (Figure 6.11).
In Umbria, the situation differs slightly from that in the other two Regions: the second age group (25-34 years of age) accounts for a lower percentage than the youngest age group (<25 years of age).

Hepatitis C Virus (HCV)

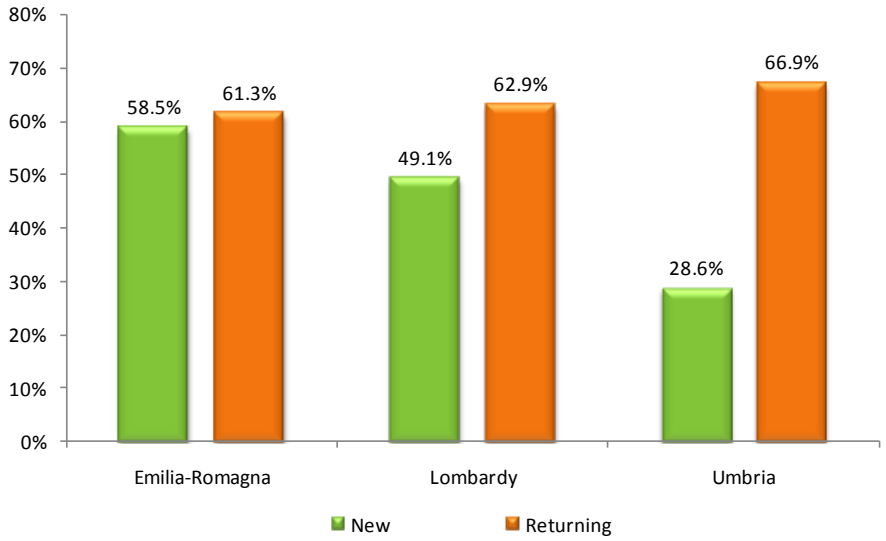
Among subjects tested for the hepatitis C virus, a higher number of women tested positive for the disease than men in Emilia Romagna and Lombardy. In Umbria, on the other hand, the highest percentage was among men: 65.4% of men vs. 62.5% of women (Figure 6.12).

Figure 6.12: Prevalence of injecting drug users tested for HCV who tested Positive, by gender. The year 2012



Source: Based on data from the SIND information flow

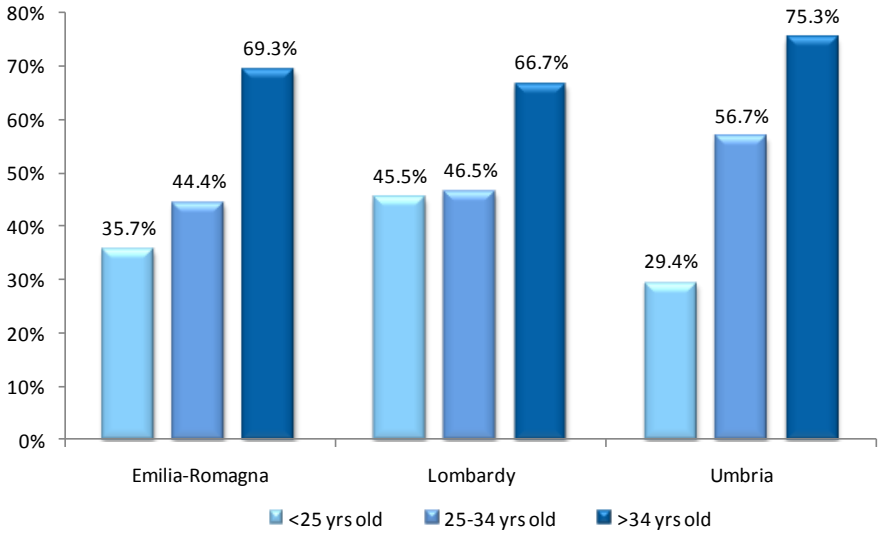
Figure 6.13: Prevalence of injecting drug users tested for HCV who tested Positive, by treatment type. The year 2012



Source: Based on data from the SIND information flow

As was also the case for HBV, there was a higher prevalence of HCV-positive test results among returning clients tested (over 60%) in comparison with new (58.5% in Emilia-Romagna, 49.1% in Lombardy, 28.6% in Umbria), with the greatest difference (38 percentage points) being observed in Umbria (Figure 6.13).

Figure 6.14: Prevalence of injecting drug users tested for HCV who tested Positive, by age group. The year 2012



Source: Based on data from the SIND information flow

When comparing prevalences between different age groups, we find a more delineated trend for HCV than for HBV. Subjects younger than 25 have the lowest percentage prevalence, while subjects older than 34 have the highest percentage prevalences. The minimum variance between the two percentages was 21 percentage points, and the highest was 46.

6.3 Other drug-related health correlates and consequences: drug-related traffic accidents

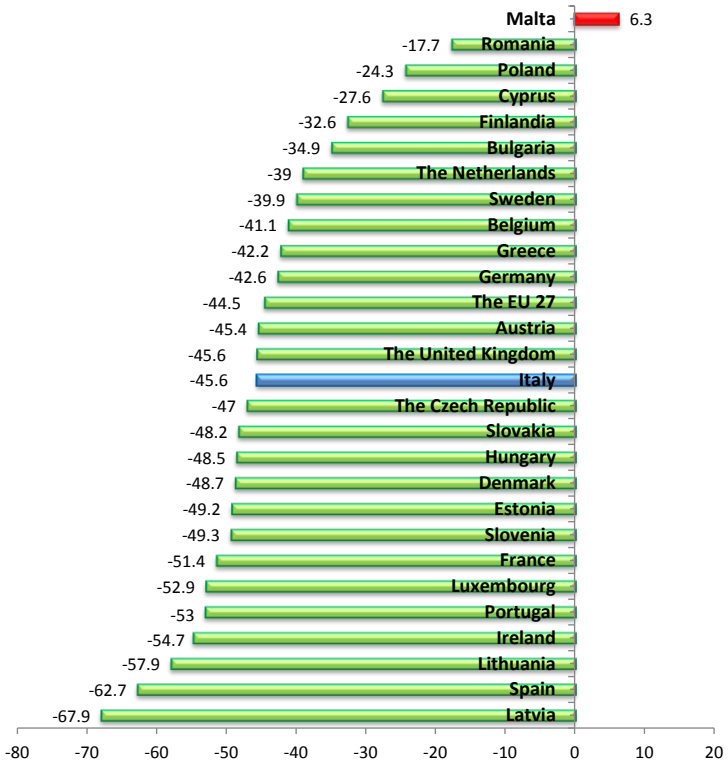
According to the World Health Organisation, traffic accidents are the ninth most-common cause of death among adults worldwide, the first most-common among young people 15-19 years of age and the second most-common both among children ages 10 to 14 and among young adults age 20 to 24. Furthermore, it is estimated that, unless appropriate measures are taken to counter this phenomenon, traffic accidents will represent the third-greatest cause of death and disability worldwide by the year 2020.
There are a number of different factors which can contribute to this phenomenon: the behaviour and physical-psychological state of the driver; vehicle condition and vehicle safety; traffic circulation patterns; the dangers linked to the transportation of hazardous products.

The EU goal for the reduction of mortality linked to drug-related traffic accidents

The European Union's White Paper of 13 September 2001 set a goal that mortality caused by traffic accidents would have fallen by 50% by 2010. The 27 EU nations have pursued this goal, achieving an average reduction of 42.9% (42.4% for Italy). In 2011, Italy had not yet achieved the goal, even if the recorded decrease of -45.6% was greater than the European average (-44.5%). Expressed as absolute values, the number of deaths fell from 4,090 in 2010 to 3,860 in 2011, a 5.6% decline.
In comparison with other large European nations, Italy is behind Spain (-62.7%), Portugal (-53.0%) and France (-51.4%), has come even with the United Kingdom and is ahead only of Germany (-42.6%) (Figure 6.15).

Figure 6.15: Deaths in traffic accident in Member countries of the European Union (the EU27), percentage variations. The years 2001-2011

Percentage variations in the numbers of deaths in traffic accidents

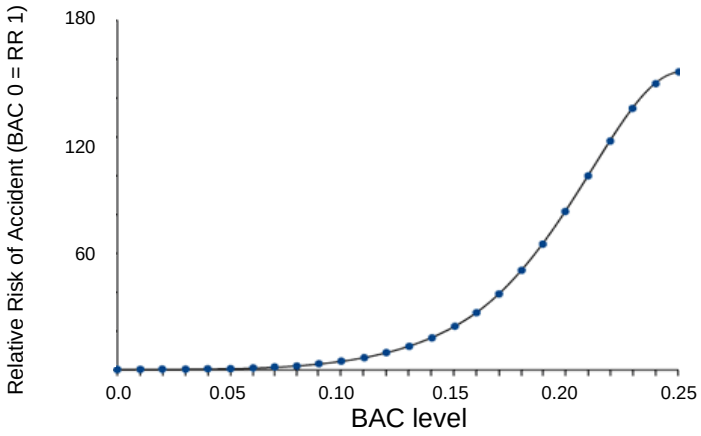


Source: the 2012 Automobile Club of Italy (ACI) and National Institute of Statistics (ISTAT) Report

Among the causes of traffic accidents which are connected to the driver's

state, both alcohol and drugs play important roles, the former having greater weight in the case of serious or fatal traffic accidents and the latter becoming especially dangerous when in combination with the former.

Figure 6.16: Estimate of risk of fatal crash involvement (accidents involving only one vehicle) by BAC level



Source: the National Monitoring Centre for Alcohol

Faced with this sort of evidence, the WHO affirms that there are no safe alcohol levels when driving, and that an "alcohol-free" driving environment should therefore be taken into consideration.
This notwithstanding, driving under the influence of alcohol is taken to mean when the blood alcohol concentration (BAC) is above the legal limit, which, in Italy, is 0.5 grams per litre. Revisions of the literature and experience at the European and international levels show that a blood alcohol level of between 0.5 and 0.5 grams/litre is already associated with a risk of involvement in a fatal accident that is 3 times the risk in comparison with a blood alcohol level of zero (this rises to 6 times the risk at levels of between 0.5 and 0.8 and 11 times the risk at levels of between 0.8 and 0.9). This can also be seen in Figure 6.16.
If we look at absolute numbers for accidents, we find that a comparison of 2010 and 2011 data shows no significant change in those indicators linked to alcohol. Those linked to drug use, however, increased, especially with regard to fatalities (Table 6.6).

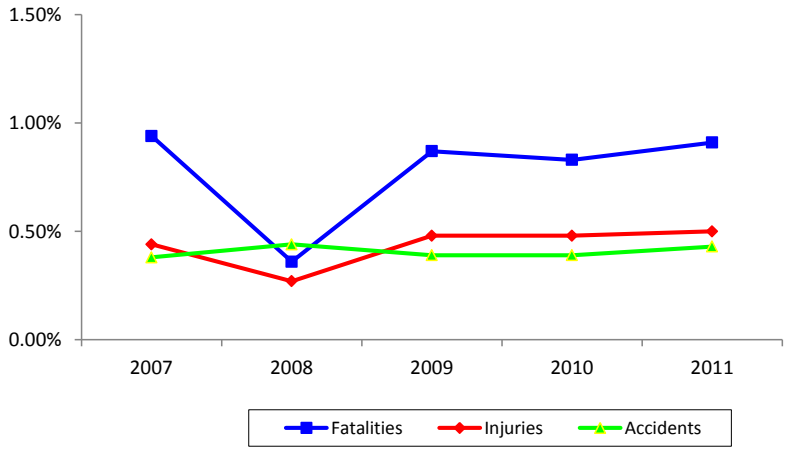
Table 6.6: Traffic accidents (fatalities and injuries) and their causes; absolute values and percentages. The years 2010-2011.

	2010			2011		
	Acciden	**Fatalities**	**Injuries**	**Accidents**	**Fatalities**	**Injuries**
Alcohol	5,400	136	8,276	5,211	122	8,095
Drugs	848	35	1,489	886	35	1,472
Total	**6,248**	**171**	**9,765**	**6,097**	**157**	**9,567**
No substance	209,157	4,066	297,493	199,541	3,703	282,452
Grand Total	**215,405**	**4,237**	**307,258**	**205,638**	**3,860**	**292,019**
Alcohol	2.51%	3.21%	2.69%	2.53%	3.16%	2.77%
Drugs	0.39%	0.83%	0.48%	0.43%	0.91%	0.50%
Total	**2.90%**	**4.04%**	**3.17%**	**2.96%**	**4.07%**	**3.27%**

Source: Department for Anti-drug Policies (DAP), based on data from the National Institute of Statistics (ISTAT)

Over 4% of fatalities in 2010 and 2011 were officially caused by alcohol or drugs

Figure 6.17: Trends in fatalities and injuries caused by drug-related traffic accidents in Italy, the years 2007-2011; percentage values



An increase in fatalities in drug-related traffic accidents

Source: Based on data from the National Institute of Statistics

Focusing our attention on drug-related traffic accidents, we find that there was a slight increase in the number of these types of accidents and in the number of fatalities caused by them in 2011 (in comparison with the previous two-year period); the percentage of injuries in these types of accidents, however, remained largely stable with respect to the 2009 and 2010 percentages. This indicates that, in addition to having increased in number, the drug-related accidents have also become more frequently fatal in comparison with previous years.

6.4 Drug related deaths and mortality of drug users

6.4.1. Drug-induced deaths (overdoses)

As per the instruction of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon, the following section on the mortality of drug users will be divided into deaths by acute intoxication, or overdose, and deaths among drug addicts due to other causes. This section will address the former, while the following section will examine the deaths of patients hospitalised for drug-related diseases.
In Italy, incidences of overdose are recorded in the Special Death Register of the Central Directorate for Anti-Drug Services of the Ministry of the Interior, where incidents in which the Police Forces have been involved are recorded on an evidential basis (i.e. unmistakable signs of drug-induced intoxication).

Table 6.7: Deaths by overdose, by gender and year of death. The years 1999 – 2012.

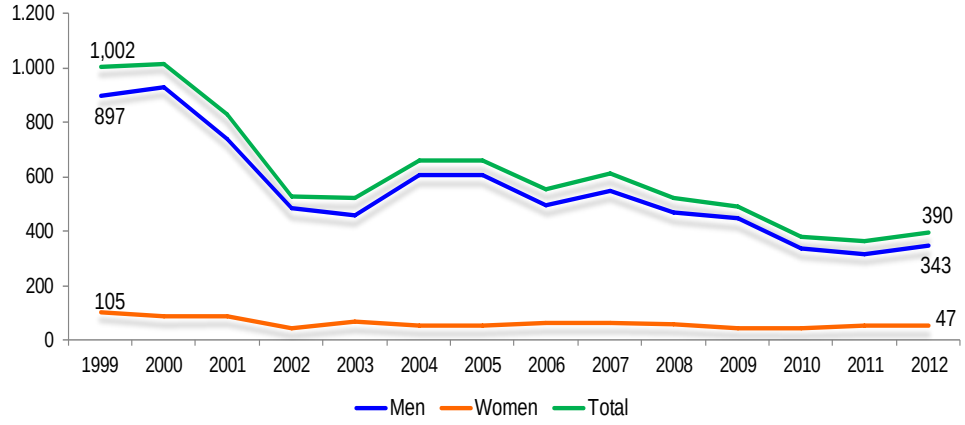
	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
M	897	931	737	478	454	602	602	492	546	462	440	332	314	343
F	105	85	88	42	63	51	51	59	60	55	44	42	48	47
Tot.	**1002**	**1016**	**825**	**520**	**517**	**653**	**653**	**551**	**606**	**517**	**484**	**374**	**362**	**390**
M/F	8.5	11.0	8.4	11.4	7.2	11.8	11.8	8.3	9.1	8.4	10.0	7.9	6.5	7.3

Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services

Data provided by the Central Directorate for Anti-drug Services show that, after 1999, a year in which 1,002 deaths by overdose were recorded, there was a decline in the phenomenon which lasted until 2003, when the number of deaths was 517. Numbers remained largely stable from 2004 to 2007, albeit with some limited variability, at between 551 and 653 deaths. The following years saw a new decline, with numbers reaching their lowest point in 2011, but rising by 7.7% in 2012, when there were 390 deaths (Figure 6.18). The direction of the trend has been largely similar for men and women, although the ratio of male to female deaths is approximately 9 men per every one woman (9.3); this ratio fluctuates between a minimum of 6.5 in 2011 (when 13.3% of the deaths were among women) and a maximum of 11.8 in 2004-2005 (when women accounted for 7.8% of these deaths) (Table 6.7).

The trend in recent years has been a decline in the number of drug-related deaths, although there was a slight increase in 2012 in comparison with 2011

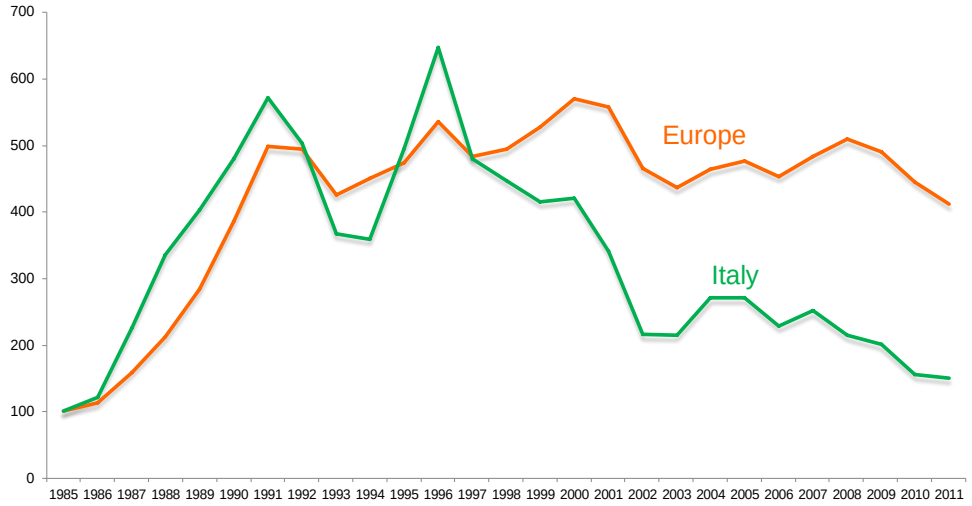
Figure 6.18: Deaths by overdose, by gender and year of death. The years 1999-2012



Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services (CDAS)

The number of deaths by acute drug-induced intoxication (overdose) in Europe and Italy shot up during the Nineteen-Eighties and early Nineteen-Nineties. In Italy, these deaths were mostly linked to heroin use and injecting drug use. Beginning in 1997, this mortality rate in Italy began a progressive decline which continued until 2002, probably due to the increase, during those years, in the number of facilities offering treatment services and to diversification in choice of drug type on the part of users. During the following period, spanning the years from 2003 to 2009, the trend levelled off at slightly highers numbers, unlike the European average trend, which also levelled off, but at levels which were higher. During the final two years of the period of reference, the trend in index values took a slight downturn (Figure 6.19).

Figure 6.19: Trends in index values for deaths by acute drug-induced intoxication (overdose) in Europe and in Italy. The years 1985 – 2011 (Base year 1985=100)

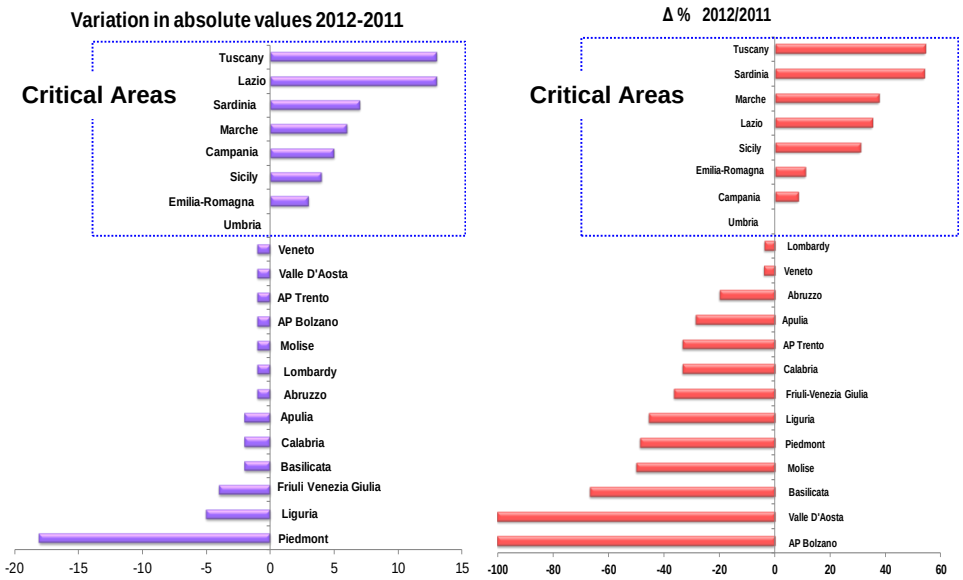


Greater decrease in deaths in Italy than in Europe overall

Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services and the European Monitoring Centre for Drugs and Drug Addictions – 2013 Statistical Bulletin

The trend in deaths by acute drug-induced intoxication (overdose) nationwide (by area where the fatality was discovered) over the last ten years shows the majority of overdose deaths occurring in the country's centre and south, with only slight variability throughout the period of reference. 2012 saw a decrease in deaths in the north of Italy and an increase in deaths in the central areas of the country. Meanwhile, the figure in Southern Italy/the Islands remained largely unchanged.
If we analyse the differences in absolute values and percentage variation values in comparison with the previous year, by Region, we find that the most "critical" regions are Tuscany, Sardinia and Lazio. On the other hand, the situation with regard to drug-related deaths improved in the Regions of Piedmont and Liguria (Figure 6.20).

Figure 6.20: A comparison of drug-related deaths. The years 2011-2012



The following Regions saw an increase in the number of deaths in 2012: Tuscany, Lazio, Sardinia, Marche, Campania, Sicily and Emilia Romagna

Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services (CDAS)

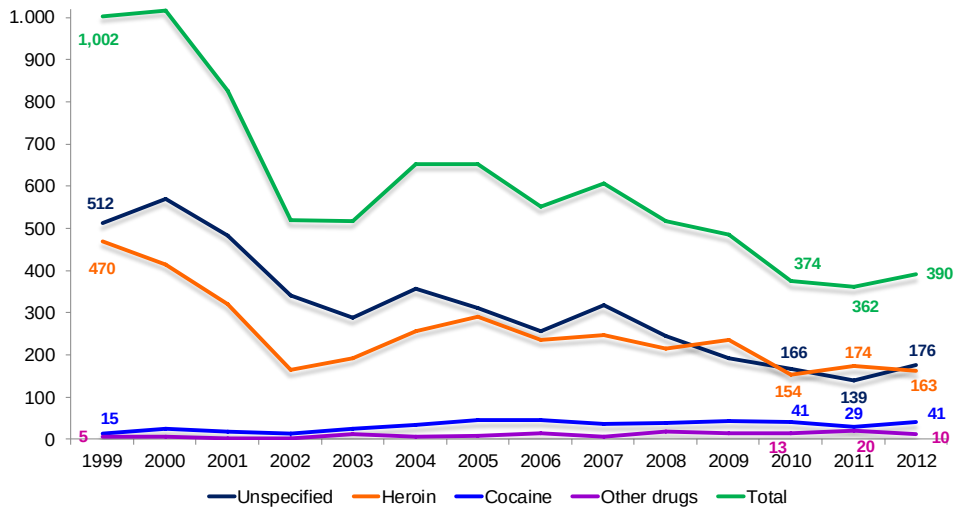
Of all drugs, heroin is the number one cause of death

In approximately 45% of deaths recorded in 2012 it was not possible to detect the drug which had presumably caused the death. In approximately 42% of cases, the cause of death could, with reasonable certainty, be traced back to heroin, while in 11% of cases it could be traced back to cocaine, to methadone in 2% of cases and to other substances in the remaining 1%. Heroin therefore reaffirms its place as the drug which causes the greatest number of deaths and drug addictions. In 2010, the average age at death for subjects dying of heroin overdose was 38, while it stood at 35 for cocaine overdose victims.

