DEMAND REDUCTION INTERVENTIONS

1 Strategies in Demand Reduction at National Level

1.1 Major strategies and activities

As has already been noted in Section 1 concerned with national strategies and policies, a National Drugs Plan was adopted in February 2002 which identifies the focus and priorities for action on drug misuse. For demand reduction, the most important elements are:

- Renewed emphasis on primary prevention, engaging public and private organisations, the community and the family
- Increased utilisation of abstinence focused treatment and an expansion of residential drug free treatment
- Changes to improve accessibility to treatment, including treatment provision within the justice system
- Evaluation to ensure that the most effective, evidence based interventions are used in prevention, treatment, recovery and rehabilitation.

At the time of writing, the changes or developments required to implement and measure the impact of the National Plan have only started to be put into place. The Plan was adopted by the Government in February 2002.

In April 2002 the Minister of Labour published the basis for financing projects through the National Drugs Fund \(^1\). The areas identified are closely associated with the priorities of the National Plan, for instance, with a focus on integrated actions, interventions around the use of new drugs along with development of early warning systems, reduction of chronic drug use through expansion of drug free treatment options, expanded services for women drug users, training and updating of relevant staff, evaluation of interventions, placement of former drug users into training and employment and work with European partners on interventions with drug users moving within the European Union.

In June 2002 a Ministerial Decree from the Minister of Health in association with the Minister of Welfare \(^2\) was published. This set out the basis for the operation of the Pathological Dependency Departments and the role of the Ser.T. as an operational unit. It provides for accredited private social organisations to be treated on an equal basis with the Ser.T. and provides for a drug user or his family to seek treatment anywhere in the country, reversing the previous requirements for a drug user to present to the Ser.T. serving his or her area of residence for an assessment of treatment needs and subsequent placement in a treatment programme.

1.2 Approaches and new developments

1.2.1 New and innovative approaches

During 2001 there were no new or particularly innovative approaches. Rather, there was the development and gradual implementation of the new approaches promoted through the regulations approved in 1999, which have been described in detail in previous reports to the EMCDDA.

Broadly speaking, the developments have been towards more integrated systems of prevention, treatment, recovery and re-integration at the local level through the establishment of Departments for Pathological Dependencies, including illicit and

---

\(^1\) Provvedimento 10 aprile 2002 “Atto di indirizzo generale per la presentazione da parte delle Amministrazioni dello Stato dei progetti da finanziare con le risorse del Fondo nazionale di intervento per la lotta alla droga” Gazzetta Ufficiale della Repubblica Italiana, 30.4.2002 (General Directions to Central and Local Government bodies for the presentation of projects funded through the National Drugs Fund)

licit psychotropic substances, alcohol, gambling and eating disorders, with the responsibility of developing strategic planning and implementation plans. Relevant public and private organisations are expected to be involved in both planning and implementation aspects. It is also expected that other specialities should be involved in delivery, such as mental health, child health and maternity services.

The National Drugs Plan has only recently been adopted and, as described above, actions to implement it at local level are now being prepared but no major changes have yet occurred at the local level. It should also be noted that there is a clear separation of role between the national and local administrations. At the national level legislation and regulations establish the basis for strategic planning and service delivery and allocate resources to the Regions. At the local level, planning is expected to reflect an assessment of local needs and delivery of services appropriate to these needs. Thus, although a broad national framework has been established and specific resources have been targeted in line with the National Drugs Plan, it is the responsibility of Regions to deliver services in line with their own assessment and judgement of needs. Substantial variations in strategy and services are likely to continue at the Regional level within the flexibility established by the legislative and financial framework.

1.2.2 Socio-cultural developments relevant to demand reduction
There have been no major socio-cultural developments relevant to demand reduction in the reporting period. The changes which have occurred or which are in process essentially relate to policy. These include the new National Drugs Plan, increased powers for Regional administrations and a changing role for central administration as facilitator rather than deliverer of services. The impact of developments is likely to be seen gradually over the next few years.