Decline in number of heroin overdoses, increase for cocaine

After 1999, when 470 deaths attributed to heroin were recorded, there was a decline in the phenomenon. This decline lasted until 2002, when the number of deaths fell to 165. Between 2004 and 2009, with the exception of a peak in 2005, numbers remained largely stable at between 200 and 250 cases per year. During the last three years of the period of reference, figures were lower (154 in 2010 and 174 in 2011) and in 2012 there was a 6.3% decrease over the previous year's number. As far as regards deaths attributable to cocaine overdose, this figure rose slowly but steadily until 2010, then dropped dramatically in 2011; in 2012, however, it shot up by 41.4%, with the number rising from 29 to 41 deaths (Figure 6.21).

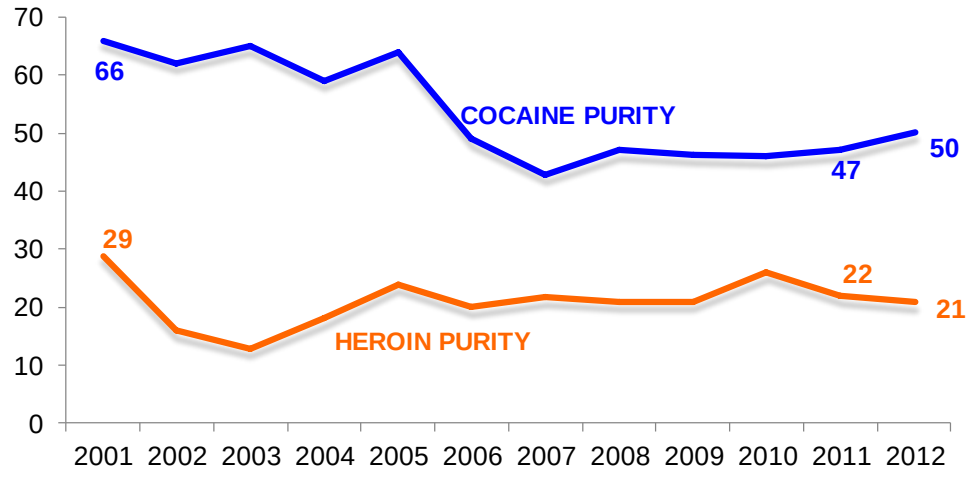
Figure 6.21: Percentage of deaths by acute drug-induced intoxication (overdose) by drug type. The years 1999 – 2012



Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services (CDAS)

When separating these deaths according to drug type, we also examined the trend in percentages of active principle in the principal drugs in the study. Cocaine, in particular, showed a strong decline in purity beginning in 2006, with levels remaining stable until 2011. In 2012 there was found to be a slight increase in the average percentage of pure drug cocaine contained as it rose from 47% to 50% (Figure 6.22).

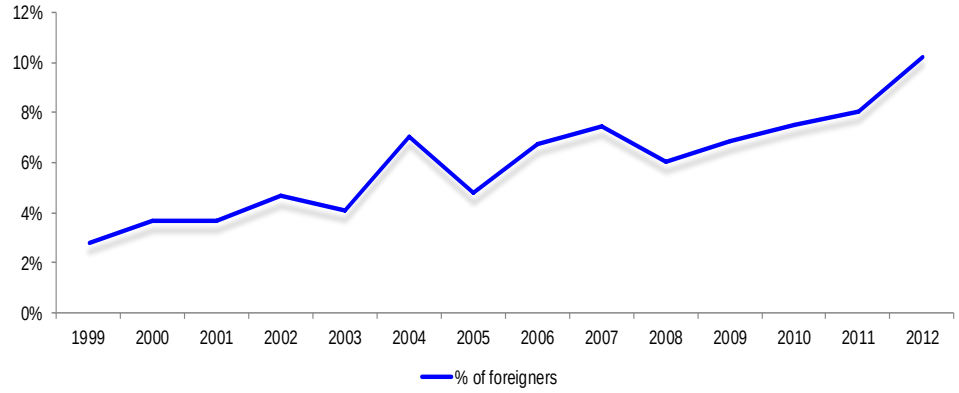
Figure 6.22: Average percentage of active principle in cocaine and heroin. The years 2001-2012



Source: Based on data from the Ministry of the Interior - Central Anti-crime Directorate of the State Police

The number of deaths among foreigners in our country (Figure 6.23) has risen, albeit unsteadily, over the last ten years, from over 3% at the beginning of the period of reference to over 10% in 2012.

Figure 6.23: Percentage distribution of deaths by overdose among the foreign population. The years 1999 – 2012



An increase in the percentage of foreigners among overdose cases

Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services (CDAS)

6.4.2. Mortality and causes of deaths among drug users

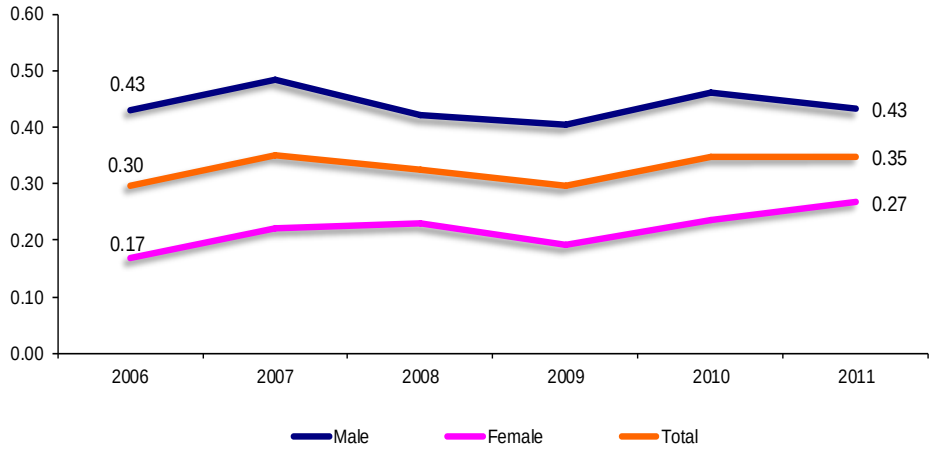
Acute intoxication from one or more psychoactive drugs is the most common cause of death among drug users, but the phenomenon of mortality extends to other causes as well, some less immediately "attributable" to the direct effect of the same drug (death from heart problems or liver disease) or deaths indirectly related to the use of drugs (e.g. accidents, medical conditions or diseases directly linked to, but different from, acute intoxication [overdose]).

It is still difficult to reconstruct the various causes of drug-related deaths

Attribution of cause of death is based upon the first diagnosis of cause of death made by the doctor certifying death or by the doctor conducting the post-mortem examination, and not upon specific clinical documentation.

There is therefore an issue of proper and complete clinical verification of the “initial cause”, or, in other words, “the disease, or cause, which set off the chain of events which resulted in death”.

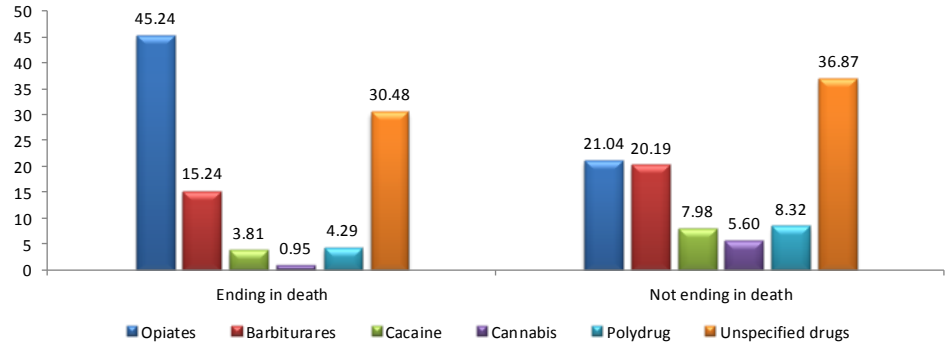
Figure 6.24: Rate of drug-related hospital admissions ending in death (hospitalisations per 100,000 population), by gender. The years 2006 – 2011



Source: Based on information contained in Hospital Discharge Records – Ministry of Health

Premature death, which may occur in the cases of very young people as well as people who are not necessarily addicted or in chronic situations, can be the result of either natural causes (above all infections and cardiovascular problems/complications) or non-natural causes (overdose, suicide, homicide, traffic and workplace accidents). These elements, however, are rarely recorded as being linked to the effects of drugs. Additional information regarding drug-related deaths, although only partial compared to the above, may be deduced from analysis of hospital discharge forms from cases of drug-related hospital admissions.

Figure 6.25: Percentage distribution of drug-related hospital admissions ending in death and not ending in death, by drug type. The year 2011

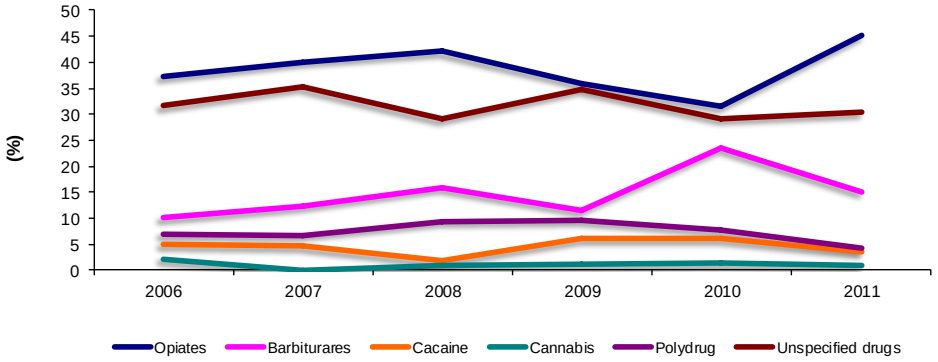


Source: Based on information contained in Hospital Discharge Records – Ministry of Health

In 2011, as in previous years, hospital admissions ending in death account for less than 1% of total drug-related hospital admissions (210). A comparison of rates of hospital admissions ending in death over the last five years shows a decline during the period from 2007 to 2009 (206 in 2007, 192 in 2008 and 177 in 2009) followed by an increase in deaths during the last two years (208 in 2010 and 210 in 2011). If we consider the numbers by gender, we find an increase of 0.84% in deaths among female

patients hospitalised for drug-related reasons (this percentage stood at (0.64% in 2009 and 0.7% in 2010). On the other hand, the percentage of deaths fell by 0.96% among male patients hospitalised for drug-related reasons (0.86% in 2009 and 1.0% in 2010).

Figure 6.26: Percentage of drug-related hospital admissions ending in death, by drug type. The years 2006 - 2011



Source: Based on information contained in Hospital Discharge Records – Ministry of Health

Between 2006 and 2011, the drugs which caused the greatest numbers of deaths were opiates; deaths caused by opiates increased until 2008 (37.4% in 2006, 40.3 % in 2007 and 42.2% in 2008) and then decreased in 2009 and 2010 (36.2% in 2009 and 32.7% in 2010); this trend changed direction over the most recent two-year period (45.2% in 2011). Deaths caused by unspecified substances also rose during the most recent two-year period (29.3% in 2010 and 30.5% in 2011). Of those drugs which caused lower percentages of deaths, the number of deaths caused by barbiturates fell by 8.3 percentage points over the last two years, from 49 deaths in 2010 to 32 in 2011; subjects over 65 years of age are those most affected (22 deaths in this age group).

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

First approaches to harm reduction in Italy

Italy had its first experiences in preventing drug-related diseases in the early 1990s. These largely involved the need to deal with the emergency that was the spread of HIV among drug addicts. These initial experiences were extremely important, from both epidemiological and epistemological standpoints. In other words, while they proved effective at combating the spread of HIV, they also made a marked contribution to consolidating a pragmatic approach to drug addiction. This was the beginning of the shift towards contacting and "taking into care" those who, because at that time in their lives they did not wish to stop using drugs, were not receiving treatment from addiction services.
After over fifteen years of working to prevent the spread of drug-related diseases and to reduce the risk and the harm caused by drugs in Italy, the range of services and initiatives continues to be heterogeneous and diversified, despite the fact that the anti-drug strategy of the Council of Europe still places particular emphasis on the importance of reducing harm in social and health spheres.

7.1. Prevention of drug-related emergencies and reduction of drug-related deaths

Goals of the National Action Plan on Drugs

The 2010 – 2013 National Action Plan on Drugs devotes a large section to the treatment and prevention of drug-related diseases, with a specific action area covering the following goals:

1. To further integrate drug-related disease prevention as a part of treatment programmes.
2. To establish new national operational guidelines for the launch, maintenance and/or refocusing of drug-related disease prevention activities throughout the country.
3. To prevent and reduce the risk of death by overdose.
4. To prevent and reduce the risk of acquiring and transmitting drug-related infectious diseases including HIV, the viral hepatitides, TBC and sexually transmitted diseases.
5. To launch gender-oriented programmes.
6. To prevent and reduce the social risks linked to drug use: marginalisation; discrimination; stigmatisation; involvement in criminal networks; incarceration; loss of positive social networks; prostitution; leaving school and loss of learning capacity; loss of employment and loss of production capacity.

Monitoring actions in drug-related disease prevention

During the course of 2013, the Department for Anti-drug Policies conducted a study to monitor actions at a Regional level in the sphere of drug-related disease prevention. These were divided according to objectives within the action area and evaluated in relation to the National Action Plan on Drugs 2010-2013.

The radar charts below show the points assigned to each goal in each Region, based on the following scale of “compliance”:

1: no information (level close to radar chart origin)

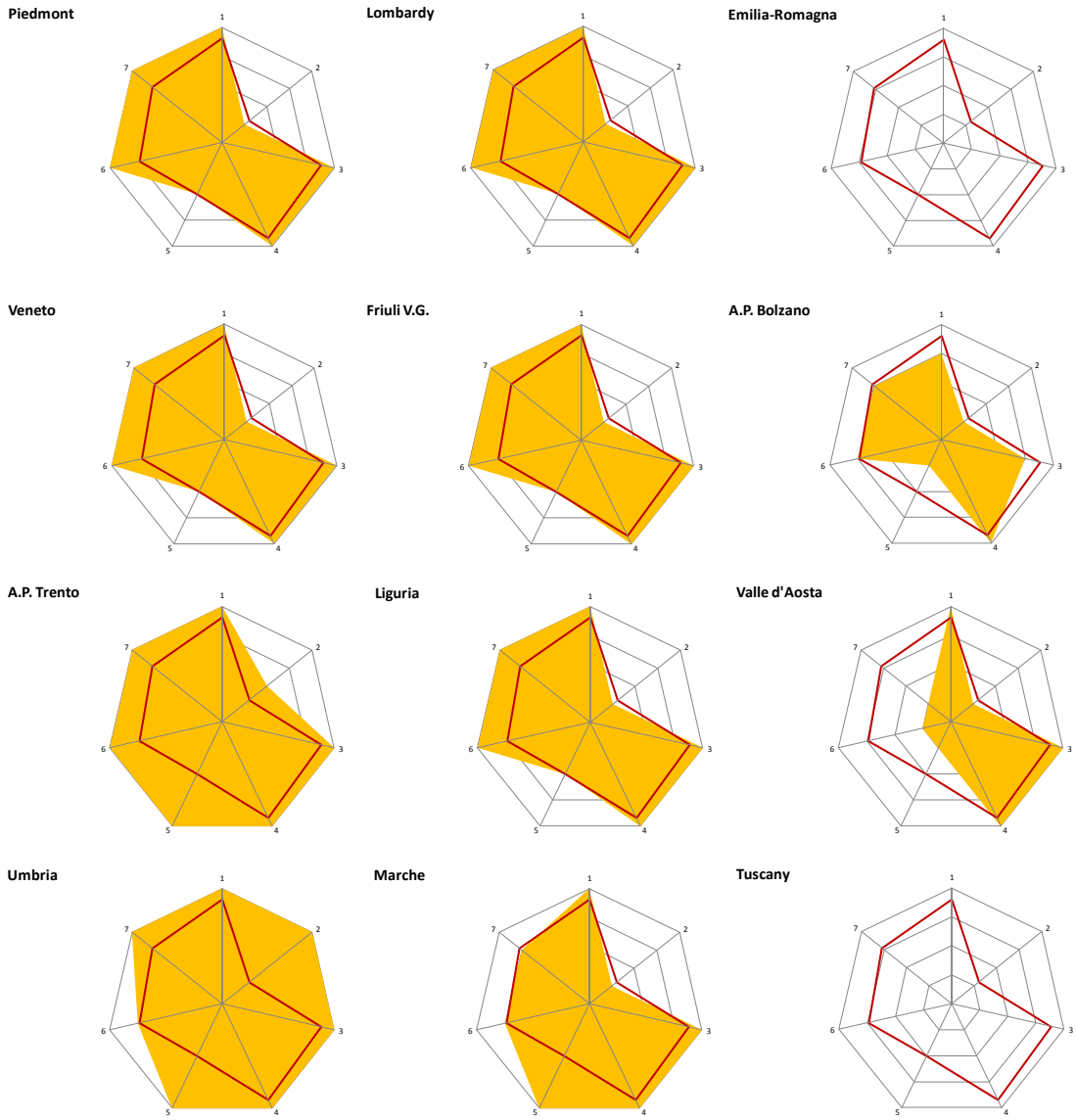
2: goals are present in the Region

3: goals actualized through project activities

4: goals actualized through routine activities (level corresponds to most external circumference of radar chart).

The red lines represent the national average obtained by calculating the arithmetic mean of the points obtained for each of the goals in each Region and Autonomous Province being evaluated.

Figure 7.1: Regions/A.P.s and their scores for actualization of goals in the Prevention of Drug-related Diseases Action Area of the NAPD – the year 2012



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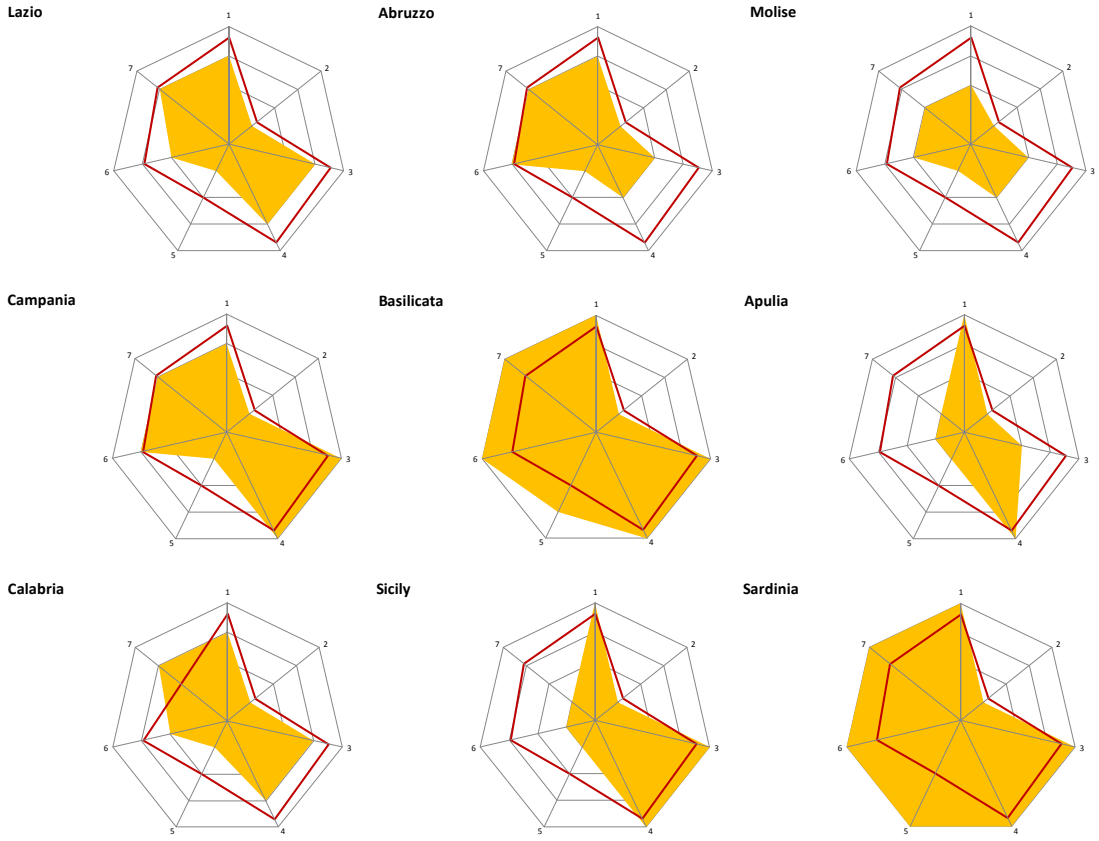


NAPD Goals – Chart Key:

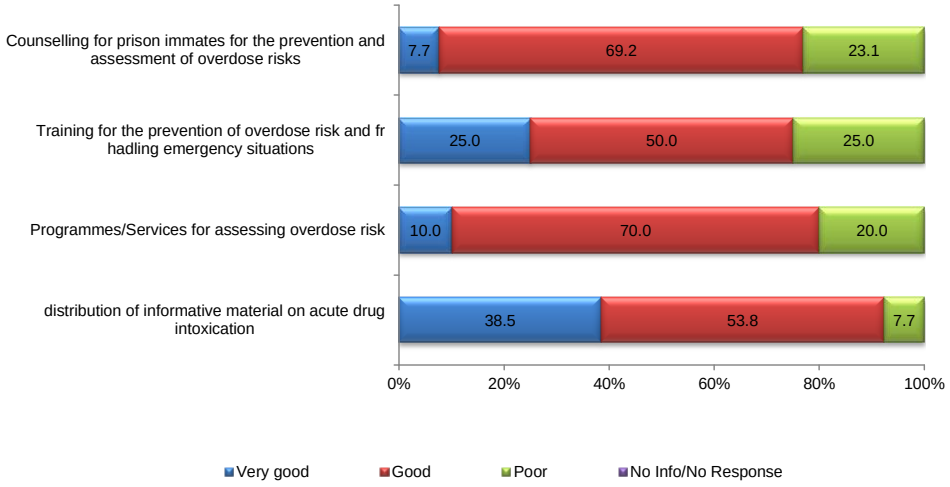
1. Integrating the prevention of drug-related diseases with treatment initiatives
2. New national operational guidelines and new directions for work to prevent drug-related diseases
3. Reducing risk of death by overdose
4. Reducing transmission of infectious diseases such as HIV, viral hepatitis, etc.
5. Activating gender-oriented programs
6. Reducing drug-related social risks
7. Reducing drug-related family problems

As the radar charts show, the NAPD actions for which no initiatives have been undertaken in any of the Regions or Autonomous Provinces but one are the following: defining new national operational guidelines and directions for work to prevent drug-related diseases at a Regional level and the activation of gender-oriented programmes. In most cases, these two goals are either absent from the Regions or present as goals only within Regional plans. The exception is the Region of Umbria, which reported having launched routine activities encompassing all the actions set forth by the NAPD.
Turning our attention to actions to reduce the transmission of HIV, hepatitis and other infectious diseases, to reduce risk of death by overdose, to reduce drug-related social risks and drug-related family problems, we find that most of the Regions and APs have incorporated these as routine activities, especially in the northern Regions (Piedmont, Lombardy, Veneto, Friuli Venezia Giulia, Liguria and the A.P. of Trento) as well as in the Regions of Basilicata and Sardinia.
However, no data were received from Emilia Romagna or Tuscany.

The information collected from the Regional Administrations by means of Structured Questionnaire (SQ) 23 regarding the “Prevention and reduction of drug-related diseases and of acute drug intoxication mortality”, and specifically the reduction of drug-related deaths, shows a higher number

of priority programmes for the prevention of death by acute drug intoxication being in effect in 2012. In over 80% of Regions, informative material on the topic was distributed and counselling was provided to prison inmates for the prevention and assessment of overdose risk in that specific population. Only 50% of Regions had programmes/services for assessing overdose risk in effect or had conducted training for the prevention of overdose risk and for handling emergency situations. Assessment of availability (Figure 7.2) was generally good and stood at over 70% across the board.

Figure 7.2: Assessment of the availability of priority programmes for the prevention of death by acute drug intoxication. The year 2012



Source: Based on data from the survey conducted by means of EMCDDA questionnaires sent to the Regions

There were positive findings regarding prevention programmes in recreational venues (discotheques and other places) such as, for instance, the distribution of drug-use prevention information in 81.3% of discotheques and in 62.5% of other recreational venues. Findings regarding the placement of bins and containers for the deposit of illicit drugs, on the other hand, were negative, with none being present in the discotheques or other recreational venues of the Regions.
Other types of programmes, which had not been reported to exist in discotheques or other recreational venues by the Regions and Autonomous Provinces in 2011, returned to be reported by 18.8% of Regions and APs in the year of reference.
The availability of prevention programmes for discotheques and other recreational venues (distribution of information for the prevention and reduction of harm associated with drug use; the presence of personnel trained in emergency medical response; chill-out rooms) was generally good, with the exception of programmes falling under the category of "other".
The assessment of the training of emergency-response personnel was very positive.

In comparison with 2011, the amount of funds set aside for the prevention of acute mortality grew by nearly two-million euros (+23.9%). This was largely a consequence of the large investments made in this area by the Region of Lombardy.

2 million euros more than in 2011

The Regions launched targeted, structured services in support of policies and strategies encouraging the prevention of drug-related diseases and risk limitation.

In 2012, there were 110 structured services in existence in the Regions and Autonomous Provinces (10.6% fewer than in 2011) serving over eighty-thousand individual clients. The only type of service which increased its numbers in 2012 was that of street units (LRD) dealing with alcohol and other risks associated with nightlife.

49 street units for the prevention of drug-associated health risks.

Specifically, there were 49 street units for the prevention of drug-related health risks, 25 street units (LRD) dealing with alcohol and other risks associated with nightlife, 12 street units handling problems associated with prostitution, 14 daytime drop-in services, 3 24-hour low-threshold reception centres, 2 dormitories specialized in pathological addictions and 5 services providing for basic needs.

7.2. Prevention and treatment of drug-related infectious diseases

As described in previous chapters, the National Information System on Addictions (SIND), established under the SIND Decree of 11 June 2010, has taken the place of the previous aggregate data flow which existed under the Ministerial Decree of 20/09/1997. Under the new system, there have been a series of problems and technical difficulties (typical when launching complex new information systems) with the flow of information on 2012 client test results for HIV, the hepatitis B virus and the hepatitis C virus from the Regions to the Ministry of Health, as well as with the subsequent transfer of data to the Department for Anti-drug Policies (DAP). This has led to a significant decrease in the amount of data which can be used to create an updated representation of the national situation that incorporates the 2012 data on drug-related infectious disease test results. Data regarding hepatitis B and hepatitis C results are missing for approximately 80% of addiction-services clients, which makes it impossible to process the data for the DRID indicator.

Scale of the phenomenon in Italy

An analysis of data received from the Regions of Lombardy, Emilia Romagna and Umbria reveals a high variability between results for HIV tests conducted on new addiction services clients (results ranging from 0% to 5% HIV-positive among new clients tested) and returning clients (results ranging from 2% to 5% HIV-positive among returning clients tested).

There was also a certain amount of variability in results for new and returning clients tested for the hepatitis C virus. Among new clients tested during the year, the prevalence of HCV-positive results ranged between 12% and 22%, while the figure ranged from 40% to 55% among retuning clients.

Results for hepatitis B virus testing among new addiction services clients was largely in line with HCV-test results for the same population, ranging from 8% go 21% HBV-positive. Among returning clients, however, the number of HBV-positive results were lower than for HCV-test results in that population, ranging from 13% to 27%.

From an examination of Hospital Discharge Records from the three-year period from 2009-2011, we can see that the number of drug-related hospital admissions fell by 3.6% during that time, with a rate of 2 per thousand total hospital admissions. Medical emergencies accounted for most of these admissions, and there is still a high percentage of voluntary discharges (9.7%), a figure which is the same as it was in 2010. A

comparison with 2006 numbers reveals that drug-related hospital admissions mostly involve diagnoses of a psychiatric nature, traumas and poisonings. It is interesting to note that the number of drug-related hospital admissions with a principal or secondary diagnosis related to infectious diseases is in decline (5.3% of total drug-related hospital admissions in 2011 vs. 7.9% in 2006).

There has been an on-going, long-term decline in the number of drug-related deaths, a decline which has been sharper in Italy than in Europe as a whole. In 1999, there were 1,002 drug-related deaths, while in 2012 there were 390, a slight increase over the 2011 figure (+7.8%). There has also been an increase in the average age of death in these cases, which rose from an average of approximately 32 in 1999 to 37 in 2012.
Figures regarding death by acute intoxication in Italy over the last ten years show that the highest numbers of these deaths occur in the central-southern area of the country, despite some small variation over the course of the time period in consideration.
Of all drugs, heroin is the primary cause of death by overdose, responsible for 42% of deaths, a decrease with respect to the previous year's figure (48%). It is followed by cocaine, which is responsible for 10% of drug-overdose deaths, an increase over the 2011 figure (10%).

In the face of the significant decline over recent years in HIV, hepatitis B and hepatitis C testing being offered by drug addiction services, a decrease which could lead to substantial delays in the early diagnosis of said diseases and a consequent reduction of access to antiretroviral therapies, the Department for Anti-drug Policies, following the publication of the "Screening and early diagnosis of the principal drug-related infectious diseases" guidelines, has strongly supported the expansion of testing for these important infectious diseases among the drug-addicted population.

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

In order to encourage the adoption and application of these guidelines, in 2011 the DPA launched a targeted project, Early Diagnosis and Treatment of Drug-related Diseases (known as DTPI), which has been entrusted to the AIDS Operations Centre of the Higher Institute of Health. 70 centres for addiction care were operationally involved in this initiative in 2012.

Publication of "Drug Use and Drug-related Infectious Diseases" by the Department for Anti-drug Policies

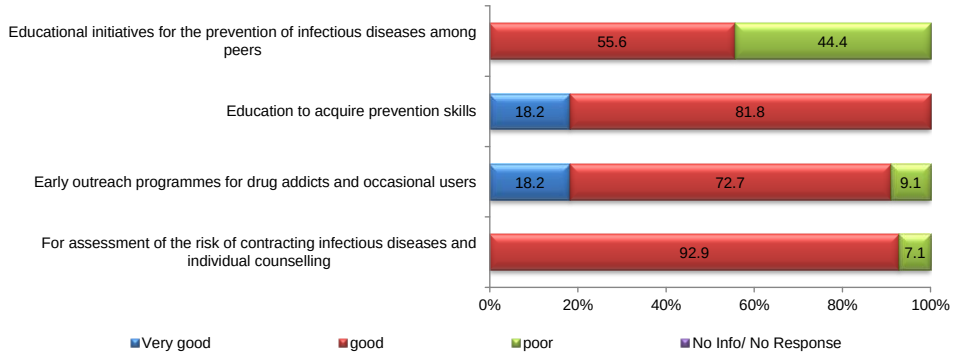
In addition to this initiative, in order to encourage the expansion of testing for these important diseases among the drug-addicted population, the DAP published a document in 2012, entitled "Drug use and drug-related infectious diseases". It promotes an "early detection" strategy which not only guarantees timely treatment for those in need, but also insures a reduction in numbers of individuals unwittingly infecting others. The document is intended for all medical doctors who treat patients with addiction problems: doctors working for drug-addiction services, general practitioners and other specialists, such as infectious disease specialists, who often treat patients are current or former drug users.

Initiatives for the prevention of drug-related infectious diseases in therapeutic communities and in prisons, by Region

Information regarding drug-related infectious disease prevention initiatives in prisons and in social-rehabilitation facilities was collected from Regional Administrations through the use of the EMCDDA structured questionnaire. It was found that the most common prevention initiatives were, specifically, those concerning infectious disease risk assessment and individual counselling, with 87.5% of the Regions and Autonomous Provinces reporting that such actions had been carried out both in therapeutic communities and in prisons; assessment of the availability of

early outreach programmes for drug addicts and occasional users was also good, at 68.8%. Availability of educational initiatives for the prevention of infectious diseases among peers within the prison environment was found to be poor, however, standing at only 25%.

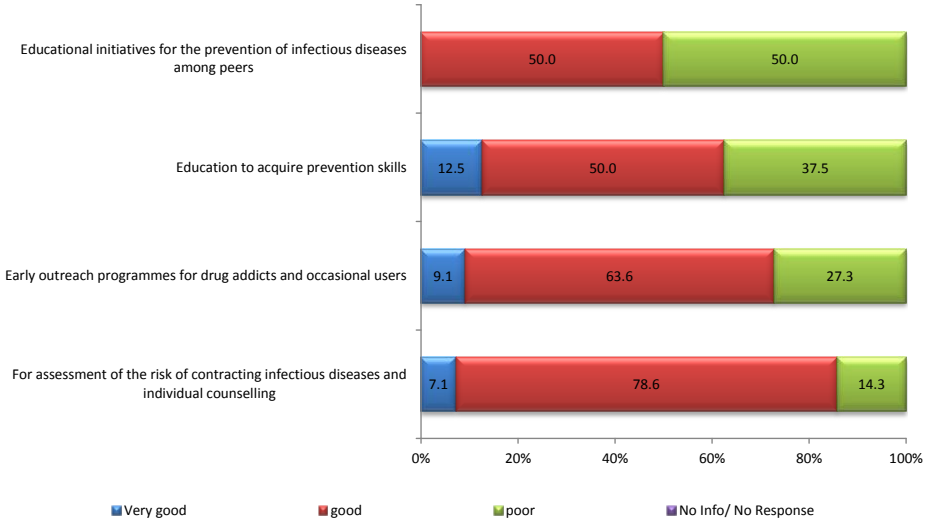
Figure 7.3: Assessment of availability of drug-related infectious disease prevention services in therapeutic communities – the year 2012



Source: Based on data gathered through EMCDDA structured questionnaires provided to the Regions

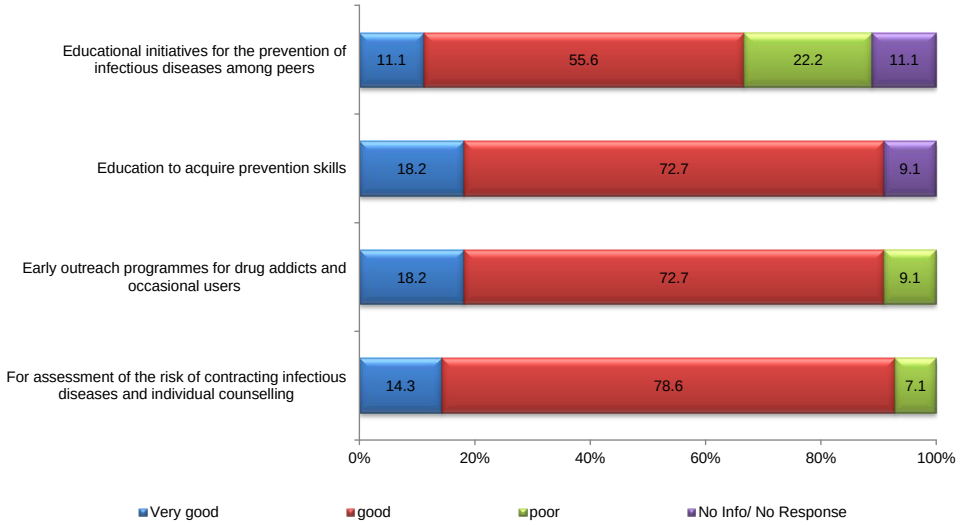
Assessments of the availability of infectious disease prevention services in therapeutic communities (Figure 7.3) and in prisons (Figure 7.4) returned overall positive findings, with services for assessing the risk of contracting infectious diseases and individual counselling services receiving especially high marks.

Figure 7.4: Assessment of availability of drug-related infectious disease prevention services in prisons – the year



Source: Based on data gathered through EMCDDA structured questionnaires provided to the Regions

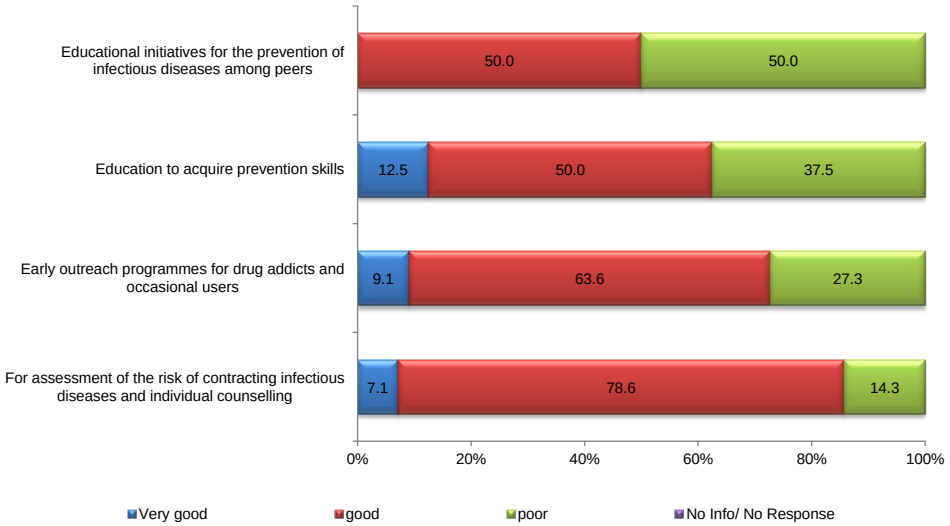
Figure 7.5: Assessment of accessibility of drug-related infectious disease prevention services in therapeutic communities – the year 2012



Source: Based on data gathered through EMCDDA structured questionnaires provided to the Regions

Accessibility of these services (Figures 7.5 and 7.6) was once again given a generally positive assessment. Specifically, the accessibility of services for the assessment of the risk of contracting infectious diseases and individual counselling was rated as good in both therapeutic communities (92.9%) and in prisons (85.7%).

Figure 7.6: Assessment of accessibility of drug-related infectious disease prevention services in prisons – the year 2012



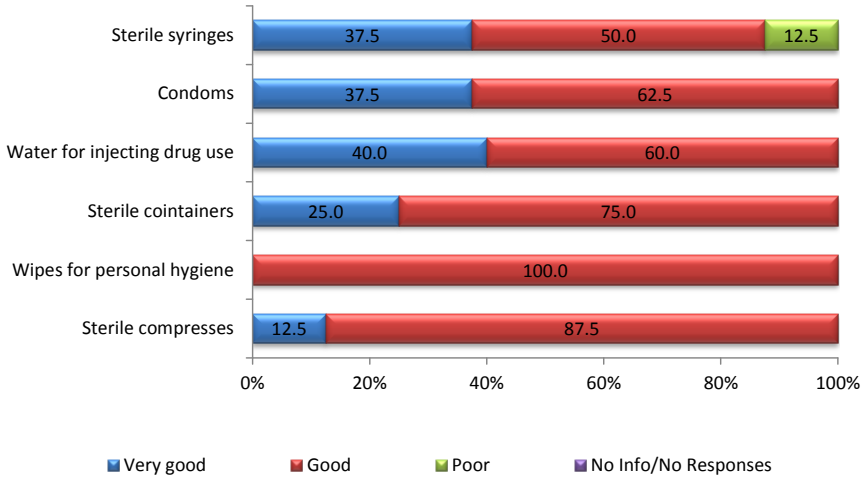
Source: Based on data gathered through EMCDDA structured questionnaires provided to the Regions

Few Regions and Autonomous Provinces have launched training initiatives to acquire prevention skills that target specific groups. To be precise, 56.3% have launched such initiatives for professionals in the drug addiction services field, 62.5% for those who work in prisons and 18.8% for other groups, while only 6.3% of such initiatives target pharmacists.
However, where they do exist, training initiatives were found to have a

very good availability assessment (over 90% on average) as well as an overall positive assessment of their accessibility.

No more than 50% of Local Public Drug Addiction Service Units (SerT) distribute training paraphernalia in the context of training programmes to acquire prevention skills. Specifically, none reported distributing tin foil for inhaling drugs.
Where paraphernalia was distributed however, assessments were good across the board, especially for water for injecting drug use and condoms (Figure 7.7).

Figure 7.7: Assessment of availability of paraphernalia (where it exists) to be employed in training to acquire prevention skills. The year 2012



Source: Based on data gathered through EMCDDA structured questionnaires provided to the Regions

8. SOCIAL CORRELATES AND SOCIAL REINTEGRATION

Foreword

This chapter is devoted to the social consequences for particularly vulnerable subjects who regularly use illicit drugs. Specifically, the profiles of marginalised subjects were analysed using the data on clients in care of local drug addiction services collected by means of the National Information System on Addictions (SIND) information flow.
The data presented in this chapter regard a group of 54,620 individuals in the care of addiction services in 2012 and was used for the purpose of completing the TDI tables. As has already been explained in Chapter 5, these data refer to 85% of the overall total number of clients receiving care from the service units from information was received.

Data sources

TDI data

The information flows employed as part of the Treatment Demand key indicator, which exist thanks to the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA), involve the gathering of data concerning subjects' living situations, in particular regarding the nuclear family within which the drug addict lives on a day-to-day basis and the type of accommodation it is. This information is collected by Drug Addiction Services and forms part of the core data that make up the individual information flow for each client undergoing treatment (the National Information System on Addictions [SIND] information flow).

SQ 28 data

Further information was recorded by providing the Regional Administrations responsible for issues concerning drug addiction with EMCDDA Structured Questionnaire SQ 28 to complete.

8.1 Social exclusion

8.1.1 Employment situations

50.5% of addiction services clients are employed; 34.2% are unemployed

An analysis of the characteristics of the individuals comprising the sample group of subjects makes it possible to sketch a profile of the employment situation of subjects undergoing treatment for drug use with drug addiction services.
In the sample group in question, it was found that 34.2% of all clients were unemployed, while 50.5% were employed in some capacity and in various ways (occasionally or continuously).

Table 8.1: Percentage distribution of drug addiction services clients according to type of employment, gender and type of client (new or returning). The year 2012

	New clients			Returning clients			Total		
Type of employment	**M**	**F**	**Tot**	**M**	**F**	**Tot**	**M**	**F**	**Tot**
Stable employment	39.9	31.2	38.4	43.9	32.6	42.3	42.1	31.9	40.5
Occasional employment	9.6	10.1	9.7	10.0	11.6	10.2	9.8	10.9	10.0
Unemployed	33.1	30.1	32.6	35.1	37.5	35.5	34.2	33.9	34.2
Student	8.4	13.9	9.3	3.0	6.5	3.5	5.4	10.1	6.1
Financially inactive	3.7	10.9	4.9	3.8	8.8	4.5	3.7	9.8	4.7
Other	5.3	3.9	5.1	4.2	3.0	4.0	4.7	3.4	4.5

Source: Based on data from the Ministry of Health

Higher level of unemployment among returning clients (35.5%)

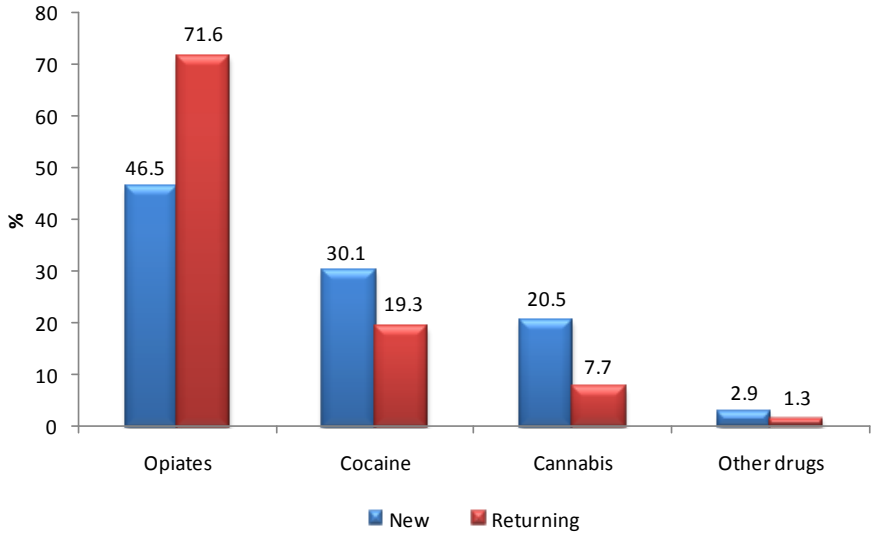
The employment situation appears to be more critical among returning clients, of whom 35.5% are unemployed, compared to 32.6% of new clients. Indeed, of returning clients, 37.5% are unemployed women while 35.1% are unemployed men.

However, when comparing these two groups based on employment rate, we find a higher figure among returning clients (52.5% vs. 48.1%). We find the opposite situation with regard to individuals who are still students. 9.3% of new clients are still studying, while the figure stands at just 3.5% for returning clients.

If we turn our attention to primary drug of use data and compare the percentage of opiate users among the unemployed with the percentage of opiate users in the client population as a whole, we can see that there is a higher percentage of opiate users among the unemployed than there is in the total sample group (61.0% of the unemployed vs. 55.5% of the total sample). On the other hand, there is a lower percentage of cocaine users among the unemployed than in the sample group as a whole (23.9% vs. 24.2%), a situation which is reflected among cannabis users (13.1% vs. 17.1%).

Among unemployed clients, we observe significant differences between new clients who use opiates and returning clients who use opiates (46.5% vs. 71.6%). We find the opposite situation for cocaine and cannabis users: the percentage of unemployed cocaine and cannabis users who are returning clients is significantly lower than the percentage of unemployed cocaine and cannabis users among new clients (10.8 and 12.8 percentage points less, respectively) (Figure 8.1).

Figure 8.1: Percentage distribution of unemployed drug addiction services clients according to drug type and type of client (new or returning) – The year 2012



Source: Based on data from the Ministry of Health

8.1.2 Homelessness

An analysis of the information flow makes it possible to identify specific characteristics of subjects undergoing treatment with drug addiction services which concern their housing situations (whether they have a permanent residence, live in some type of facility or are homeless).

A small percentage of addiction services clients are homeless (5.0%)

85.6% of the subjects of the analysis reported having a permanent residence, while 5.0% on the other hand, were found to be homeless.

An in-depth analysis based on gender and type of client (new or returning) shows that 83.9% of new clients and 87.3% of returning clients have a permanent residence, with more women having a permanent residence than men, regardless of whether they are new or returning clients. The

percentage of subjects who reported living in various types of facilities was, on the other hand, higher among new clients than among returning ones (10.7% vs. 8.0%). This reflects the situation among homeless clients (5.4% homeless among new clients and 4.7% among returning) (Table 8.2).