1.2.3 Developments in public opinion
There has been no specific public opinion survey relating either to drug misuse or to demand reduction policy specifically during the year. There is, therefore, no clear basis for stating whether there has been any change in public opinion. There has been presentation of and debate about the National Drugs Plan and the new regulation concerned with the operation of the Ser.T. in the media. However, this presentation and debate has either been a reporting of the changes, or a statement of national policy and the basis for changes, or comment on the changes from those directly involved in planning or delivery. It is difficult, therefore, to call this public opinion. Rather, it is a policy and professional debate held in the public arena with no clear response from the wider public.

1.2.4 New research findings
Several major national research programmes are due to report shortly but have not as yet provided final data. These include the follow-up study of drug dependents in treatment with the Ser.T. (VEdeTTE), an evaluation of the quality of the Ser.T. and an evaluation of the quality of therapeutic communities. Preliminary data from these programmes has at present only provided quantitative data on the number of services involved and/or the number of clients recruited into the study. Qualitative data is still awaited.

1.2.5 Specific events
No specific events at the national level have been held during the year which have a direct bearing on demand reduction strategy.
2 Prevention

2.1 School programmes

2.1.1 Specificities of programmes

Health education and information on the dangers of alcohol, tobacco and drugs is promoted and co-ordinated by the Ministry of Education, Universities and Research and is within the framework of ordinary educational and didactic activities. At the local level, co-ordination and promotion of the initiatives contained in the annual programme has been delegated to the Director of Education for the Province who uses a technical committee which has the responsibility to determine the criteria for allocating the funds dedicated to health promotion activities. On this basis, there is no specific model used and the programmes which operate in schools but rather health promotion activities which are developed or implemented according to locally perceived needs. Every educational institute has a teacher with proven ability and experience for carrying out health education and drug prevention. As part of the national activity, training courses have been provided for these teachers.

2.1.2 Models of school interventions

There is a wide range of models available for health education and promotion and no specific national guidance on the model which should be used, only on the core criteria which should be included in a prevention programme. These elements were described in the last report to the EMCDDA and will not be repeated here.

In general there has been a move away from the use of external experts to provide special drug education programmes. Rather the model has been to use specialist input to health education where this is appropriate in the curriculum. The choice of external expert will vary from Province to Province according to the expertise available. At present there is no nationally collated data which can provide a succinct analysis of the range of models used or how they are implemented in practice.

2.1.3 Prevention programmes available

At the national level, several different prevention programmes are being piloted using resources from the National Drugs Fund. These build on work which has been previously reported on the training of teachers responsible for health education and maintaining the work of the information and counselling centres based within schools.

“Student Oriented Schools” is aimed at the upper secondary schools and seeks to establish a framework for students to learn from each other and, through the centrality of the educational relationship, to identify vocations and develop their potential. The project is now in an advanced state and is being externally evaluated by CENSIS. At present no data from the project is available.

“Life Skills Education” is based on the approach to health promotion advocated by the World Health Organisation. It is intended that it should be complementary to other developments in the educational sphere by including health promotion dimensions within a process of personal development and social citizenship.

The “Peer Education” project is based on a recommendation of the European Community, which identified this approach as an effective model, along with Life Skills education. The project aims to involve and prepare students, teachers, head teachers, parents and staff from a range of bodies through training and evaluation at Provincial, Regional and national levels. The training and evaluation has been delegated to a university and to a national association operating in the dependency sector. To date the project has been presented to 4,000 students, 400 students have been trained, 100 public and private organisations have been engaged, 240 teachers have been trained to follow
and co-ordinate the planned activities and 190 parents have been trained to follow the planned activities.

The "Provincial Council of Students for Drug Prevention" aims to link with the Provincial Student Councils on the theme of well-being, working in collaboration with public and private bodies. The activities include a survey of the needs of young people in the 15 – 18 age group, prioritising interventions on the basis of the survey, establishment of a commission to follow each phase of the project, development of a project in collaboration with relevant experts, training for those to be involved and implementation at both Provincial and individual school levels. The project is being linked into the Youth Network of UNDCP and currently involves 10 Provinces.