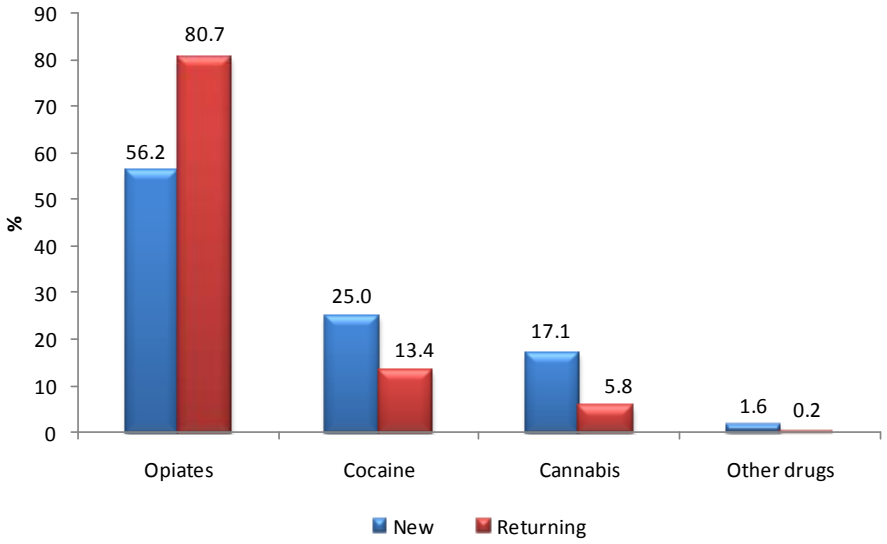
Table 8.2: Percentage distribution of drug addiction service clients according to housing situation, by gender and type of client (new or returning). The year 2012

	New clients			Returning clients			Total		
Housing situation	**M**	**F**	**Tot**	**M**	**F**	**Tot**	**M**	**F**	**Tot**
Permanent residence	82.5	91.7	83.9	86.6	91.3	87.3	84.6	91.5	85.6
In a facility	12.0	4.3	10.7	8.6	4.8	8.0	10.2	4.5	9.4
Homeless	5.5	4.1	5.4	4.8	4.0	4.7	5.2	4.0	5.0

Source: based on data from the Ministry of Health

In comparison with the population of drug addiction service clients as a whole, among homeless clients there is a higher percentage of opiate users (67.8% vs. 55.5%) and a lower percentage of cocaine users (19.5% vs. 24.2%) and cannabis users (11.7% vs. 17.1%).

Figure 8.2: Percentage distribution of homeless drug addiction services clients according to type of drug used and type of client (new or returning). The year 2012



Source: Based on information from the Ministry of Health

Disaggregating this information according to the type of user, we can see that the percentage of homeless opiate users in care of Local Public Drug Addiction Service Units (SerT) is lower for new clients in comparison with returning ones (56.2% vs. 80.7%), while the opposite is true for cocaine users (25.0% vs. 13.4%) (Figure 8.2).

8.2 Social reintegration projects

The 2010-2013 National Action Plan on Drugs includes, among its five principal action areas, one specifically devoted to the social and work reintegration of drug addicts. Rehabilitation and reintegration are a central and integral part of the action plan, as these two aims reinforce the belief

The 2010-2013 National Action Plan on Drugs

that it is not only possible, but also of fundamental importance to always and completely rehabilitate drug addicted individuals and fully reintegrate them into society. To this end, the National Action Plan puts forward a number of concrete solutions which involve the establishment of drug treatment units devoted solely to the goal of reintegration.

2010-2013 National Action Plan Goals

National Action Plan goals focusing on this area, which were flanked within the document by specific actions which should be undertaken in order to achieve them and indicators for monitoring their results, are listed below:

1. Ensure organisational conditions and availability of human, technological, logistical and financial resources suitable for reintegration work.
2. Reduce drug addicts' tendency to resort to criminal and illegal activities, as well as prostitution, by promoting targeted social and work reintegration programmes.
3. Standardise, on a national level, the principles and principal methods of rehabilitation and reintegration.
4. Promote concrete actions and targeted projects to increase the number of rehabilitation activities involving both the social and interpersonal spheres of drug addicts undergoing treatment with drug addiction services and in therapeutic communities.
5. Improve the education and professional skills of drug addicts undergoing treatment.
6. Encourage the development of operative units specialised in reintegration activities within Addiction Departments.
7. Integrate and coordinate reintegration activities among the various local agencies (Local Public Addiction Service Units [SerTs], therapeutic communities, local and provincial administrations, Local Health Authorities and associations of business owners).
8. Directly involve public companies and administrations (local governments, provincial governments, Local Health Authorities) in social and work reintegration activities for drug addicts through the allocation of contracts to social cooperatives operating in this sector.
9. Encourage the reintegration of drug addicts into the employment structure of ordinary businesses.
10. Orient organisations which deal with social and work reintegration towards developing corporate social responsibility programmes in order to encourage the creation of organisations for reintegration which are capable of generating their own income and thus self-financing their activities.
11. Promote a nationwide targeted project for social and work rehabilitation and reintegration, in order to support the process of innovation in this sphere throughout the country.

Monitoring actions at a Regional level in the action area of rehabilitation and social and work reintegration of drug addicts

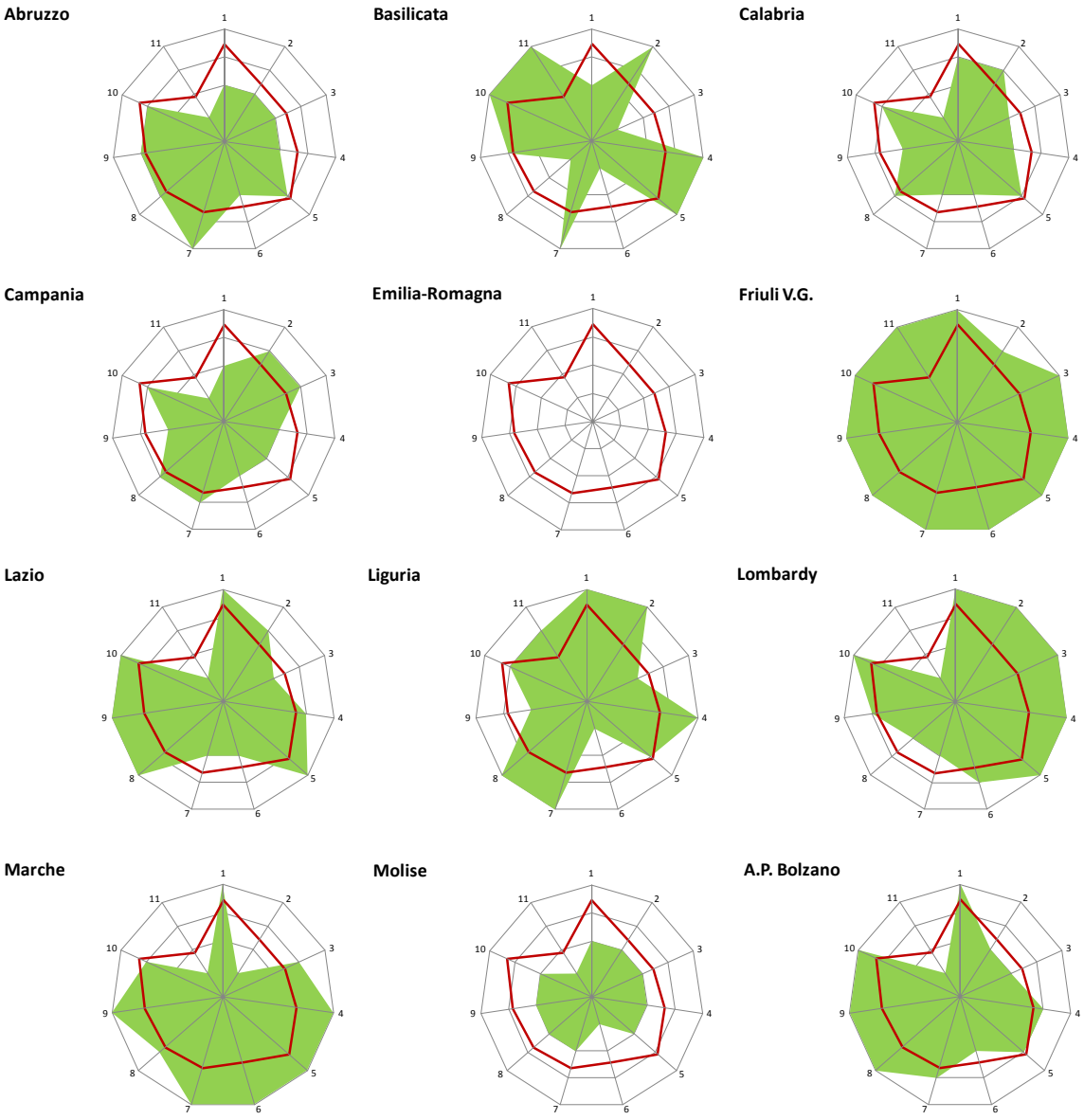
During the course of 2013, a study was conducted to monitor actions conducted by the Regions and Autonomous Provinces in the sphere of rehabilitation and social and work reintegration of drug addicts, divided according to objectives within the action area and evaluated in relation to the National Action Plan on Drugs 2010-2013.

The radar charts below show the points assigned to each goal in each Region, based on the following scale of “compliance”:

1: no information (level close to radar chart origin)
2: goals are present in the Region
3: goals actualized through project activities
4: goals actualized through routine activities (level corresponds to most external circumference of radar chart).

The red lines represent the national average obtained by calculating the arithmetic mean of the points obtained for each of the goals in each Region and Autonomous Province being evaluated.

Figure 8.3: Regions/A.P.s and their scores for actualization of goals in the Rehabilitation and Reintegration Action Area of the NAPD – the year 2012



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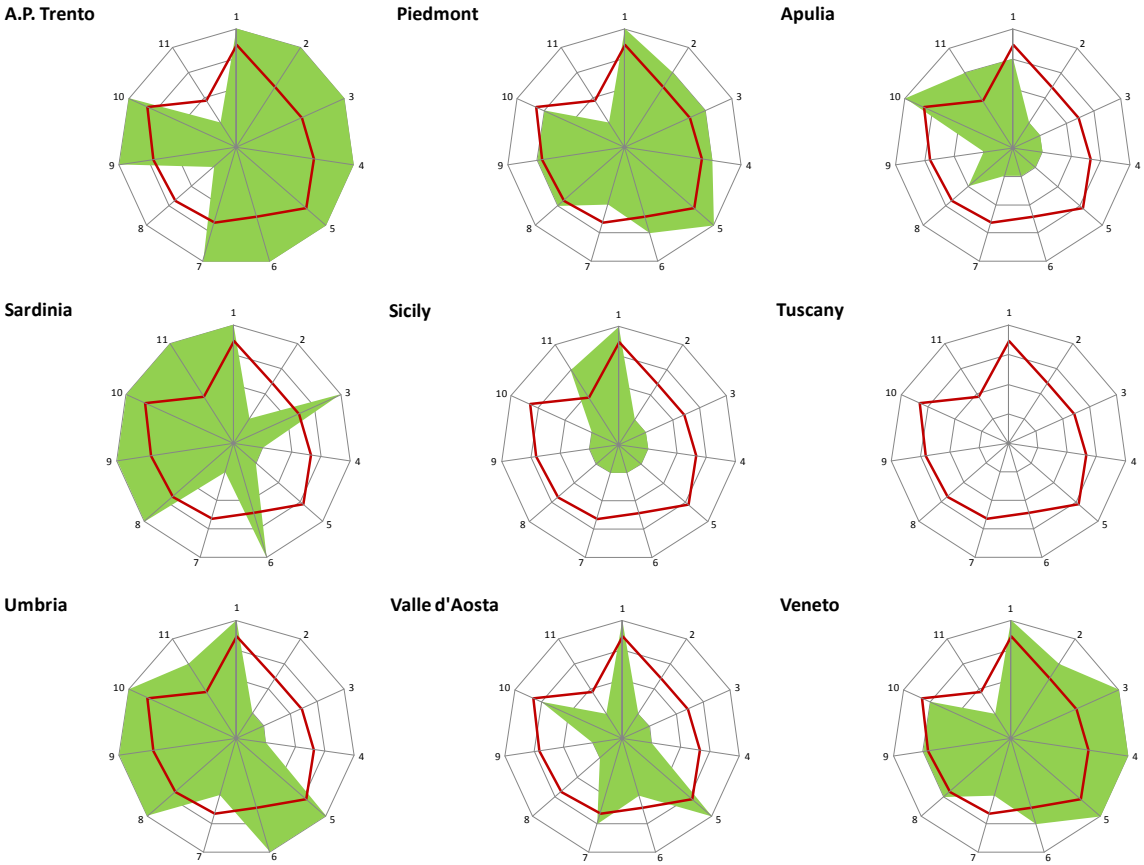


NAPD Goals – Chart Key:
1. Guaranteeing organisational conditions
2. Reducing criminal/illegal activities through reintegration programmes
3. Standardising the principles and main methods of rehabilitation and reintegration
4. Promoting rehabilitation in Local Public Drug Addiction Service Units and Therapeutic Communities
5. Improving the education and professional skills of drug addicts in treatment
6. Promoting the development of operative units specialising in reintegration activities within Addiction Departments.
7. Supplementing and coordinating reintegration work among the various local agencies
8. Promoting the allocation of contracts to social cooperatives for purposes of work reintegration
9. Encouraging reintegration into the employment structure of ordinary businesses
10. Promoting social responsibility programmes
11. Promoting a nationwide project for rehabilitation and reintegration

Only in three Regions were there at least seven goals which had achieved a score of 4 (Friuli Venezia Giulia, Liguria, the A.P. of Trento and Sardinia), a sign that the degree of actualization of the NAPD at a national level is not as satisfactory as it might be.
The Regions of Molise, Calabria and Campania did not achieve a score of four for any single goal and they also had the lowest average total scores for all goals combined (1.8 for Molise, 2.4 for Calabria and 2.4 for Campania). On the other hand, no data at all were received from Emilia Romagna or Tuscany.

On the questionnaires provided by the European Monitoring Centre in 2012, nearly 65% of Regions and Autonomous Provinces (A.P.) reported having targeted and established strategies for the social reintegration of current and former problem drug users; most of these (90%) had made the relevant official documents available online.
The goal most often referred to in was social and work reintegration.

65% of Regions and Autonomous Provinces reported that they had targeted reintegration strategies

Table 8.3 shows all of the Regions and Autonomous Provinces which, on the EMCDDA questionnaire, reported having social reintegration projects funded from Regional Social Funds and/or through other special public funding channels for the year 2012.
In comparison with 2011, there has been a dramatic overall decrease in funding (-21.4%), largely attributable to the discontinuance of funding in Calabria, Emilia Romagna, Marche and Sicily. Lombardy alone accounts for nearly a quarter (24.6%) of total funding nationwide.

21.4% less funding for social reintegration programmes; that means over €2 million less than in 2011

Table 8.3: Total amount dedicated by Regions and Autonomous Provinces to finance social reintegration projects over the course of 2012

Regions and APs	Amount	%
Abruzzo	0.00	-
Basilicata	0.00	-
AP of Bolzano	1,459,908.00	19.7
Calabria	0.00	-
Campania	974,978.00	13.2
Emilia Romagna	0.00	-
Friuli Venezia Giulia	1,131,500.00	15.3
Lazio	0.00	-
Liguria	0.00	-
Lombardy	1,819,828.00	24.6
Marche	Data requested but not provided	2.2
Molise	0.00	-
Piedmont	998,200,00	13.5
Apulia	465,591.02	6.3
Sardinia	Data requested but not provided	-
Sicily	Data requested but not provided	-
Tuscany	400,264.00	5.4
AP of Trento	50,000.00	0.7
Umbria	93,055.00	1.3
Valle d'Aosta	Data requested but not provided	-
Veneto	0.00	-
Total	**7,393,144.02**	**100.0**

Source: Based on data collected by means of the EMCDDA questionnaires sent to the Regions

Over 7 million euros for social reintegration programmes

8.2.1 Housing

In 2012, an average of 50% of Regions and Autonomous Provinces had created housing programmes specifically targeting individuals undergoing social and healthcare treatment for drug use.

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

In most cases, these subjects are able to take advantage of temporary housing (shelters) or reception centres providing temporary lodging, created to provide assistance to socially excluded groups (64.7%). 52.9% of Regions and Autonomous Provinces, in the interests of more effective social reintegration, provide residential facilities for persons undergoing treatment for drug use which are devoted specifically to the reintegration of current and former drug users.
The number of long-term housing initiatives fell, with 41.2% of Regions

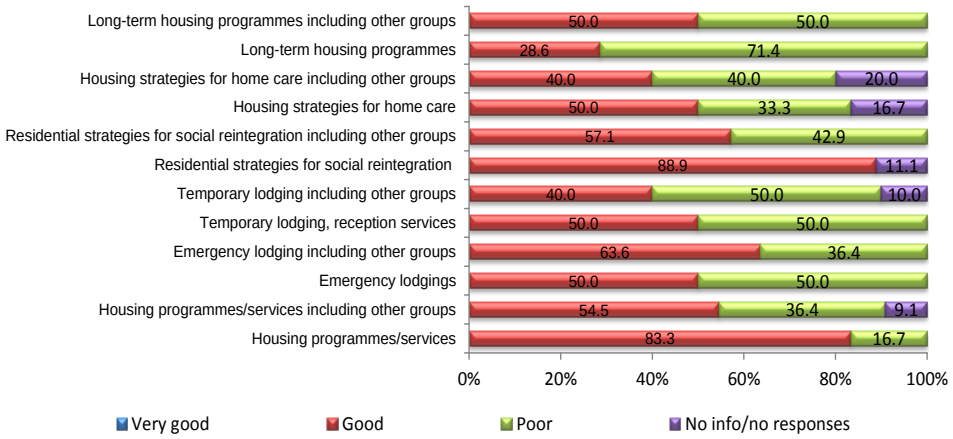
52.9% of Regions and APs report that they provide residential facilities for the social reintegration of drug addicts

reporting the existence of these types of programmes, a number which rises to 58.8% if we include similar programmes which target other socially disadvantaged groups as well.

Availability of residential facilities for social reintegration is very good

The availability of these different types of services (Figure 8.3) was assessed as being, on average, at least "good" by 54.7% of Regional representatives (in comparison with 57% in 2011), and a high percentage (88.9%) assessed the availability of residential facilities for social reintegration as being "good".

Figure 8.4: Assessment of the availability of housing services specifically targeting current and former drug users. The year 2012



Source: Based on data from the survey conducted by means of EMCDDA questionnaires sent to the Regions

Accessibility of housing services was reported as being good

The Regions and Autonomous Provinces judged the level of accessibility to these kinds of services to be quite good. The ability to access housing services devoted specifically to current and former drug users was judged to be, on the average, 'good' across the board. Assessments of residential facilities for social reintegration and of emergency lodgings stand out for the positive marks these two categories received from all respondents.

8.2.2 Employment

Few professional training programmes have been put into effect

In 2012, workplace reintegration was reported as being a high priority goal by the Regions and the Autonomous Provinces.

Employment and job training programmes created exclusively for current and former drug users were put into effect in 52.9% of the Regions and Autonomous Provinces. If we include in this figure programmes which are open to other socially disadvantaged groups as well, the percentage rises to 70.6%. This action area has improved greatly with respect to the 2011 figures (52.9% vs. 35% and 70.6% vs. 35%).

Most regional representatives reported the launch of assisted work reintegration programmes.

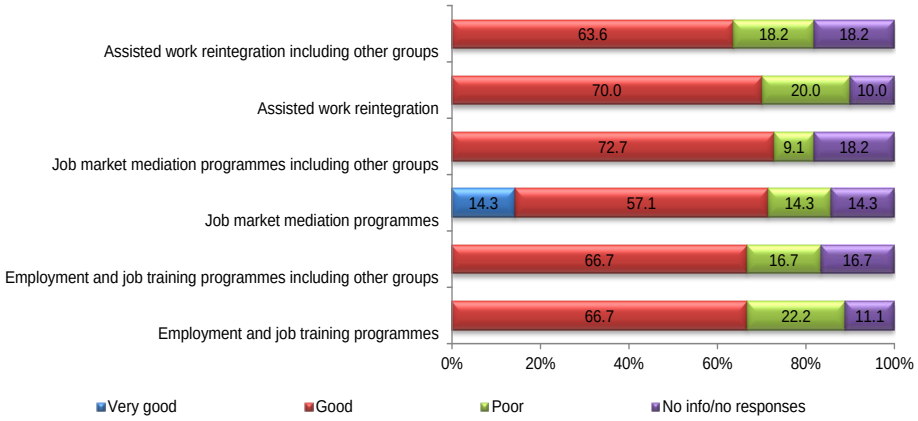
Good availability of employment services reported

The level of availability of employment services designed exclusively for current and former drug users was given, on the average, a positive evaluation (nearly 70% positive assessments [68.5%]). Employment and job training programmes open to other groups as well were given especially positive availability assessments.

Even higher assessments were given regarding the accessibility of employment services. Assessments were positive across the board and ranged from a minimum of 57.1% for job market mediation programmes to a maximum of 90.0% for assisted work reintegration programmes specifically targeting current or former drug users.

A high level of accessibility reported for employment services

Figure 8.5: Assessment of the availability of employment services specifically targeting current and former drug users. The year 2012



Source: Based on data from the survey conducted by means of EMCDDA questionnaires sent to the Regions

8.2.3 The completion of education

By "education", what is meant is the attainment of a secondary level of education or a specialization, but not special training for a specific type of job.
In 2012, 58.8% of Regions and Autonomous Provinces created educational programmes/services targeting more than one type of socially disadvantaged group, while 52.9% created programmes aiming to help individuals complete their basic education, also targeting more than one socially disadvantaged group. A smaller number (23.5%) launched programmes for the completion of secondary education and 11.8% for the completion of university studies and doctoral work. Availability and accessibility of these initiatives were given an overall positive evaluation.

Programmes to assist in the completion of education at below 40%

8.2.4 Other social reintegration programmes

Once again in 2012, among the social reintegration activities of note planned for current and former drug users, we find psychological assistance focusing on social and family relationships in effect in 82.4% of Regions and Autonomous Provinces.
Financial aid and legal consulting programmes existed in over 50% of regions, while other initiatives nearly reached the 50% mark.
It should be pointed out that very positive evaluations were given for the availability and accessibility of psychological assistance programmes.

A high number of psychological assistance programmes

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

9.1. Introduction

Foreword

Firstly, Law Enforcement Agencies plan and conduct actions in the sphere of drug prevention and actions to prevent the spread of illicit drugs. These include actions to fight the production, illicit trafficking and possession of illegal drugs, to prevent drug use on the level of the individual subject and to combat the problem of subjects who drive under the psychological and physical influence of alcohol or drugs. Secondly, Judiciary entities contribute to the process through the application of specific criminal penalties under drug law (DPR 309/90).

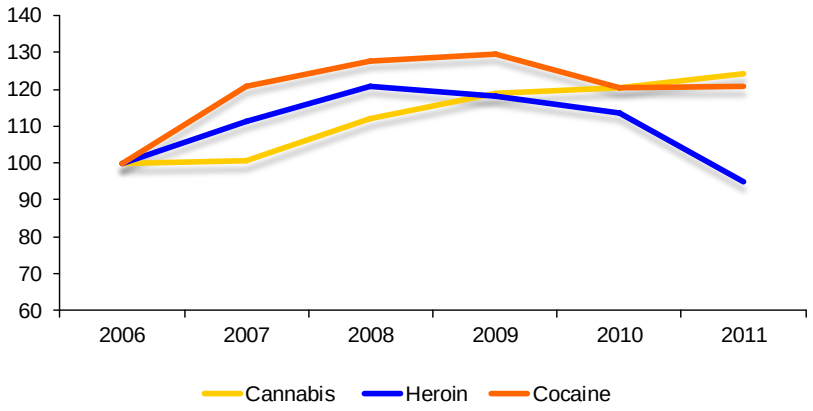
Information sources

Reports of actions undertaken by Law Enforcement are collected and filed (respectively) by the Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources of the Ministry of the Interior (when dealing with violations for possession and use of illicit drugs [Art. 75 of DPR 309/90] [ST 11 – IT 02]) and by the Central Directorate for Anti-drug Services (DCSA) of the Ministry of the Interior (when dealing with information on operations to fight the production and illicit trafficking of drugs [Art. 73 and Art. 74 of DPR 309/90] [ST 11 – IT 01]).

Once charges have been filed by Law Enforcement for offences committed in violation of drug law (DPR 309/90) or other offences committed by drug-addicted subjects, criminal proceedings are opened and penalties applied, which are then recorded and filed in the archives at the Department of Judicial Affairs, Office 3 (Criminal Records). The entrance of adults and minors into the correctional system as a result of criminal penalties applied is the responsibility of the Department of Prison Administration (DPA) for adults and of the Department of Juvenile Justice for minors (ST 12 – IT 01).

9.2. Drug-related crime

Figure 9.1 Trends in index values (*) for offences (criminal and non) in violation of drug law within EU Member States, by drug type. The years 2006 - 2011



Europe: Rising trend in offences linked to cocaine and cannabis

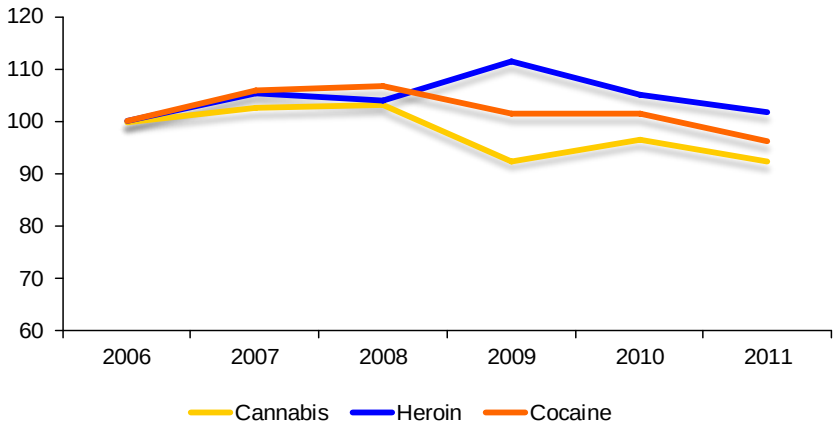
A decrease in offences linked to heroin

(*) Index values: percentage variation in comparison with base-year (= 2006) value

Source: European Monitoring Centre for Drugs and Drug Addictions – 2012 Annual Report (Table DLO -3 of the 2013 Statistical Bulletin)

Overall trends in the number of reports of illicit activities in violation of drug law (criminal and non) in Europe in the period from 2006 to 2011 show a progressive increase in offences linked to cocaine and cannabis (in most European countries, cannabis-related offences represent a percentage ranging between 50% and 70% of drug offences reported in 2011), but a decrease in offences linked to heroin beginning in 2008.
We can see that there was a slight overall decrease in the number of reports of offences in violation of drug law (Art. 73, Art. 74 and Art. 75) linked to heroin in Italy during the three-year period spanning 2009-2011. The number of reports for offences linked to cannabis and cocaine during the same time period, however, remained largely stable.

Figure 9.2: Trends in index values (*) for reports of illicit activities in violation of drug law (Art. 74, Art. 74 and Art. 75) in Italy. The years 2006 - 2011



Italy: a decrease in offences reported (pursuant to Articles 73, 74 and 75) for heroin, cocaine and cannabis

(*) Index values: percentage variation in comparison with base-year (= 2006) value

Source: Based on Data from the Ministry of the Interior - Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources and the Central Directorate for Anti-drug Services

9.3. Drug-law offences

9.3.1. Subjects reported under the requirements of Art. 75 of DPR 309/90

According to the information collected by the Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources of the Ministry of the Interior (formerly the Central Directorate for Documentation and Statistics), a total of 32,694 subjects (data most recently updated on 15 March 2013) were reported for drug possession for personal use (Art. 75[1] DPR 309/90, ST 11 – IT 2) in 2012. Of these, 30,628 were male (accounting for 93.7 % of the total) and 2,066 were female (6.3% of the total).

[1] A report is filed under the requirements of Art. 75 of DPR 309/90 every time Law Enforcement effects a seizure of drugs being held for personal use. Once the report has been filed, the subject is summoned to the competent Prefecture for an interview and for application of the appropriate measures. Ever since Law 49/2006 came into force, the Prefecture responsible for administrative proceedings is no longer that where the violation was proven to have occurred, but rather, the Prefecture of the place of residence of the subject reported for the violation.

Subjects reported pursuant to Art. 75 of DPR 309/90 and the amendments thereof

The number of subjects reported under the requirements of Art. 75 of DPR 309/90 and the amendments thereof, 37,907, decreased during the time period of reference with respect to the number reported during the same period of the year 2011, although the data for the most recent three-year period should still be considered provisional[2].

Table 9.1: Characteristics of persons reported to the Prefectures by Law Enforcement Agencies pursuant to Art. 75. The year 2012

Characteristics	2011		2012		Δ%
	No.	%c	No.	%c	
Subjects reported					
Reported for the first time	21,125	72.4	23,786	72.8	12.6
Already reported in previous years	8,065	27.6	8,908	27.2	10.5
Total	**29,190**	**100.0**	**32,694**	**100.0**	**12.0**
Frequency					
Once during the year	27,937	95.7	31,347	95.9	12.2
At least twice during the year	1,253	4.3	1,347	4.1	7.5
Male	27,275	93.4	30,628	93.7	12.3
Female	1,915	6.6	2,066	6.3	7.9
Average age					
Male	26.5		26.4		
Female	26.8		26.7		
Reports filed, by drug type					
Opiates (heroin, methadone, morphine)	3,036	10.4	2,494	7.6	-17.9
Cocaine/Crack	3,908	13.4	4,578	14.0	17.1
Cannabinoids	21,956	75.2	25,210	77.1	14.8
Stimulants	140	0.5	178	0.5	27.1
Other drugs	150	0.5	234	0.7	56.0
Total	**29,190**	**100.0**	**32,694**	**100.0**	**12.0**

Source: Based on Data from the Ministry of the Interior - Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources

Rising trend in the number of persons over the age of 30

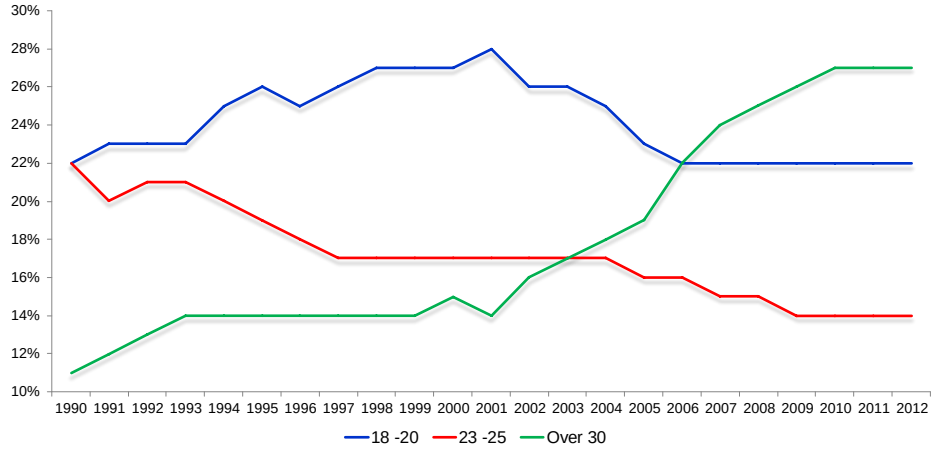
Of those reported in 2012, 2,801 subjects (9% of the total) were under 18 years of age. Of this subgroup, 2,619 were male and 182 were female. The average age of subjects reported was approximately 26, with the highest prevalence figures among the age group 18-22 (35%) and the age group over 30 (27%). Trends among the different age groups between 1990 and 2012 show that, over the course of the years, most of the persons reported pursuant to Art. 75 were between 18 and 25 years of age, and the percentage of persons reported who are over the age of 30 began to rise more substantially starting in 2002 (Figure 9.3).

[2] Based on data from the year 2012, most recently updated on 15 March 2013, 32,694 subjects were reported for violations under Art. 75. Data is continuously updated by the personnel of the Drug Addiction Operating Units of the Territorial Government Offices (known as UTGs) of the Prefectures and is considered to be consolidated after a minimum of approximately two years.

Percentages for the two youngest age groups (14 or younger and 15-17 years of age) have not shown any substantial increase. Nonetheless, Drug Addiction Operating Units personnel confirm that, based on information acquired during interviews at the Prefectures, the age at first use of narcotic and/or psychotropic drugs has become lower while, during recent years, there has also been a higher incidence of polydrug users, who often combine alcohol consumption with drug use.

Drug Addiction Operating Units of the Prefectures report a lowering of age at first use and a rise in polydrug users who combine alcohol consumption with drug use

Figure 9.3: Percentage distribution of persons reported pursuant to Art. 75, by major age groups. The years 1990 – 2012



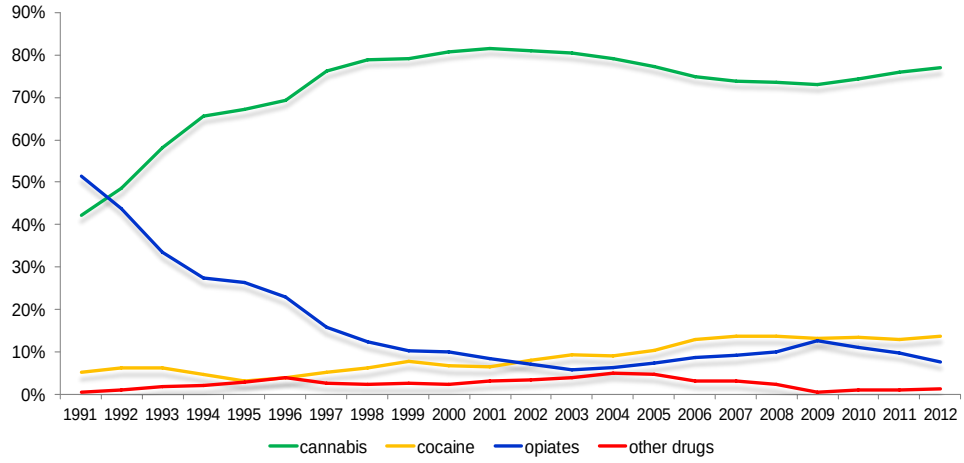
Source: Based on Data from the Ministry of the Interior - Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources

Since 2002, the number of persons reported who are over 30 years of age has increased, while the number under 25 years of age has decreased

As far as types of drugs are concerned, most of the persons reported in the year 2012, meaning 77% of subjects (reported for the first time and recidivists), were found to be in possession of cannabinoids, followed by cocaine (14%) and then by those in possession of heroin, who accounted for 7% of the total of persons reported for the year of reference. If we add to those reported for heroin use the numbers for those reported for methadone, morphine and other opiates, we obtain a percentage equal to 7.6%.

Reports filed by drug type: 77% of reports filed were for cannabis

Figure 9.4: Percentage distribution of persons reported pursuant to Art. 75, by drug type. The years 1991 – 2012



Source: Based on Data from the Ministry of the Interior - Department for Civil Administration Personnel Policies and for Instrumental and Financial Resources

In comparison with the past, there has been a slight decrease over the last four years in the number of persons found in possession of heroin for personal use, while the number of cannabinoid users, which had declined progressively until 2009 (from 81% in 2002 to 73% in 2009), began rising again in 2010, though only slightly (75%), and saw a further slight increase in 2012 (77%). Users of hashish or marijuana clearly account for the largest percentage of persons reported for possession for personal use pursuant to Art. 75 (Figure 9.4).

Decrease in the number of heroin users reported

Increase in the number of cannabinoid users reported starting in 2009

The number of persons in possession of cocaine for personal use (which rose from 10% in 2005 to 13% in 2006 and 14% in 2007 and 2008) fell slightly in 2009 (to 13%) and numbers remained more or less stable until 2012 (14%). Cocaine nonetheless remains the second-most commonly-reported drug, a figure which is particularly alarming when we consider that a large portion of the subjects reported are between 18 and 25 years of age. Trends in drug use among the subjects reported to the Prefectures are in line with figures and estimates gathered on international and European levels, and demand particular attention due to the fact that most subjects reported consider themselves to be "occasional users", and thus represent an important source of information for estimates of use among the general population.

Trends in numbers of cocaine users reported remained stable

9.3.2 Subjects brought before the Judicial Authorities for offences in violation of D.P.R. 309/90

Table 9.2: Characteristics of charges brought before the Judicial Authorities by Law Enforcement Agencies for violations of DPR 309/90. The year 2012

	2011		2012		Δ%
Characteristics	**No.**	**%c**	**No.**	**% c**	
Gender					
Male	33,673	91.5	31,993	91.5	-5.0
Female	3,123	8.5	2,978	8.5	-4.6
Total	**36,796**	**100.0**	**34,971**	**100.0**	**-5.0**
Italians	24,148	65.6	22,745	65.0	-5.8
Foreigners	12,648	34.4	12,226	35.0	-3.3
Art. 73 – Italians	24,109	65.5	22,739	65.0	-5.7
Art. 73 – foreigners	12,647	34.4	12,226	35.0	-3.3
Of whom for Art. 74 – Italians	2,164	70.5	2,282	67.7	5.5
Of whom for Art. 74 – foreigners	906	29.5	1,090	32.3	20.3
Average age					
Italians for Art. 73 offences	31.9		32.0		
Foreigners for Art. 73 offences	30.0		30.3		
Of whom Italians for Art. 74 offences	37.5		37.1		
Of whom foreigners for Art. 74 offences	34.5		33.6		
Measures taken					
Arrested	28,552	77,6	27,300	78.1	-4.4
At liberty	7,936	21,6	7,267	20.8	-8.4
Untraceable	308	0,8	404	1.2	31.2

A 4.4% decrease in arrests

Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services

Over 22,700 anti-drug operations: high level of prevention and anti-drug activity. Nearly 35,000 charges brought (a 5% decrease over 2011 numbers)

Turning our attention to activities in the fight against drug-law violations, Law Enforcement Agencies conducted 22,748 anti-drug operations in Italy in 2012, resulting in 34,971 charges brought for crimes related to the production, trafficking and sale of illegal substances, conspiracy with intent to traffic and other crimes and offences in violation of Presidential Decree DPR 309/90 (Articles 73, 74 and other Articles of DPR 309/90, ST 11 – IT 1), registering a 5% decrease in comparison with 2011.

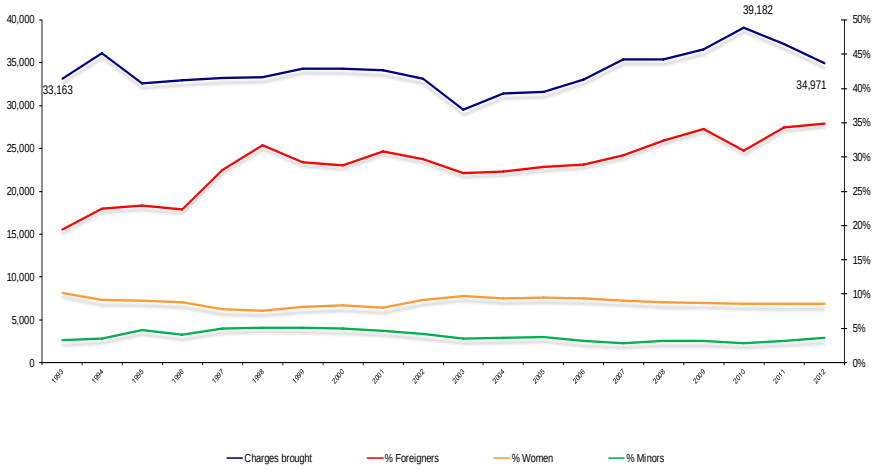
Characteristics of subjects reported: 65% Italians 35% foreigners Low number of women (approximately 9%)

65% of subjects reported to the Judicial Authorities in 2012 were Italians and 8.5% were women. The average age of persons reported was approximately thirty-one, with some variation based on nationality (32 years of age for Italians and 30 years of age for foreigners), and even greater variation based on the type of offence committed (31 years of age for Art. 73 and 36 years of age for Art. 74).

Trends in charges brought before the Judicial Authorities

Following 2003, the year in which the fewest subjects were charged (approximately 29,500), the number of reports filed with the Judicial Authorities increased progressively until 2010, when the highest value in seventeen years was recorded; numbers decreased in 2011 and 2012 (Figure 9.5).

Figure 9.5: Persons charged with crimes during the course of anti-drug operations conducted by Law Enforcement Agencies; percentages of foreigners, women and minors charged. The years 1993 – 2012



Update of statistics on charges brought and the percentages brought against foreigners and minors, the years 2008-2012.

Source: Based on data from the Ministry of the Interior – Central Directorate for Anti-drug Services

Increase in the % of foreigners charged

The percentage of foreigners apprehended and brought before the Judicial Authorities also decreased in 2012 (35% of the total number of persons charged during the course of anti-drug operations). In addition, the number of women reported to the Judicial Authorities in 2012 stood at 2,978, a 4.6% decrease over the 2011 number. In terms of absolute values over the past 11 years, the number of charges brought against women peaked in 2010, but if we consider the percentage of women reported in relation to the total number of charges brought, the maximum value was recorded in 2003 (9.7%) and the lowest in 2001 (approximately 8%). Regarding charges brought against minors, there were a total of 1,263 in 2012 (3.6% of the total of persons reported on a national level), an increase of 7.5% over 2011.

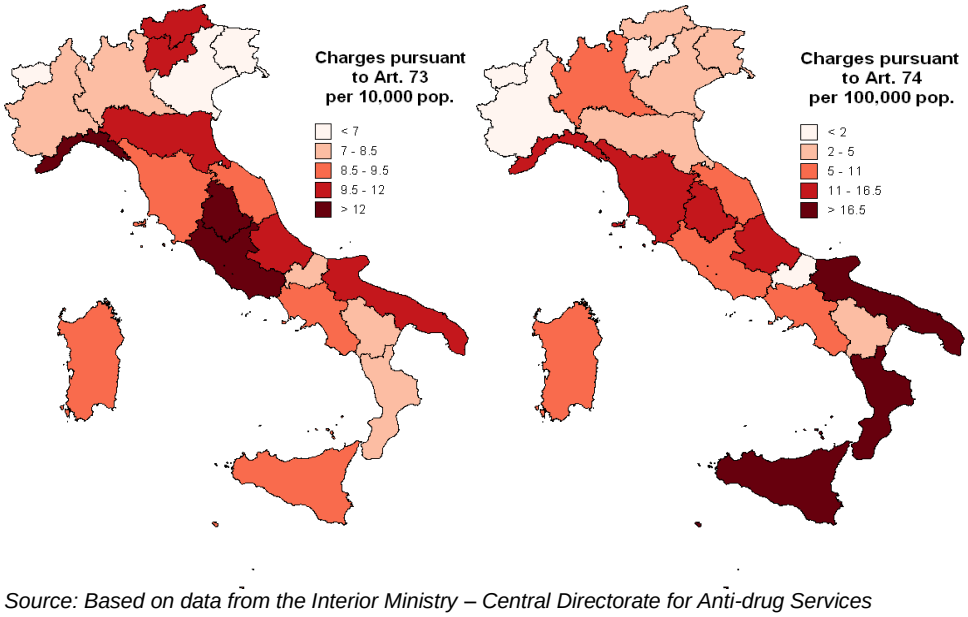
4.6% decrease in the number of women reported

7.5% increase in the number of minors reported

Reports filed by type of offence

Anti-drug actions conducted by Law Enforcement Agencies in 2012 differed based upon the type of crime they targeted (t.n. crimes under Art. 73 or under Art. 74). The majority of charges for crimes in connection with the production, trafficking and sale of illegal drugs were brought in Lombardy (14.6% of total charges), followed by Lazio (13.1%), Campania (9.8%) and Sicily (8.3%), with no substantial differences with respect to distribution in the previous year. The distribution of quantities of charges by Region shows that the highest number of charges were filed in Liguria (15.4 charges per 10,000 population), in Lazio (12.6 charges per 10,000 population), in Umbria (12.1 charges per 10,000 population) and in Abruzzo (11.7 charges per 10,000 population) (Figure 9.6).

Figure 9.6: Charges filed for offences pursuant to Art. 73 of DPR 309/90 per 10,000 population, by region where operations were conducted and number of charges filed for offences pursuant to Art. 74 of DPR 309/90 per 100,000 population. The year 2012



Source: Based on data from the Interior Ministry – Central Directorate for Anti-drug Services

The largest number of charges for more serious offences were filed in the southern part of the country (17.5% of the total number of charges were filed in Sicily, 13.6% in Apulia) and 11.6% in the centre, in Lazio. Distribution of charges filed by Region also shows the highest values in the southern Regions, starting with Sicily (17.1 charges filed per 100,000 residents) and Calabria (16.8 charges filed per 100,000 residents (Figure 9.6).

Principal reports filed, by drug type: 40.3% cannabis 35.4% cocaine 16% heroin

40.3% of reports filed with the Judicial Authorities for violations of drug laws had to do with the trafficking of cannabis, an increase over the 2011 percentage (37.3%). Cannabis was followed by cocaine (35.4%) and, on a smaller scale, heroin, which, at 16%, showed a decrease with respect to the 2011 percentage (18.5%). 90% of Italians against whom charges were brought were male, with the exception of charges for heroin trafficking, for which the percentage falls to 82%. There are higher percentages recorded for the foreign male population, on the other hand, especially with regard to heroin and cannabis (96% and 97%, respectively).

Subjects charged for the trafficking of synthetic drugs are younger

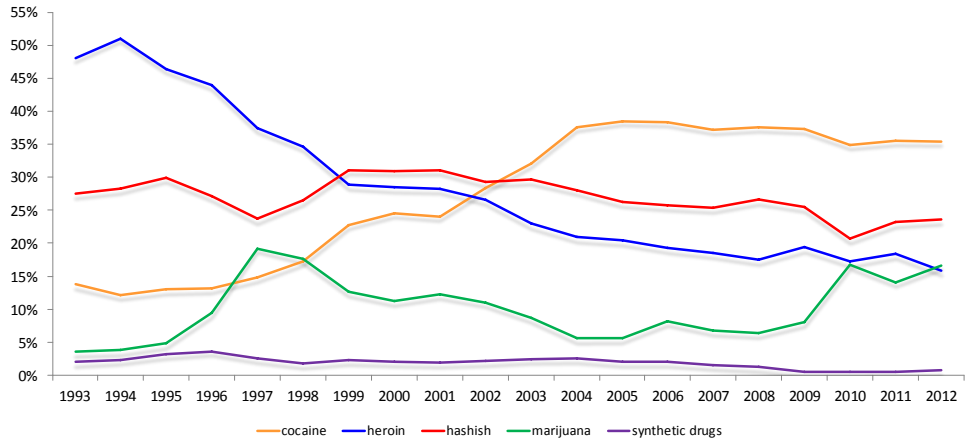
Persons charged with the trafficking of synthetic drugs were generally found to be younger (26 years of age) with respect to those whose cases were submitted to the courts for other drugs, and the average age for

women was found to be higher than for men (33 and 32 years of age, respectively, in the Italian population and 32 and 30 years of age among the foreign population).