2.1.4 Evaluation studies and results
During the report period several studies on school based drug prevention have been published. Pagano et al (2001) report on a prevention project in five schools in Naples. The project involved meetings with classes, use of a brief questionnaire, discussion of the results and afternoon meetings to discuss specific topics. 317 students were involved (145 female and 172 male) with a median age of 17.5. From the project the authors identified that drug availability was high and that there were substantial preconceptions about drugs which led to inaccurate beliefs and prejudiced effective prevention. They proposed the need for those engaged in drug prevention to be clear and explicit about their own belief systems. Ranieri et al (2001) report on a school based primary prevention project in Arezzo. An exhibition entitled “Getting High” visited five institutions and was seen by over 2,300 young people. Linked with the exhibition a questionnaire was developed which was first administered three weeks before the exhibition was to be shown. The results showed that ecstasy was widely available, that alcohol was used extensively to deal with depression and that there was a link between alcohol and drug use. Importantly, the study found that families and local health services were the main reference points for young people at risk and that teachers had a minimal role. Semboloni et al (2001) report on a multi-media prevention project carried out in a secondary school on the outskirts of Genoa. The aim was to create a group of opinion leaders who could act as points of reference for pupils and encourage them to come forward with prevention ideas. A working group of students and one teacher met during school hours over a period of two years to discuss AIDS and drug prevention with experts from within and outside the school. A questionnaire was used to knowledge and behaviour before, during and at the end of the research. A total of 170 pupils were involved in the project, 67% of whom had not used drugs, 28% had used drugs at least once and 5% did not respond. The knowledge and behaviours of the “opinion leaders” group and the control group was broadly similar when the questionnaire was first administered. There were, however, substantial differences developing by the time of the third administration. The role of the opinion leaders was of importance and they were used by the other pupils to provide information, especially with regard to new drugs. The process of feedback to the teachers and to parents was also found to be important in sustaining and strengthening the focus on prevention. Importantly, the opinion leaders took the initiative to identify younger pupils who could be involved in the project and who would continue the prevention work in future years.

2.1.5 Research projects
The national projects described above are all being evaluated and the results will be provided as they become available. At present there continues to be a shortage of research on primary prevention within Italy.
2.2 Youth programmes outside school
These types of programmes are largely conducted by the Counselling and Information Centres or by outreach programmes undertaken by public or private services. In large urban settings and localities, where young people gather, mobile information and counselling centres have been used. There has been no published evaluation about the impact of this type of service although personal observation suggests that they are under used because young people are unwilling to be observed entering them. The work of the Counselling and Information Centres has been described in previous reports. They are based within schools and drug prevention and counselling for those concerned about drugs is part of their remit. No statistical or qualitative data about their work was available for 2001. Secondary prevention programmes aimed at young people in leisure settings appear to have been more successful and these are considered in the section concerned with outreach work.

2.3 Family and childhood
2.3.1 Definitions used
On the advice of the Ministry of Education, the focus in elementary schools has been on interpersonal relations, personal hygiene and education on the environment, food and the imagination. Particular attention has been paid to experiential programmes and the use of interactive modules. For teachers, courses have been provided to help them deal with over-impulsive behaviour and aggressive behaviour and training support has been offered in the management of mental and behavioural problems in children. The form of prevention which is being developed is rooted in helping the children to develop their identity, to stimulate their imagination and to build capacity and confidence in personal relations.

2.3.2 Types and characteristics of interventions
The major activity in this area continues to be the Family Project (Progetto Famiglia). Through this the Ministry of Education has sought to involve the parents of pupils, offering them the opportunity to participate in systematic meetings and specific initiatives. The aims have been:
- to create a deep and lasting relationship between school staff, social workers and parents aimed at studying and challenging the dependence phenomenon,
- to improve the competence and educational capacity of parents so that they are better able to handle problematic behaviour in children and young people,
- to support coordinated interventions, to improve relations between the family, schools, voluntary and private social organisations and local institutions with the aim of supporting children to develop autonomy and to reduce psycho-biological vulnerability
- to increase the perception of adolescents of the risks involved in using drugs
At the local level there have been a range of activities and initiatives to promote effective interaction between the child and parents. Parental attachment and effective parenting has been at the core of this area of activity. Local organisations, both the Ser.T and social enterprises, have been involved in this area and have undertaken a range of actions at the commune and the elementary school levels. Unfortunately there is little data published on this work or on its outcomes.
2.3.3 Research projects and evaluation results
As has been noted previously, the Family Project is being evaluated and publication of this work is currently awaited. There has been no other research or evaluation published with a specific focus on this area. The evaluation studies reported under the “School Programmes” section all referred to the role and importance of the family and parents in promoting or sustaining drug prevention. However, the concentration was on the school population and the reports provided comment rather than data about the family function in prevention.

2.4 Other prevention programmes
2.4.1 Description of:

- **Peer to peer**
  As mentioned above, a peer to peer prevention programme is being developed at the national level by the Ministry of Education financed by the National Drugs Fund. The project is still in the operational stage and information about the evaluation results will be provided when they become available. Although it is known that peer to peer approaches to drug prevention have been used by different organisations in Italy, no recent descriptive or analytical data has been published.

- **Telephone help-lines**
  The national drugs telephone help-line has continued to operate during the year. There are some local telephone help-lines but no reports have been published detailing their activities.
  In 2001 there was a further change in the way the national service operated. It had previously operated as a call centre but in May 2001 it was incorporated into the Contact Centre of the Department of Social Affairs, now the Ministry of Welfare. This resulted in a changed number, a requirement to select the service from a list of service and there was also a minimal charge for calls. Additionally, in 2001 advertising of the number through the national campaign ended. Taken together, these changes appear to have had a significant impact on calls to the service. In particular, it is noticeable that there was a significant fall in the number of calls following the changes from free number to call centre to contact centre. The average monthly number of calls in 1999 was 1,500, falling to 1,250 in 2000 and to 771 in 2001. Table 21 shows comparable data for 1999 - 2001. There was a reduction in the percentage of new callers and an increase in the percent of calls from mothers. Almost half the callers found the Drogatel number in the telephone book, where it is listed in the first section “Emergency Numbers”. 27.8% of callers were in the 26 – 35 age group, 21.3% in the 36 – 45 age group and 18.1% in the 46 – 55 age group. Whilst there was a slight increase in the percentage of calls from those under 26, the larger increase in calls came from the older age groups, in particular the 36 – 45 and 46 – 55 age groups. Heroin (36.7%), cannabis (21.7%) and cocaine (21.4%) were the drugs most frequently mentioned. Comparative figures for 1999 show that the percentage of calls concerned with heroin and with cocaine – 27.7% and 15.5% respectively in 1999 – have risen significantly whilst the percentage related to cannabis has remained the same. Over half of all callers sought information about

<table>
<thead>
<tr>
<th>Callers to Drogatel 1999 - 2001</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of calls</td>
<td>20,001</td>
<td>15,000</td>
<td>9,252</td>
</tr>
<tr>
<td>% of new contacts</td>
<td>46.2</td>
<td>45.4</td>
<td>38.6</td>
</tr>
<tr>
<td>% of calls aged &lt;26</td>
<td>19</td>
<td>21</td>
<td>22.6</td>
</tr>
<tr>
<td>% of calls from mothers</td>
<td>20</td>
<td>22</td>
<td>24.6</td>
</tr>
<tr>
<td>% of regular drug users</td>
<td>23.6</td>
<td>23</td>
<td>21.9</td>
</tr>
</tbody>
</table>

Table 20  
*Source: Drogatel*
available services, around one third information about drugs and issues related to their use. Mothers and partners also sought psychological support to deal with the situation, whilst fathers sought support and suggestions about how they should behave in the face of drug use.