Trends in charges brought, by drug type: larger % of charges for marijuana

Over the last seventeen years, the profile of illicit drug trafficking has evolved considerably. The percentage of charges for the sale of heroin fell from 48% in 1993 to 16% in 2012, in contrast with a dramatic increase, until 2004, in the percentage of reports filled for cocaine dealing, which has levelled off in recent years. Over the last two years of reference, we can see a significant increase in the percentage of charges brought for the sale of marijuana (from 16.8% in 2010 to 14.1% in 2011 and 16.7% in 2012) and a rise in hashish sales (approximately 21% in 2010 vs. 24% in 2012) (Figure 9.7). In terms of absolute values, in comparison with 2011, 2012 saw a 7.6% increase in the number of reports filed for the sale of synthetic drugs.

Figure 9.7: Subjects charged with crimes during the course of anti-drug operations conducted by Law Enforcement Agencies, by type of illegal drug seized. The years 1993 – 2012



Source: Based on data from the Interior Ministry – Central Directorate for Anti-drug Services

9.4. Other drug related crime

The transfer of responsibility for prison health care services to the National Health Service

On 1 April 2008, a Decree of the Presidency of the Council of Ministers transferred responsibility for healthcare services, relative labour relations and financial resources, related instrumental resources and equipment for prison healthcare services to the National Health Service. In addition, the monitoring of inmates with drug-related problems, which had remained the responsibility of the Ministry of Justice – Department of Prison Administration until 2010, passed to the Regions, in accordance with the agreement signed at the Unified Conference on 18 May 2011. Under this agreement, the Operative Units of Local Public Drug Addiction Services working in prisons are required to collect data, by means of special forms, on inmates with alcohol or drug addiction problems. For adults, this data is collected every six months (on 30 June and 31 December) and the information collected refers to the situation as it stands on the data-collection day. For minors, on the other hand, data is gathered once for the entire year.

Although the information collection system specified in the Unified Conference of 18 May 2011 has been launched, the Department of Prison Administration (DPA) has maintained its own data collection system for adults with drug-related social and healthcare problems as well.

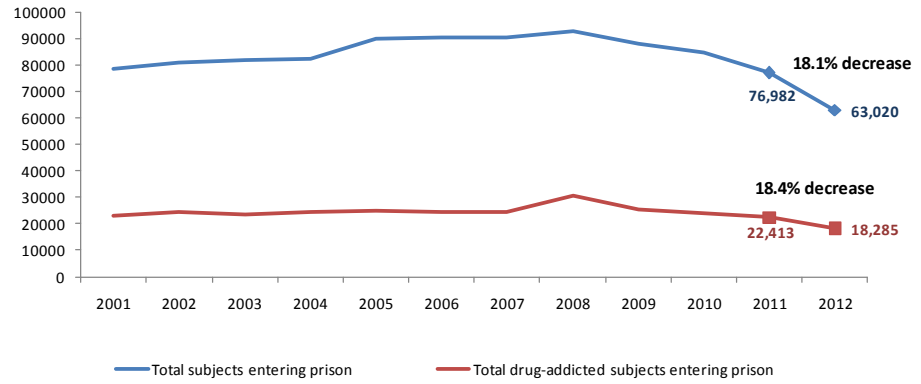
The numbers refer to the total number of subjects entering prison from

outside the penitentiary system in 2012 and those in prison during that year, both total numbers and numbers for drug-addicted inmates alone.

Decrease in numbers entering prison in 2012

In comparison with 2011, 2012 saw a drop in the overall number of subjects entering prisons, which fell from 76,982 to 63,020, an 18.1% decline (Figure 9.8). The number of subjects with drug-related social and healthcare problems entering prisons also fell, by 18.4%, dropping from 22,413 to 18,285, but still accounted for 29% of the total.

Figure 9.8: Trends in total number of subjects and subjects with drug-use problems **entering prison each year** – the years 2001-2012



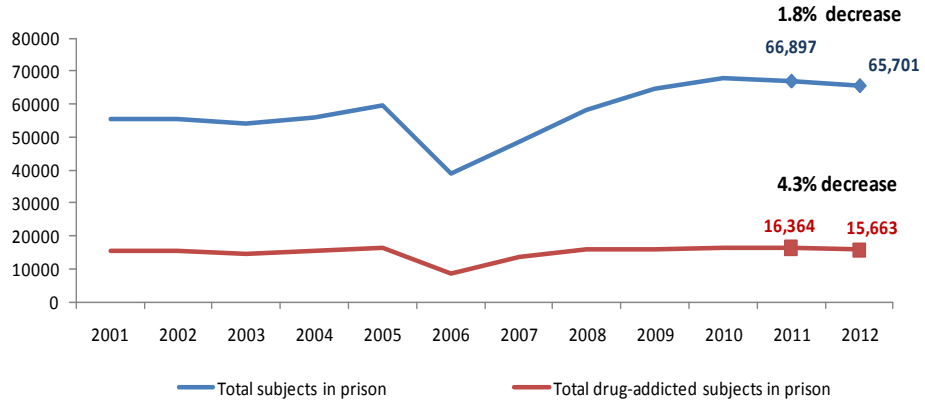
Source: Based on data from the Department of Justice – the Department of Prison Administration – December 2012.

This trend is also confirmed by an analysis of data on the prison population and the subpopulation of these who have drug-related problems collected on 31 December.

The number of inmates in prison on 31 December fell from 66,897 in 2011 to 65,701 in 2012, a 1.8% decrease (Figure 9.9). The number of inmates with drug-related social and healthcare problems also fell, by 4.3%, dropping from 16,364 in 2011 to 15,663, representing 24% of the total prison population on 31 December 2012.

Figure 9.9: Trends in the total number of inmates and the number of inmates with drug-related problems **in prison on 31 December** – the years 2001 –2012

A drop in the prison population in 2012



Source: Based on data from the Department of Justice – the Department of Prison Administration – December 2012.

9.5. Prevention of drug-related crime

A report is filed under the requirements of Art. 75 of DPR 309/90 every time Law Enforcement effects a seizure of drugs being held for personal use. Once the report has been filed, the subject is summoned to the competent Prefecture for an interview and for application of the appropriate measures.

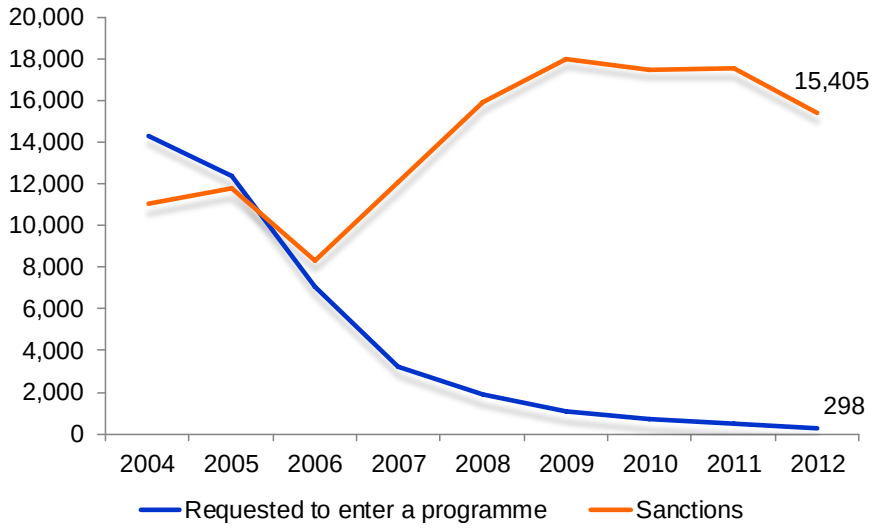
Prevention action effected by the Drug Addiction Operating Units of the Prefectures

Before Law 49/2006 entered into force, if the subject, even one who had previously committed an offence of the same nature, showed willingness to begin a rehabilitation programme, then administrative proceedings would be halted while the subject was sent to a Local Public Drug Addiction Services Unit in order to complete such a programme. Upon successful programme completion, the proceeding would be filed. Under the new law, with the exception of cases that fall under Paragraph 14 of Art. 75 dealing with formal invitations, sanctions would be issued against the subject who was reported for drug possession, who would only then be invited to present him or herself at a Local Public Drug Addiction Services Unit for a rehabilitation programme. The new law thus jeopardizes the rehabilitation efforts carried out by the Drug Addiction Operating Units (t.n. known as NOT) of the Prefectures over the years, since subjects who have been reported do not see the benefit in signing up for a treatment programme which is going to last from three months to a year. The data presented below was processed based upon the law in force.

It is crucial that the role of the Drug Addiction Operating Units of the Prefectures (NOT) be re-evaluated and redeveloped

Ever since Consolidated Law 309/90 entered into force, the Drug Addiction Operating Units of the Prefectures (NOT) have been working effectively to dissuade offenders, especially among the young, from drug use. Without the prevention assistance that they can only receive by attending interviews with officials and social workers, these drug users would be deprived of the support network which the Operating Units have been able to assist in creating, with the help of other local organizations (such as Local Public Drug Addiction Services Units [SerT] and Therapeutic Communities).

Figure 9.10: Administrative sanctions and requests to undergo treatment and rehabilitation programmes following the filing of a report pursuant to Art. 75. The years 2004 – 2012



Since 2006, there has been a steep decline in the number of subjects sent into treatment and rehabilitation programmes

Source: Based on Data from the Ministry of the Interior - Department for Civil Administration Personnel Policies and for Instrumental and Financial

Measures taken

In 2012, 13,660 subjects were interviewed by the Drug Addiction Operating Units (NOT) of the Prefectures. Following these interviews, 9,145 subjects were invited to refrain from drug use in the future (formal invitation).

A decrease in administrative sanctions

In 2012, 15,045 administrative sanctions were imposed by the Prefectures under the requirements of Paragraph 1 of the afore-mentioned Art. 75. Of these, 10,216 (66.3%) were imposed following interviews held at the Drug Addiction Operating Units of the Prefecture Territorial Government Offices (UTGs) and 5,189 (33.7 %) were imposed as a result of the failure of the subjects to present themselves for their interviews.
In comparison with the previous year, when 17,512 sanctions were imposed, the 2012 figure therefore shows a decrease, taking into consideration the fact that the figure is more provisional.

A decrease in the number of subjects invited to enter programmes

In the year of reference, 298 subjects were invited to enter treatment and rehabilitation programmes with Drug Addiction Services or at social-rehabilitation facilities. During the same period, administrative proceedings against 1,559 subjects were filed as a result of them having completed their prescribed treatment programmes. The number of subjects sent into treatment and rehabilitation programmes has fallen drastically, not only in comparison with the previous year, when the number of subjects invited to enter programmes after having been reported was 438, but also in comparison with the 2010 figure (655) and figures from previous years (Figure 9.10).

The failure to suspend sanctions in cases where subjects accept the invitation to undergo treatment and rehabilitation continues to be an issue (Law 49/2006)

As discussed above, under Law 49/2006, currently in force, sanctions are no longer suspended if subjects complete a programme, as they were under previous laws, but are imposed regardless. Only afterwards is the subject who has been reported invited to undergo a treatment and rehabilitation programme. It is for this reason that the subjects reported are no longer motivated to accept the invitation to enter rehabilitation programmes. This explains the steep decline in the number of individuals entering these programmes. When invited to begin treatment, many do not accept to do so, since the sanctions against them would not be suspended in any case.

9.6. Interventions in the criminal justice system

9.6.1. Alternatives to prison

Table 9.3: Drug addicts in the care of social services who are on probation or have been released on parole. The year 2012

Increase (+7.6%) in the number of drug-addicted subjects who were granted parole

Characteristics	2011[1]		2012		Diff.%	Δ% 2012/2011
	No.	% c	No.	% c		
Gender						
Male	2,192	93.7	2,366	94.0	+0.3	+7.9
Female	148	6.3	152	6.0	-0.3	+2.7
Total	2,340		2,518			+7.6
Nationality						
Italians	2,103	89.9	2,309	91.7	+1.8	+9.8
Foreigners	162	6.9	185	7.3	+0.4	+14.2
Unknown	75	3.2	24	1.0	-2.2	-68.0
Average age						
Male	37.8		38.0			+0.2

continue

continue

Characteristics	2011[1]		2012		Diff.%	Δ% 2012/2011
	No.	% c	No.	% c		
Average age						
Female	37.3		36.9			-0.4
Total	37.8		38.0			+0.2
Age groups						
18-24	109	4.7	133	5.3	+0.6	22.0
25-34	770	32.9	794	31.5	-0.6	3.1
35-44	976	41.7	1,020	40.5	-0.8	4.5
45-54	398	17.0	472	18.7	+1.7	18.6
> 54	87	3.7	99	3.9	+0.2	13.8

[1] 2011 data updated in 2013

Source: Ministry of Justice - Department of Prison Administration - Directorate-General for the Execution of External Sentencing

Special cases concerning probation or release on parole into the care of social services are governed by Art. 94 of DPR 309/90 and can involve, in accordance with the Law, both alcoholics and drug addicts, although, in actuality, nearly all of the cases involve drug addicts.

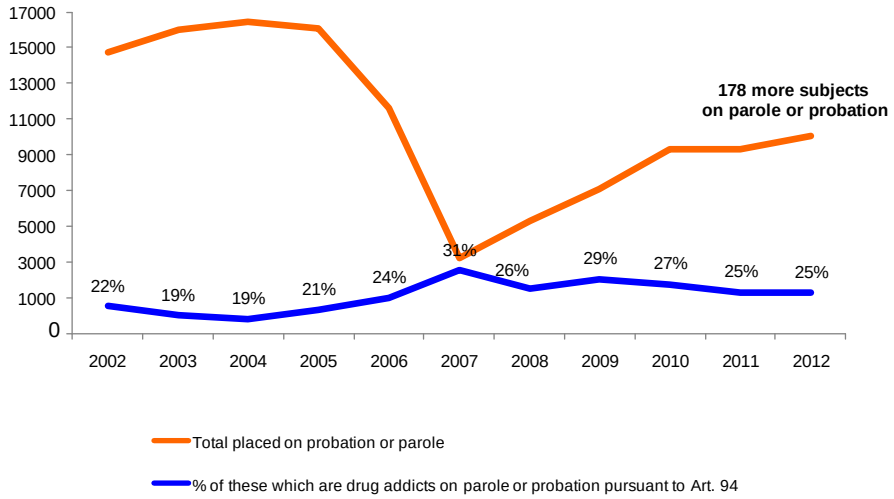
In 2012, a total of 10,018 new persons were placed in the care of social services. Of these, 2,518 were drug addicts granted probation or parole under Art. 94 of DPR 309/90, accounting for a total of 25% of the total number of persons placed in the care of social services.

In 2012, 25% of persons placed on probation or parole into the care of social services were drug addicts

Apart from a slight fluctuation in 2011, the number of subjects who have benefited from alternatives to imprisonment increased steadily from 2007 to the present (+7.8% in 2012 in comparison with the previous year). It should be noted that the significant decrease in the numbers of subjects placed on parole or probation with social services during the three-year period spanning the years 2005 to 2007, when numbers fell from over 16,000 subjects placed on parole or probation to fewer more than 3,200, can be attributed to the effect of the implementation of Law 241 of 31 July 2006, the Collective Clemency Bill. The application of this law, in addition to bringing about the dismissal of measures for those cases carried forward from previous years for which there were on-going proceedings involving offences committed on or before 2 May 2006 carrying custodial sentences of no more than three years, strongly affected the number of cases taken on by services during the course of the year.

The number of drug addicts who have benefited from alternatives to imprisonment, while still making up 25% of the total number of subjects benefiting from alternatives to imprisonment, has grown, as an absolute value, by 178 units, raising the 2012 figure (2,518 subjects placed on probation or parole) to match 2010 levels.

Figure 9.11: Total subjects on probation or parole, and percentage of that total who are drug addicts placed on probation or parole pursuant to Art. 94. The years 2002 – 2012

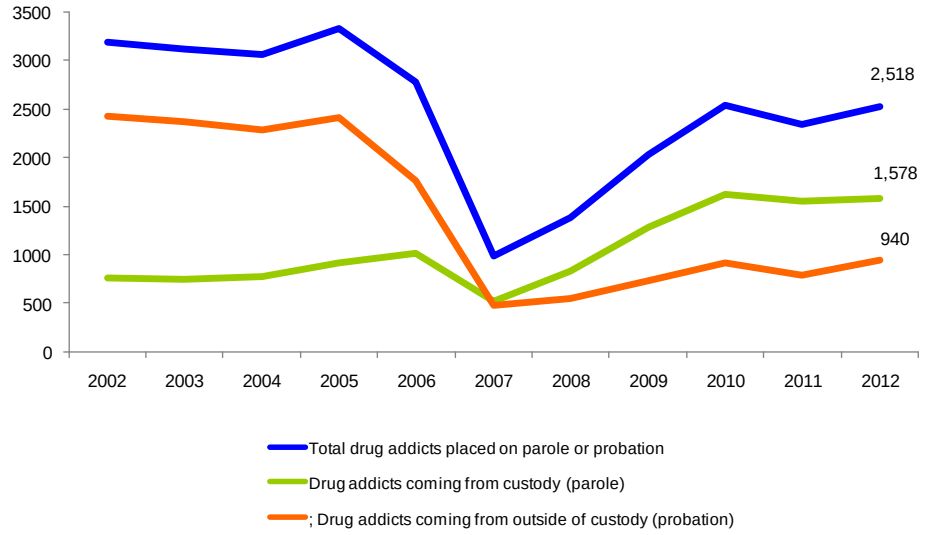


Source: Ministry of Justice - Department of Prison Administration - Directorate-General for the Execution of External Sentencing

In line with figures from previous years, 94% of subjects placed on parole or probation pursuant to Art. 94 were men. The average age was 38, a slight increase over the previous year (38 vs. 37.8), with a particular increase in persons between the ages of 35 and 44, which is the age group most highly represented (40.5%).
Foreigners, whose numbers are never very high among subjects placed on parole or probation with the Office for the Execution of External Sentencing, comprised 7.3% of the total in 2012.
The number of subjects placed on parole with the Office of External Sentencing (known as UEPE) has grown over the last two years, rising from 36.7% in 2006 to 52.2% in 2007, to reach 62.7% in 2012, a slight decrease with respect to the 2011 number (-3.5 percentage points). This figure should be viewed in light of the reduction of sentences established by Law 241/06 which, with the exception of a few types of crime, accelerated the possibility of benefiting from alternative measures for subjects given custodial sentences longer than six years and, at the same time, brought about a steep decline in the number of subjects serving sentences of up to six years in length who benefit from such alternative measures and who might have been granted the possibility to benefit from them without first serving time in prison.

Large increase in the number of subjects placed on parole with the Office of External Sentencing: from 36.7% in 2006 to 62.7% in 2012

Figure 9.12: Number of drug addicts placed in care of social services coming from custody (parole) or from outside of custody (probation). The years 2002 – 2012



Source: Ministry of Justice - Department of Prison Administration - Directorate-General for the Execution of External Sentencing

More revocations among subjects on parole than among subjects on probation

As a percentage of the total number of subjects who benefited from parole or probation in accordance with Art. 94 of DPR 309/90 during the course of the most recent year of reference, 8.2% of persons sentenced using alternative measures had their alternative sentencing revoked, almost all as a result of the improper serving of the sentence. Another 17.2% of those serving alternative sentences saw their probation or parole end due to their proceedings being filed. In general, if we compare subjects' data based upon whether they had served prison time, we find that most revocations were for cases involving subjects on parole after having served custodial sentences (41.1% of revocations from parole as opposed to 17.4% from probation). The opposite is true for proceedings filed; most of those subjects who had their proceedings filed were on probation (58.9% of proceedings filed for subjects on parole vs. 82.6% for subjects on probation). Specifically, in comparison with 2011, there was a greater percentage of revocations for improper serving of sentence among those on parole and a greater number of revocations for other reasons for subjects on probation as well as subjects on parole.

9.7 Drug use and problem drug use in prison

As discussed above, a Decree of the Presidency of the Council of Ministers, issued on 1 April 2008, transferred responsibility for healthcare in prisons to Health Units, and thus the monitoring of inmates with drug-related problems, which had remained the responsibility of the Ministry of Justice – Department of Prison Administration until 2010, passed to the Regions, in accordance with the agreement signed at the Unified Conference on 18 May 2011.

Beginning in 2012, an information flow created and managed by the Department for Anti-drug Policies has taken the place of the one belonging to the Ministry of Justice. As a result, data are now available regarding drug-addicted individuals in prisons and the social and healthcare services being supplied to them.

Under the requirements of the information flow created by the Unified Conference agreement, the Regions are required to collect data on

inmates with alcohol- or drug-related problems by means of special forms, completed by the prison Operative Units of Local Public Drug Addiction Services (SerT).

These forms contain the following information:

- The number of subjects with drug-related problems
- The number of subjects who have been diagnosed as having drug dependence (the main requirement for parole)
- The number of subjects requesting parole
- The number of subjects released on parole

This process is needed to monitor:

- The characteristics of inmates with regard to drug use
- Their treatment needs
- The willingness, availability and accessibility of probation or parole as alternatives to imprisonment

Using this new means of monitoring the prison population with alcohol- or drug-related problems, substance addiction is established based on clinical diagnosis (ICD-IX CM), and is not only based on medical history or self-reported.

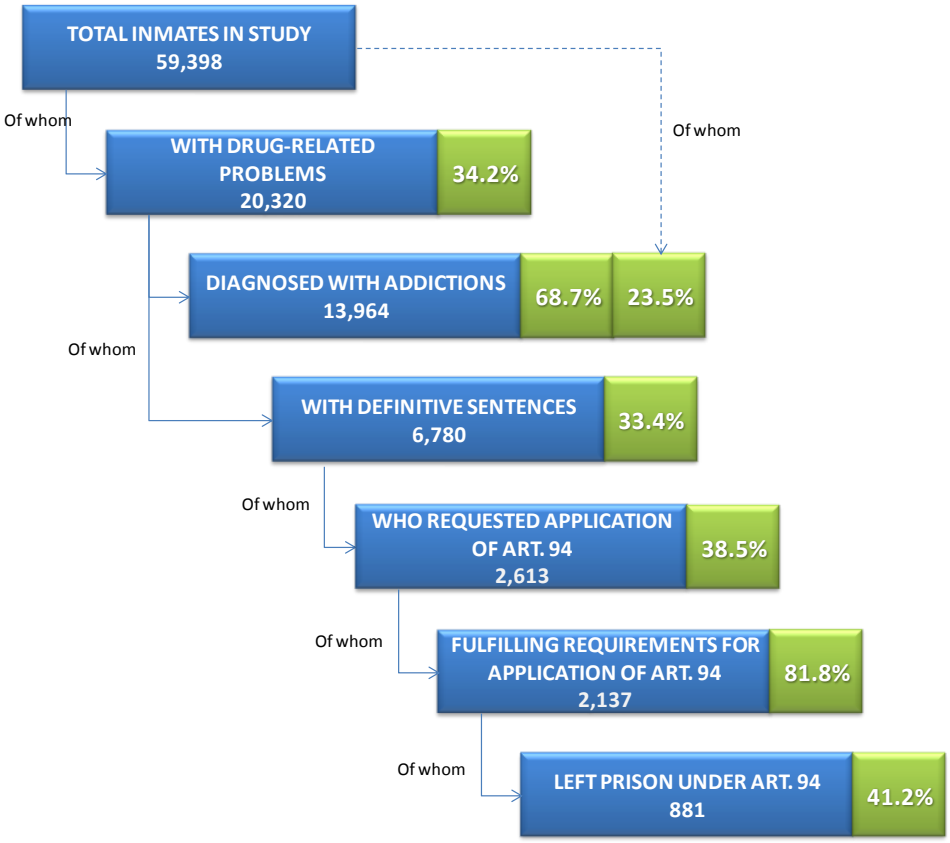
9.7.1. Incarcerated adult drug addicts

Monitoring was conducted for the first time in 2012, using 2011 data. Coverage of the national territory was found to be only partial, and the quality of the information was not always satisfactory. The 2013 study, on the other hand, showed significant improvement in the information flow, both in terms of coverage as well as in terms of data quality, with 100% of Regions responding and 90% of the prison population being represented.
In addition to substituting the data flow from the Ministry of Justice, this study fills the need for a collection of data and information capable of better representing the situation of drug-addicted and alcoholic prison inmates and of establishing the number of subjects who have the right to benefit from and who do benefit from alternative measures under Art. 94 of DPR 309/90.
Figure 9.13 shows the data collected during the course of the Department for Anti-drug Policies' monitoring of drug addicts in prisons, carried out in 2013 and based on 2012 data.
The results of this survey reveal that 23.5% of inmates (13,964 subjects) were diagnosed with a clinical substance addiction, while a total of 34.2% of inmates (20,320 subjects) were users, although not all of these were addicted.

38.2% of drug-addicted inmates subjected to drug testing upon entering prison

38.2% of subjects with drug-related problems were found to have been subjected to drug testing upon entering prison (26.2% in 2011). Turning our attention to the demographic characteristics of inmates with drug-related problems (either addiction or use), we find that, similarly to last year, 96.7% of these are men. Additionally, within this population, 69.2% of men and 68.5% of women are between 25 and 44 years of age. Distribution by age group reveals no great differences between the two genders, with the exception of the 35-44 age group, where there is a clear predominance of males (37% vs. 34%), and the 55-64 age group, which includes a higher percentage of women (3.7% vs. 4.8%).

Figure 9.13: Inmate population flow (percentages refer to the previous level)

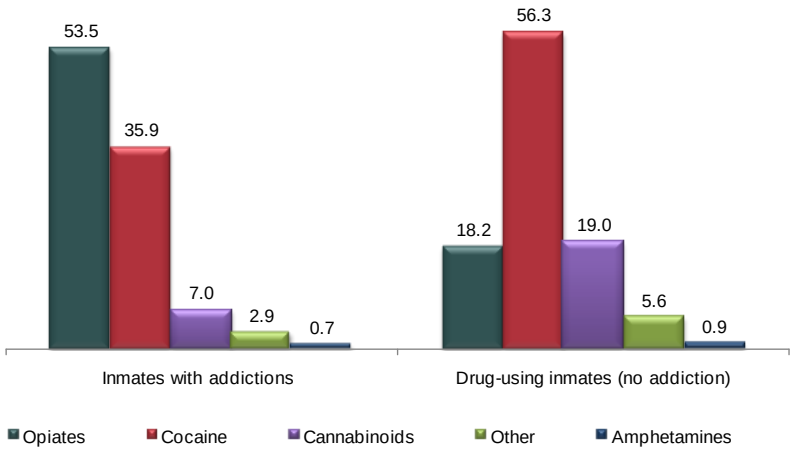


There are 20,320 prison inmates with drug-use problems (with or without addiction), equal to 34.2% of the prison population. Of these, 13,964 were diagnosed with an addiction (ICD IX CM), while the remaining 6,356 è were diagnosed as users without addictions (ST 12 – IT 2)

Source: Based on the Department for Anti-drug Policies' Study on Drug Addicts in Prison – Form 1 – December 2012

**Note: during the course of 2012, 56.4% of parole cases were filed due to closure of proceedings*

Figure 9.14: Subjects with drug-related problems by type of addiction and first drug used. Data in the form of percentages. The year 2012



Distribution of inmates with drug-related problems, according to types of drugs used ST 12 – IT 2

Source: Based on the Department for Anti-drug Policies' Study on Drug Addicts in Prison – Form 1 – December 2012

Turning our attention to the citizenship of these subjects, we find that, in 41% of cases, nationality is unknown. 43.6% are Italian citizens (8,857 subjects) and 15.3% (3,111 subjects) are foreigners (of whom 82% come from outside of the EU).

Inmates with drug-related problems exhibit different choices in drug type based upon whether they have addictions (ICD–IX CM diagnosis) or simply use drugs: Among drug-addicted inmates (who account for 68.7% of inmates with drug-related problems), although opiates remain the drug of choice (53.5% are opiate addicts, a decline with respect to the 2011 figure of 65%), the number of cocaine addicts rose to 35.9%, a 4.8% increase over 2011 numbers), while the number of cannabis addicts shot up from 2.3% in 2011 to 7%. Among inmates who use drugs but are not addicted, cocaine remained the drug of choice (56.3%, a slight increase over the 2011 figure of 54.9%), while the number of opiate users fell (18.2% vs. 24.1% in 2011), but the number of cannabinoid users rose from 13.2% in 2011 to 19% in 2012.

Choice of drug type differs between addicts and users

It should also be mentioned that, regardless of whether inmates were diagnosed as addicts or users, 41.9% of subjects with drug-related problems (a total of over 8,500 cases) were polydrug users at the time of entering prison (the figure stood at 37.1% in 2011).

42% of inmates with drug problems are polydrug users

9.7.2. Juvenile drug-users passing through the juvenile justice system

Beginning in 2012, with the passing of the responsibility for healthcare to the Health Units, the characteristics of drug-addicted minors in prisons or other types of custodial institutions is collected by Local Public Drug Addiction Services Units (SerTs), according to the principle of local competence.

For each subject, alcoholism or drug addiction according to the ICD –IX CM diagnosis is distinguished from mere use in the absence of an addiction diagnosis. In 2013, the rate of response on the part of the Regions was quite high, considering the difficulty of collecting data on minors in facilities other than Correctional Institutions for Minors (known as IPMs), characterised by the short periods for which minors stay in them. Specifically, information was collected from almost all of the country's Correctional Institutions for Minors, and from approximately half of Italy's alternative custodial facilities.

Table 9.4: Regions which provided information on Juveniles with drug- or alcohol-related problems in prisons or other custodial facilities. The year 2012

Correctional Institutions for Minors	Reception Centres	Communities	Social Services for Juveniles
Piedmont Lombardy Lazio Campania Apulia Calabria Sicily Sardinia Emilia Romagna Tuscany	Piedmont Lazio Abruzzo Calabria Emilia Romagna Sicily Apulia	Emilia Romagna Sicily Campania Apulia	Abruzzo Emilia Romagna Lombardy Apulia Sicily Lazio

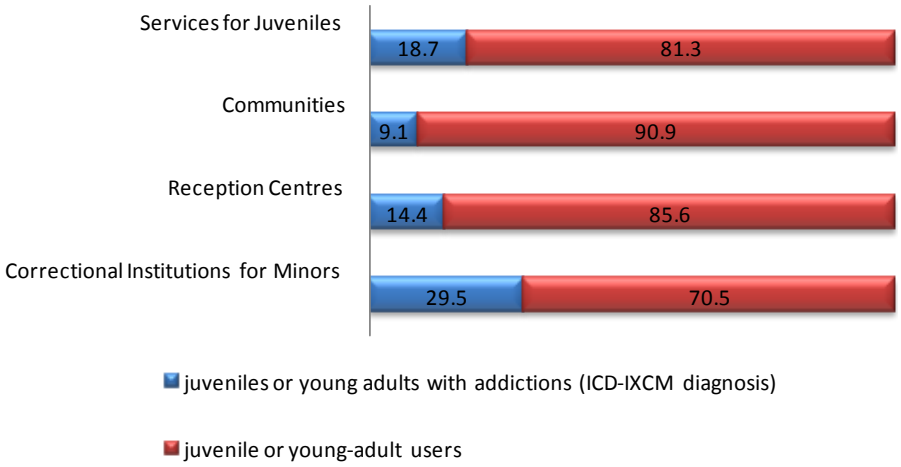
Source: Based on the Department for Anti-drug Policies' Study on Drug Addicts in Prison – Form 3 – 6 December 2012.

As was also the case last year, the number of subjects who are alcoholics or who engage in problem use of alcohol was negligible in 2012. Therefore, we will limit ourselves to describing only the situation of drug-addicted minors in prison or in other custodial facilities, with a particular focus on Correctional Institutions for Minors.

If we look at the data as a whole, we find that a total of 762 minors

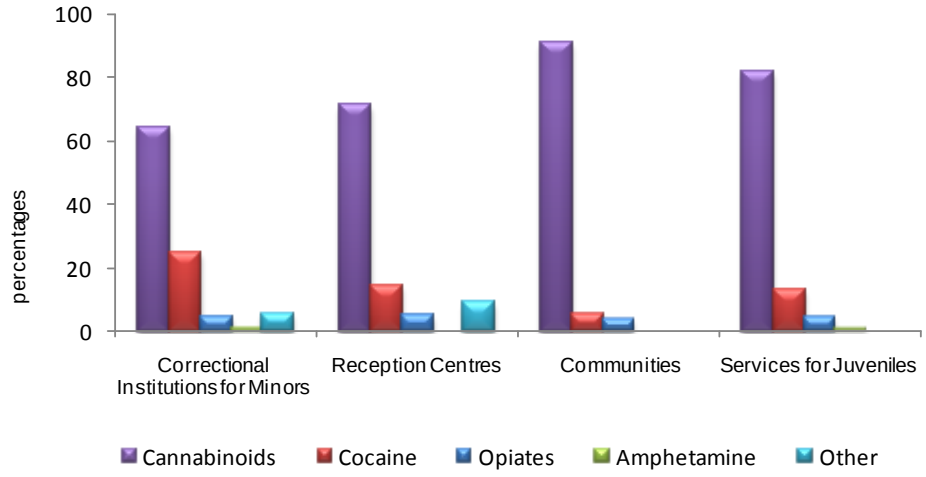
suffering from drug-related problems were in custodial facilities in 2012. Most of these were in Institutions for Minors (47%), while the percentage of minors in Communities was very low (7%).

Figure 9.15: Drug-addicted juveniles, by type of custodial facility. The year 2012



Source: Based on the Department for Anti-drug Policies' Study on Drug Addicts in Prison – Form 3 – 6 December 2011

Figure 9.16: Drug-addicted juveniles, by type of drug used and type of custodial facility. Data is given in the form of percentages. The year 2012



Source: Based on the Department for Anti-drug Policies' Study on Drug Addicts in Prison – Form 3 – 6 December 2012.

A higher number of juvenile drug addicts use cannabinoids

In comparison with 2011, the number of drug users diagnosed with addictions decreased (22.6% vs. 30% in 2011), with a proportional increase in the number of subjects who use drugs but are not addicted.
Concerning the types of drugs used, most juvenile drug addicts, regardless of whether they have been diagnosed with addictions, use cannabinoids or, on a lesser scale, cocaine. Specifically, of the addicts, 56% are addicted to cannabinoids, 26% to cocaine and 14% to opiates. On the other hand, among non-addicted drug users, 77% use cannabinoids, 16% use cocaine, and the remaining 2% use opiates.
In addition, 10.2% of juvenile problem drug users in custodial facilities are polydrug users.

As mentioned above, data collected from Correctional Institutions for Minors are representative of 89% of facilities nationwide. Given the high representivity of the sample, and the existence of detailed information regarding the social, health and legal characteristics of these facilities' inmates, what follows is a more in-depth analysis of drug addiction among minors in prison based on that data.
359 juvenile problem drug users entered Correctional Institutions for Minors in 2012, of whom 64% were Italian and a fifth were foreign, of whom the majority were from outside the EU. The vast majority of these minors are male (16 drug-addicted girls were serving time in Correctional Institutions for Minors in 2012), and most (51.5% of the sample group) were young adults (18-21 years of age). 70.5% of juvenile problem drug users in these Institutions were users only, while the remaining 29.5% were diagnosed as having addictions (the percentages found in 2011 were 64% and 36%, respectively).
For both groups, cannabinoids are the most commonly used drugs, followed by cocaine, then opiates.
Moreover, it was found that 12.8% of juvenile problem drug users were polydrug users.

9.8 Responses to drug-related health issues in prisons

9.8.1. Drug treatment

Few tests for HIV, HCV and HBV

Observing data collected through application of the new information flow regarding inmates in the care of drug-addiction services, it was found that, although the number of drug addicts in prison who had been tested for infectious diseases was higher than in the previous year, still only 34.7% of drug-addicted inmates had been tested for HIV upon entering prison (28.5% in 2011), 38.6% (30.8% in 2011) had been tested for HCV and a further 29.4% (29.25 in 2011) for HBV. Prevalences of positive results among those tested stood at 5.6% for HIV, 36.9% for HCV and 16.5% for HBV.

Table 9.5: Subjects with drug-related problems undergoing treatment. The year 2012

	Absolute values	%
Inmates undergoing treatment	12,656	9.6
who receive:		
Only pharmacological treatment	*2,598*	*20.5*
Psycho-social treatment	*3,737*	*29.5*
Integrated pharmacological and psychosocial treatment	*6,321*	*49.9*
Inmates not provided with treatment	1,308	9.4
Total	**13,964**	**100.0**

Based on the Department for Anti-drug Policies' Study on Drug Addicts in Prison – Form 1 - December 2012.

90.6% of drug-addicted inmates receive addiction treatment and prevention treatment

Regarding drug-addiction treatment, it was found that 90,6% of inmates with drug-related problems undergo treatment in prison. The most type of treatment most frequently used appears to be integrated psycho-social and pharmacological treatment, which is provided to over 6,300 inmates.
Turning our attention to juveniles in Correctional Institutions for Minors, we find that all minors diagnosed as suffering from addictions whilst in these Institutions receive addiction treatment. This percentage falls to 30.1% if

we consider both addicts and users without addictions. In any case, of the 108 subjects found to be receiving addiction treatment, 48.1% are undergoing pharmacological treatment and 49.1% are undergoing psychosocial treatment, while the small remainder undergo integrated treatment.

Only a third of drug-addicted prisoners were tested for infectious diseases upon entering Correctional Institutions for Minors

As far as testing is concerned, we find that only a third of prisoners with drug problems in Correctional Institutions for Minors were administered a drug test upon entering (27.3%). The number of subjects tested for HIV is also low (21.7%), despite the fact it doubled with respect to 2011. 37%, meanwhile, were tested for HBV and HCV (the number stood at approximately 34% in 2011).

Finally, it was found that only 9.2% of the minors being treated (33 subjects out of 359) were sent to therapeutic, social-educational or social-rehabilitation communities.

10. DRUG MARKETS

10.1 Introduction

Preface

This chapter, which describes the main characteristics of illicit drug supply in Italy, has the aim of providing the necessary information to make conjectures regarding possible future developments in drug demand. This is done in full knowledge of the increasing complexity and constant evolution of a scenario which sees the continual appearance and introduction onto the market of new drugs or mixtures of already known drugs whose effects are partly or completely unknown.

The Central Directorate for Anti-drug Services (DCSA) is the principal source of information

The profile described in this chapter is based on data collected by the Central Directorate for Anti-drug Services of the Ministry of the Interior (DCSA) and also draws on the annual report on drug-trafficking in Italy, an information source which can be referenced for further details and more in-depth analyses.

10.2 Availability and supply: drug production, supply and trafficking[1]

The role of organised crime

The Italian peninsula, due to its position at the centre of the Mediterranean Sea and its unique geography, characterized by eight-thousand kilometres of coastline, represents one of the main ports of entry for drugs into Europe, the largest market for heroin use in the world and second[2] only to North America for cocaine use. Add to these geographical factors the presence of powerful criminal organizations characterized by their use of widespread and well-established branches both outside of their regions and abroad. These groups are capable of managing international drug-trafficking operations in addition to maintaining control over their respective internal markets. Italy is an important crossroads for international drug trafficking, and especially trafficking by sea routes. This trend is characterized especially by the seizures of hashish and marijuana along the country's coasts, which account for nearly all seizures of cannabinoids in Italy. Today, in the war against cocaine, the coastline also plays a decisive strategic role, although the majority of cocaine seizures occurred at international airports up until 2008.

An increase in the amounts of drugs seized

Over the last ten years, while the trend in seizures within the country has fluctuated, the number of seizures occurring along the country's perimeter has increased in absolute terms, and rose steadily between 2008 and 2012.

This result, the fruit of a broad and targeted drug-fighting strategy applied by Law Enforcement agencies, is crucial, as it ensures that considerable quantities of drugs are prevented from entering the national and foreign markets (Italy is not only the final destination of drug-traffickers, but is also a transit area). This strategy also makes it possible to strike at the most competent and dangerous criminal organizations, those which manage the most high-risk stage of drug trafficking (moving large quantities of drugs across

[1] Based on the 2012 annual report on drug trafficking prepared by the Central Directorate for Anti-drug Services – Part Two – The state of drug-trafficking in Italy.

[2] The European market is more advantageous, both because demand is steadily rising and because a kg of cocaine sells for anywhere from 32,000 dollars in Luxembourg to 77,000 dollars in the United Kingdom, in comparison with 27,000 dollars in the U.S.A.

coastlines/borders).
The amount of drugs seized and itemisations of reports filed for crimes in violation of D.P.R. 309 of 1990 differ considerably from region to region. One of the factors which contributes greatly to this lack of uniformity, in addition to the presence of border/coastal areas, ports and airports and differences in land area and population density is the presence of established criminal organizations, which may be either Italian or foreign.
The overall national picture, as drawn from an analysis of Law Enforcement Agencies' anti-drug activities and from data and information catalogued and processed by the Central Directorate for Anti-drug Services, shows that, in 2012, the majority of national drug-trafficking was conducted by traditional, home-grown crime syndicates ('Ndrangheta, Cosa Nostra, Camorra and criminal organizations from the Region of Apulia). These large criminal organizations devoted to drug trafficking are structured as networks. Their *modi operandi* do not always conform to predefined operational models; instead, they establish cooperative working relationships whose nature is often occasional and transitory, as dynamic and rapid as they are unusual and unexpected.
In the drug-trafficking sector, as for other types of illicit traffic, the **Apulian crime syndicates** stand out in comparison with other organisations as "providers of criminal services". They act as intermediaries, especially with groups of Balkan origin, or simply provide these with services and logistical support within their territory, often sharing in their profits.

Apulia: heroin and marijuana distribution; large quantities of cannabis plants seized

This distinctive situation arises from the fact that Apulia, with its proximity to the Balkan coasts, is an important crossroads for the trafficking of heroin and Albanian-produced marijuana with a high level of active principle. The Region of Apulia holds first place both for the highest total quantity of drugs seized as well as for the highest number of cannabis plants discovered (over 4 million, which account for 97% of the nationwide total), and was at second place among the Regions for seizures of heroin.

Foreign crime

For a number of years, foreign crime has occupied a place of considerable importance in Italy. It has been characterised by its widespread expansion throughout the country and the protean nature of its organisational traits and distinguishing features, factors which increase its potential for harm.
Over the last ten years there has been a steady and continuous increase in the number of foreigners being reported for crimes. If we divide them according to their nationalities, we find that the four nations whose citizens were most often reported were, in first place, Morocco, followed by Tunisia, Albania and, in fourth place, Nigeria. Foreign criminal organisations contribute to the expansion of drug trafficking in Italy, making use of maritime traffic and of border crossings.
The situation in Italy in 2012 was a continuation of the previous year's, with no change in the cast of players participating in the drug-trafficking scene, which once again proved itself to be the most fertile terrain for criminal alliances, even in those areas with a high rate of mafia-style crime. This is due to the fact that the capacity to recognize and assimilate changes imposed by the evolution of the social and criminal contexts in which such organizations operate is a

fundamental aspect of the mafia phenomenon and an important reason behind their ability to endure over time.

10.3 Drug Operations and Seizures

Law Enforcement activities targeting the illicit drugs market are concentrated on three main fronts: illicit drug production, trafficking and sales. The following section provides a summary of the activities to combat this phenomenon carried out by Law Enforcement Agencies in 2012 and their results.

Table 10.1: Anti-drug operations and seizures of illicit drugs. The year 2012

	2011		2012		Δ %
	No.	%	No.	%	
Anti-drug operations					
Seizure	19,469	84.3	18,969	83.4	-2.6
Crime detection	1,972	8.5	1,915	8.4	-2.9
Discovery	1,530	6.6	1,764	7.8	15.3
Other	132	0.6	100	0.4	-24.2
Total	23,103	100.0	22,748	100.0	-1.5
Cocaine (kg)	6,342	16.1	5,324	10.6	-16.1
Heroin (kg)	811	2.1	951	1.9	17.3
Hashish (kg)	20,258	51.5	21,893	43.6	8.1
Marijuana (kg)	10,908	27.7	21,496	42.9	97.1
Cannabis plants (no. of plants)	1,008,215	-	4,122,617	-	308.9
Synthetic drugs (units/doses)	16,620	-	22,711	-	36.6

Source: Based on data from the Ministry of the Interior – the Central Directorate for Anti-drug Services

Slight decrease in seizure operations

Decrease in volume of cocaine seized; Dramatic increase in cannabis plants seized; Amounts of marijuana, synthetic drugs, heroin and hashish seized also increased

In 2012, Law Enforcement Agencies conducted a total of 22,748 anti-drug operations, a 1.5% decrease with respect to the previous year.
In 83.4% of cases, these anti-drug operations led to the seizure of illicit drugs, 8.4% led to crime detection and a further 7.8% led to the discovery of quantities of drugs (Table 10.1). In 2012, as in 2011, no drug-processing laboratories were discovered, unlike in 2010, when three laboratories for the processing of cocaine and liquid hashish were discovered and dismantled.

Types of operations

If we examine the details, we find that the “balance sheet” of the fight against drug trafficking in Italy in 2012 shows the seizure of approximately 50,000 kg of drugs and over four-million cannabis plants. Going into specifics, we see that quantities of drugs seized have increased for marijuana, synthetic drugs and heroin. Of the total amount of drugs seized in 2012 by Law Enforcement Agencies, over 14,000 kg of drugs were seized in customs zones (sea, air and land borders) as a result of reports and thanks to the international coordination activities conducted by the Central Directorate for Anti-drug Services.

Large numbers of cannabis plants seized

Data regarding drug seizures are reported in Standard Table number 13 (ST 13 2013). In 2012, as in the previous year, there was a significant increase in marijuana seizures, which rose by 97.1%. There was also a, 8.1% rise in hashish seizures. The largest quantities of cannabis derivatives were seized in Apulia (29.2% of the total), Lombardy (18.9%) and Liguria (13.3%).

A 97% increase in marijuana seizures

Table 10.2: Amounts of Cocaine and Marijuana seized in "maxi-seizure" operations – the years 2011-2012

	Cocaine > 20 Kg			Marijuana > 100 Kg		
Geographic area	**2011**	**2012**	**Diff. Kg**	**2011**	**2012**	**Diff. Kg**
Centre	668.6	835.1	+166.5	1,817.2	3,337.2	+1,520.0
Northeast	114.4	174.0	+59.6	-	743.9	+743.9
Northwest	696.3	1,484.4	+788.1	1,697.8	+961.1	-736.7
South and the Islands	1,101.8	2,510.0	+1,408.2	3,712.9	15,242.5	+11,529.6
Total	**2,581.1**	**5,003.5**	**+2,422.4**	**7,227.9**	**20,284.7**	**+13,056.8**

Source: Based on data from the Ministry of the Interior – the Central Directorate for Anti-drug Services

A decrease in cocaine seizures

Turning to the topic of cocaine, we find a 16.1% decrease in the amount of cocaine seized in 2012 (5.3 tons) and there was also a slight drop in the number of operations conducted, which fell from 6,899 to 6,633, a 3.9% decline. The largest seizures occurred in the port of Gioia Tauro (RC), in Settimo Milanese (MI) and in Pisa.
If we turn our attention to the cocaine seized in maxi-seizure operations conducted in 2011 and 2012 (maxi-seizure meaning amounts larger than 20 kg for cocaine) and of marijuana seized in these types of operations during the same time period (meaning amounts larger than 100 kg for marijuana), we find that these operations occurred largely in provinces located along the coast or near border crossings. These large quantities seized were therefore not meant solely for the national market; Italy is also acting as a transit zone for Europe (Table 10.2) Moreover, from the table, we can see that the amount of drugs seized increased in nearly all the provinces taken into consideration. Regarding marijuana, specifically, large quantities were discovered in the provinces of Rome, Bari, Brindisi, Foggia and Syracuse.

Investigative activities carried out over recent years reveal a new trend in strategies being employed by the principal criminal organizations, which have been widespread for quite a while in Lombardy and Lazio as well, whereby very large quantities of cocaine are introduced directly into Italian territory by means of maritime trade routes being exploited for the purpose of international drug trafficking.
This regards mainly seizures of hashish and marijuana, but also of cocaine (an 83.6% incidence of seizures in 2011 and a 70.5% incidence in 2012).

Local production and a dramatic increase in the number of cannabis plants seized by geographic area: Apulia and Calabria

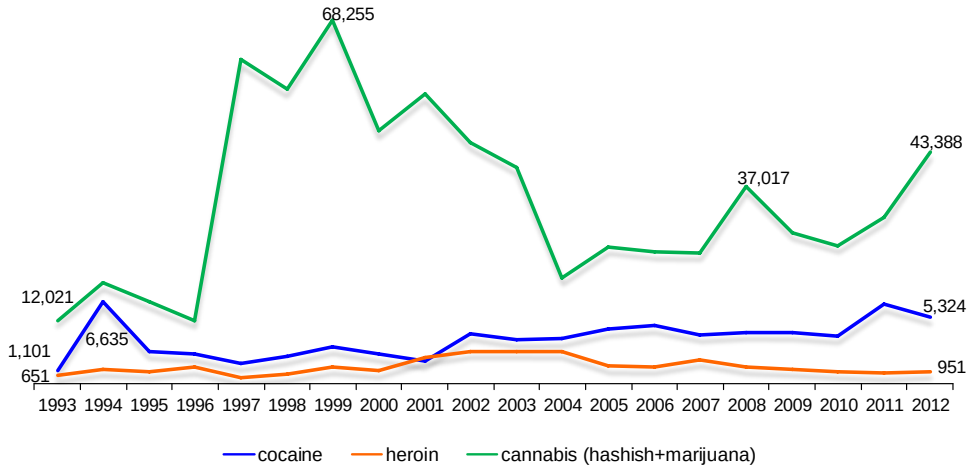
Regarding the seizure of cannabis plants, the Central Directorate for Anti-drug Services issued a warning about the spread of local production of illicit drugs by organized crime syndicates. Seizures of cannabis plants shot up dramatically last year, rising from 1,008,215 in 2011 to 4,122,617 in 2012. In 2011 the largest number of plants were discovered in Sicily, accounting for 91.8% of the overall total. In 2012, however, the largest number of plants were discovered in the Region of Apulia (97.1%), followed, on a smaller scale, by Calabria (1.3%).

Trends in the quantities of illicit drugs seized

Trends in the quantities of drugs seized over the last fifteen years place cannabis derivatives at the top of the ranking, with particularly high quantities being seized in the period spanning 1997 – 2003. From 2004 on there were two increases. One was in 2008, when Law Enforcement intercepted a quantity in excess of 37 tons, and another in 2012, when the

amount was greater than 43 tons.
Figures for the seizures of cocaine and heroin remain much less variable. Between 2002 and 2010, cocaine seizures fluctuated between 3.5 and 4.5 tons, but stood at over 5 tons in 2012, a decrease with respect to 2011, when 6.3 tons were seized. Heroin seizures, on the other hand, which had been fluctuating between 1.0 and 2.5 tons, fell to a ten-year low of 0.8 tons in 2011. In 2012, the amount of heroin increased slightly to nearly one ton (Figure 10.1).

Figure 10.1: Quantities of illicit drugs seized by Law Enforcement Agencies during the course of anti-drug operations. The years 1993 – 2012



2008-2012 data updated

Source: Based on data from the Ministry of the Interior – the Central Directorate for Anti-drug Services

10.4 Price and purity

10.4.1 Price

Trends in retail and wholesale prices of drugs represent one of the variables which determine how drug demand relates to supply. It is therefore a variable of utmost importance when analysing the effects of national and international policies for anti-drug policy management. Furthermore, price trends, when their variability is significant, can be an indirect indicator of use trends. As a matter of fact, a drop in price usually corresponds to a reduction in demand or to the appearance on the market of a competitor drug or the rise of other alternative distribution networks.
The total value of the drugs seized by Police Forces during the course of 2012, based on their average value on the market, is over 839-million euros, (this total does not include the values of synthetic drugs). This figure was calculated based upon the average “street” price per gram of each drug multiplied by the amount seized.
Collection of retail-price information is currently the responsibility of the Central Directorate for Anti-drug Services, which processes information coming from the local police forces of 12 sample cities (Palermo, Reggio Calabria, Naples, Bologna, Venice, Florence, Trieste, Turin, Rome, Genoa, Milan and Verona).
Analyses, based entirely on Standard Table Number 16 (ST 16 2013), show an increase in the maximum and minimum prices of hashish and cocaine in 2012, as well as in the minimum price of white heroin. On the

other hand, there was a decrease in the maximum prices of white and brown heroin, while the prices of amphetamines, marijuana, ecstasy and LSD remained stable (Table 10.3).

Different price variations:

Decrease in maximum prices of white and brown heroin

Amphetamine, marijuana, ecstasy and LSD prices remain stable

Increase in prices of hashish and cocaine

Table 10.3: The minimum and maximum prices per unit (gram/dose/pill) of drugs – The years 2011 and 2012

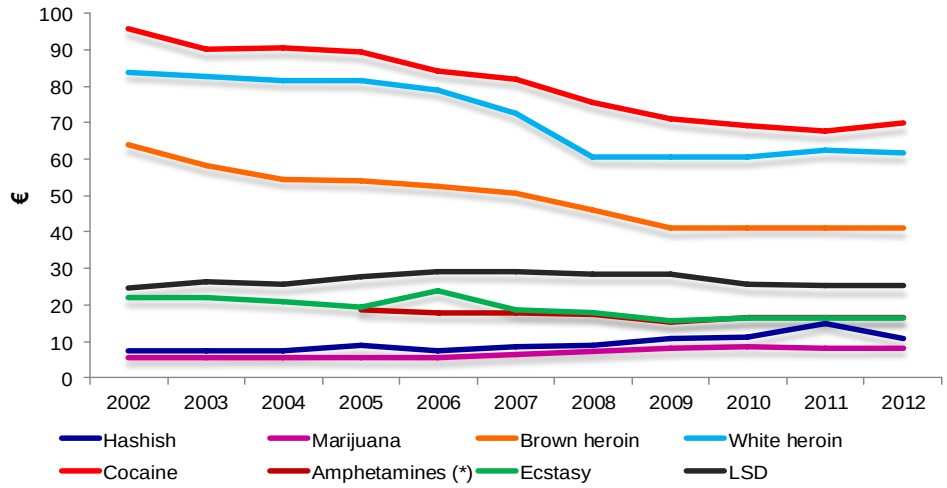
	Minimum price			Maximum price		
Drug type	**2011**	**2012**	**Δ%**	**2011**	**2012**	**Δ%**
Hashish (g)	8.3	9.2	10.6	11.5	12.6	9.1
Marijuana (g)	7.2	7.3	1.0	9.4	9.4	0.5
Brown heroin (g)	35.5	35.5	0.0	48.4	47.4	-2.1
White heroin (g)	53.3	55.0	3.1	72.0	69.0	-4.2
Cocaine (g)	55.4	57.1	3.0	80.3	82.8	3.1
Amphetamines (g)	16.0	16.0	0.0	17.4	17.6	1.1
Ecstasy (dose)	14.8	14.8	0.0	18.8	18.8	0.0
LSD (dose)	23.3	23.3	0.0	27.0	27.0	0.0

Source: Ministry of the Interior – the Central Directorate for Anti-drug Services

From 2002 to 2012, average prices fell from €96 to nearly €70 per gram for cocaine and from approximately €29 to little more than €25 for a dose of LSD. The average price of hashish fell, while the average prices of marijuana, brown heroin, white heroin and synthetic drugs remained unchanged. Overall, price trends were found to be continuing to decline (Figure 10.2).

Overall trend in average prices between 2002 and 2012 shows a downturn

Figure 10.2: Average prices per drug dose. The years 2002 – 2012



Standard Table number 16: average prices in euros

(*) Data for amphetamine prices are only available beginning in 2005
Source: Based on data from the Ministry of the Interior – the Central Directorate for Anti-drug Services

10.4.2 Purity

Data on the purity of drugs come from analyses conducted by the Drug Investigation Section of the Police Scientific Service of the Central Anti-crime Directorate of the State Police (Standard Tables 14 and 15), as set forth in the specifications established by the European Monitoring Centre for Drugs and Drugs Addictions. The data recorded refer to both high-quantity seizures and street seizures.

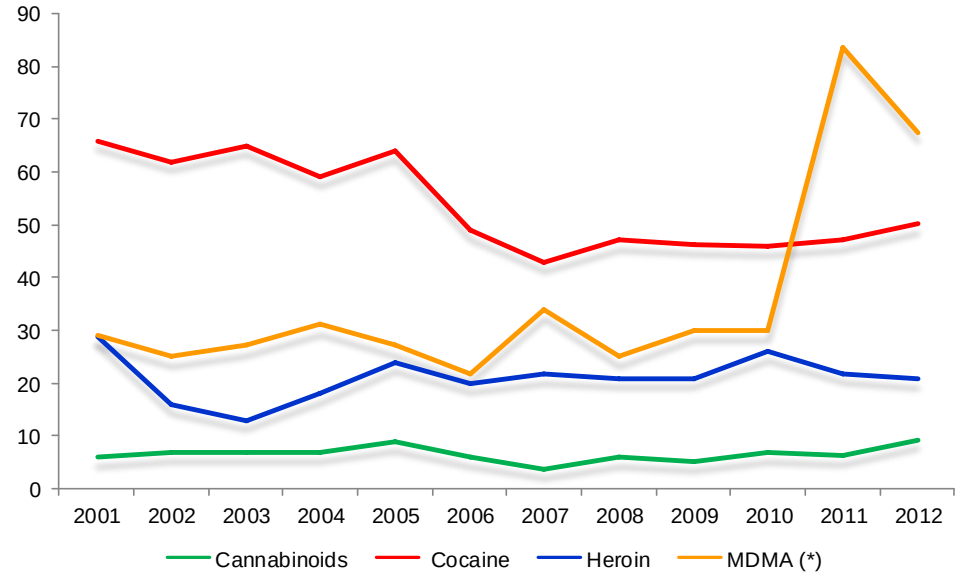
In 2012, the average percentage of active principle found in the samples analysed increased both for cannabinoids (THC), rising from 6% to 10%, and for cocaine, rising from 47% to 50%. The percentage of pure drug in heroin decreased slightly, while the number of mg of MDMA contained in each pill/unit dropped from 84 mg in 2011 to 68 mg in 2012. However, these figures are the results of analyses carried out on a small sample of drugs, and are therefore subject to high variability both within the sample itself as well as in comparison with samples of drugs collected at different times (Figure 10.3 and Table 10.3).

Increase in percentages of active principle in cannabinoids and cocaine

% of active principle in heroin remains stable

Decrease in mg of MDMA per pill/unit

Figure 10.3: Average percentages of pure drug in drugs discovered by Law Enforcement Agencies in the years 2001 to 2012



ST 14 2013: Average percentages of drug purity

(*) MDMA figures refer to the average weight in mg per pill/unit.

Source: Based on data from the Ministry of the Interior – Central Anti-crime Directorate of the State Police

Table 10.4 contains the maximum, minimum, average and median values of active principle found in illicit drugs in 2012. Variability is very high, ranging from 1% to 27% for cannabinoids, from 6% to 87% for cocaine and from 2% to 50% for heroin, while the weight in mg of MDMA per pill/unit ranged from a minimum of 27 mg to a maximum of 107 mg. All recorded variability may also be the result of having combined the types of seizures (large shipments and retail), since drugs seized in these two different situations can differ greatly in terms of the percentage of active principle they contain.

High variability in quantities of active principles (ST 15 2013)

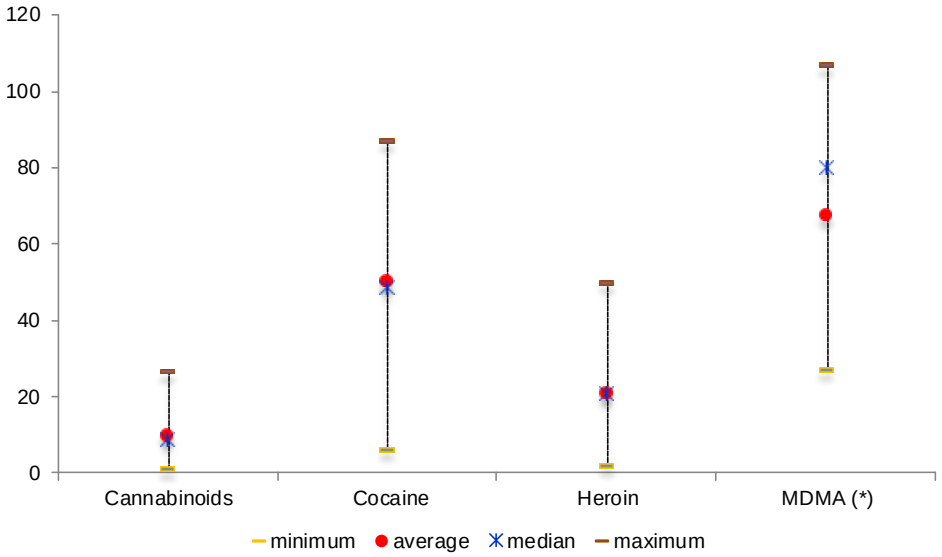
Table 10.4: Minimum, average, median and maximum active-principle values found in illicit drugs. The year 2012

	Cannabinoids	Cocaine	Heroin	MDMA(*)
minimum	1	6	2	27
average	10	50	21	68
median	9	49	21	80
maximum	27	87	50	107

(*) MDMA figures refer to the average weight in mg per pill/unit.

Source: Based on data from the Ministry of the Interior – Central Anti-crime Directorate of the State Police

Figure 10.4: Variability in the quantity of active principle in illicit drugs discovered by Law Enforcement Agencies in 2012



(*) MDMA figures refer to the average weight in mg per pill/unit.

Source: Based on data from the Ministry of the Interior – Central Anti-crime Directorate of the State Police

With regard to the percentage of active principle in cannabis and its derivatives, it should however be pointed out that the Warning System has detected extremely high percentages in some drugs seized in 2012 (38% in skunk plants and 58% in hashish oil), with a trend towards the selection and production of plants with ever higher levels of active principle. Indeed, in comparison with 2011 data for THC concentrations, minimum, average and maximum values are all higher in 2012. This preliminary data, which will have to be verified over time together with supply trends, verifiable via internet and through customer demand, points to a tendency to attempt to select and introduce onto the markets plants and intensive growing methods capable of producing ever higher levels of THC.

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List of tables

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

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

Table 2.14: Subjects tested within the Carabinieri Corp. The years 2008 – 2012.

3. PREVENTION

Table 3.1: Number of universal and selective prevention information campaigns conducted by the Regions and Autonomous Provinces during the course of 2012.

4. PROBLEM DRUG USE

Table 4.1: Prevalence estimates of subjects in need of treatment, by drug type. The years 2011-2012.

Table 4.2: Zelterman estimates for cocaine user population sizes, for both New and Already Known users, and relative confidence intervals, by geographic area. The year 2010.

Table 4.3: Horvitz-Thompson, Zelterman and Chao estimates for the size of the population of COCAINE users, both New and Already Known, and relative confidence intervals. The year 2010.

Table 4.4: Horvitz-Thompson, Zelterman and Chao estimates for the size of the population of CANNABIS users, both New and Already Known, and relative confidence intervals. The year 2010.

Table 4.5: Students who had used cannabis in the 30 days prior to the survey, by type of user (prevalence %) in the student population 15-19 years of age, by gender. The year 2013.

Table 4.6: Students who had used cannabis in the 30 days prior to the survey, by type of user (prevalence %), in the student population 15-19 years of age, by age. The year 2013.

Table 4.7: Subjects who had used cannabis in the 30 days prior to the survey, by type of user (prevalence %) in the general population 18-64 years of age, by gender. The year 2012.

Table 4.8: Subjects who had used cannabis in the 30 days prior to the survey, by type of user (prevalence %) in the general population 18-64 years of age, by age group. The year 2012.

Table 4.9: CAST scale scores for students 15-19 years of age who had used cannabis (marijuana and hashish) in the 12 months prior to the survey, by gender, age and geographic area. The year 2013.

5. TREATMENT DEMAND AND AVAILABILITY

Table 5.1: Diagnostic-therapeutic-rehabilitative facilities in accordance with the Framework for State-Regional Accord Act of 5 August 1999, by type of facility and type of treatment provided. The years 2011 – 2012**.**

Table 5.2: Transmission of SIND archive data on the part of addiction services, in accordance with Ministerial Decree 11 June 2010. The years 2011-2012.

Table 5.3: Subjects in treatment with Drug Addiction Services, by gender and type of subject (new or returning). The year 2012.

6. HEALTH CORRELATES AND CONSEQUENCES

Table 6.1: Clients in the care of addiction Services: Subjects tested and subjects not tested for HBV, HCV and HIV. The year 2012.

Table 6.2: Prevalence of clients tested for HIV who were diagnosed HIV-Positive. The year 2012.

Table 6.3: Prevalence of clients tested for HBV who were diagnosed HBV-Positive. The year 2012.

Table 6.4: Prevalence of clients tested for HCV who were diagnosed HCV-Positive. The year 2012.

Table 6.5: Addiction service clients testing positive for HBV, HCV or HIV who have engaged in injecting drug use (IDU) at least once in their lives. The year 2012.

Table 6.6: Traffic accidents (fatalities and injuries) and their causes; absolute values and percentages. The years 2010-2011.

Table 6.7: Deaths by overdose, by gender and year of death. The years 1999 – 2012.

8. SOCIAL IMPLICATIONS AND SOCIAL REINTEGRATION

Table 8.1: Percentage distribution of drug addiction services clients according to type of employment, gender and type of client (new or returning). The year 2012.

Table 8.2: Percentage distribution of drug addiction service clients according to housing situation, by gender and type of client (new or returning). The year 2012.

Table 8.3: Total amount dedicated by Regions and Autonomous Provinces to finance social reintegration projects over the course of 2012.

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

Table 9.1: Characteristics of persons reported to the Prefectures by Law Enforcement Agencies pursuant to Art. 75. The year 2012.

Table 9.2: Characteristics of charges brought before the Judicial Authorities by Law Enforcement Agencies for violations of DPR 309/90. The year 2012.

Table 9.3: Drug addicts in the care of social services who are on probation or have been released on parole. The year 2012.

Table 9.4: Regions which provided information on Juveniles with drug- or alcohol-related problems in prisons or other custodial facilities. The year 2012.

Table 9.5: Subjects with drug-related problems undergoing treatment. The year 2012.

10. DRUG MARKETS

Table 10.1: Anti-drug operations and seizures of illicit drugs. The year 2012.

Table 10.2: Amounts of Cocaine and Marijuana seized in “maxi-seizure” operations – the years 2011-2012.

Table 10.3: The minimum and maximum prices per unit (gram/dose/pill) of drugs – The years 2011 and 2012.

Table 10.4: Minimum, average, median and maximum active-principle values found in illicit drugs. The year 2012.

List of graphs

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

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

Figure 2.11: Distribution of the average number of doses of METAHAMPHETAMINE consumed per day (per 1,000 inhabitants) in each city over the three-year period 2010-2012 and corresponding confidence intervals, by geographic area.

Figure 2.12: Distribution of the average number of doses of MDMA (ECSTASY) consumed per day (per 1,000 population) in each city over the three-year period 2010-2012 and corresponding confidence intervals, by geographic area.

Figure 2.13: Distribution of grams per day of KETAMINE detected in each city over the three-year period 2010-2012 and corresponding confidence intervals, by geographic area.

Figure 2.14: Drug use in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2013.

Figure 2.15: Heroin use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2013.

Figure 2.16: Cocaine use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2013.

Figure 2.17: Cannabis use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2013.

Figure 2.18: Stimulant use (% prevalence) in the student population aged 15-19 in the 12 months prior to the survey. The years 2003-2013.

Figure 2.19: Hallucinogen use (% prevalence) in the student population aged 15-19 over the 12 months prior to the survey. The years 2003-2013.

Figure 2.20: Geo-referencing of cases of acute synthetic cannabinoid intoxication requiring emergency-room admittance recorded by the National Early Warning System beginning in 2010, names of the drugs patients had used and the types of synthetic cannabinoids they corresponded to, as detected in patient samples analysed.

Figure 2.21: Geo-referencing of cases of synthetic cathinone intoxication requiring emergency-room admittance recorded by the National Early Warning System since 2010 and types of synthetic cathinones detected in the samples analysed.

Figure 2.22: Geo-referencing of cases of methoxetamine intoxication which required emergency-room admittance, as recorded by the National Early Warning System in 2011-2012.

Figure 2.23: Distribution of gr/day of KETAMINE detected over the three-year period 2010-2012 and corresponding confidence intervals, by geographical area.

Figure 2.24: Users (prevalence %) of new drugs in the student population 15-19 years of age during the 12 months prior to the survey. The years 2012-2013.

Figure 2.25: Users (prevalence %) of new drugs in the student population 15-19 years of age, at least once in the 12 months prior to the survey. The year 2013.

Figure 2.26: 1st-level Drug testing, positive results comparison 2009-2012.

Figure 2.207: Flow of subjects subjected to testing and verification – The year 2012.

Figure 2.28: 1st-level Drug Testing by age group and result. The year 2012.

Figure 2.29: 2nd-level clinical verification – analysis by drug type – the year 2012.

Figure 2.30: 2nd-level clinical verification – analysis by diagnosis – the year 2012.

3. PREVENTION

4. PROBLEM DRUG USE

5. TREATMENT DEMAND AND AVAILABILITY

6. HEALTH CORRELATES AND CONSEQUENCES

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

8. SOCIAL IMPLICATIONS AND SOCIAL REINTEGRATION

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

Figure 9.16: Drug-addicted juveniles, by type of drug used and type of custodial facility. Data is given in the form of percentages. The year 2012.

10. DRUG MARKETS

Figure 10.1: Quantities of illicit drugs seized by Law Enforcement Agencies during the course of anti-drug operations. The years 1993 – 2012.

Figure 10.2: Average prices per drug dose. The years 2002 – 2012.

Figure 10.3: Average percentages of pure drug in drugs discovered by Law Enforcement Agencies in the years 2001 to 2012.

Figure 10.4: Variability in the quantity of active principle in illicit drugs discovered by Law Enforcement Agencies in 2012.

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