- **Community programmes**
  As with youth programmes outside school, community programmes are largely within the context of the counselling and information centres or of outreach work.
  Under the developing new strategy, with its increased focus on prevention, the active involvement of the family, church and voluntary associations is being promoted. It is intended that this should lead to much wider based prevention programmes which involve actors in all the settings where young people gather. The project financed by the Ministry of Education through the National Drugs Fund to develop primary prevention in disadvantaged areas of three Italian cities could provide a model for future development of community programmes.

- **Mass media campaigns**
  The 2001 National Drugs Prevention Campaign was conducted by Young & Rubicam of Milan and its main objective was to reduce the demand for “new drugs”. As on previous occasions, it involved the use of television and radio spots, insertions into the press, an internet site and, above all, activities linked to the world of young people. In this it built on the experience gained during the 1998 campaign and consolidated during the 2000 campaign.
  The campaign began in July with an Alex Britti concert in Rome attended by 15,000 people and ended in December. Amongst the activities were the national tour of the prevention minivan, which attended discotheques, schools, universities, social centres, beaches, shopping centres, local festivals, rave parties, pop festivals, etc. The Blue Train (Il Treno Azzuro) also operated along the Emilia-Romagna Riviera, providing safe transport as well as information and advisory services for young people. Other events included; linking with two live travelling radio shows and with the Italian Beach Soccer and Beach Volleyball championships; sponsoring sports events organised by the Italian Union of Sports for All and the Italian Centre for Sports Activity; organisation of an anti-drugs day in 10 cities with the relevant Student Councils; distribution of material to young people through 3,000 driving schools. Associated with these activities aimed at young people, a programme of training and information was carried out for key reference figures such as discotheque staff, physical education teachers, sports directors and staff of public and private services.
  At the time of writing only a limited evaluation of the campaign is available. The TV campaign achieved 16,596,634 contacts with people in the 15 to 25 age range with an average of 3.1 contacts per person. The equivalent figures for the adult population were 164,504,000 contacts and an average of 4.2 contacts per person. The radio campaign had a much higher level of contacts: 55,333,000 contacts aged 15 – 25 with an average of 9.5 contacts per person and 163,258,000 contacts with the adult population with an average of 7.6 contacts per person. This suggests that radio has a much greater capacity to reach the young population on a sustained basis. By contrast the press campaign had relatively lower levels of contact – 5,783,000 contacts (15–25) at an average 1.5 contacts per person and 25,691,000 contacts (adults) with an average of 1.4 contacts per person. It is possible that the written media is kept for longer or read by several people and it may provide a useful reference point. However, in the absence of a full evaluation no specific conclusions can be reached. 1.7
million brochures, 526,000 discotheque leaflets, 343,000 safety cards, 
150,000 driving school brochures, 35,000 posters, 33,000 T-shirts, 35,000 
key rings, 15,000 headbands and 100,000 tattoos were distributed during 
the campaign. The only evaluation results available show that, from face to 
face interviews with 403 young people (15-25) who had either attended one 
of the events at which the campaign was present or who went to 
discotheques, the two publications specifically aimed at them were 
regarded positively and considered to be very relevant to the target 
audience. There were no differences between the assessments of the 
information brochure or the discotheque leaflet and no differences between 
the assessments by age or sex. The TV spots were evaluated by 1,008 
telephone interviews with people in the 15 to 55 age group in Milan, 
Bologna, Rome and Bari. Within the context of all social campaigns, the 
drugs campaign was seen by 60%, most frequently by the 15 – 24 age 
group. The campaign was shown to be an effective vehicle to promote 
individual responsibility and to present messages about avoiding drug use. 
80% of those interviewed remembered the TV spots and there was an 
overwhelming support for the campaign, especially from the younger age 
group.

Internet
The annex listing drug related web sites in Italy shows the extent to which 
the internet is used to provide information about drugs or services for those 
concerned with drug misuse. Many of the sites are intended solely to 
provide information about an organisation and its work. An increasing 
number, however, are specifically concerned with providing news and 
information about drug misuse or designed as an inter-active site for young 
people including drug prevention as part of their remit.
In the former group, there are an increasing number of documentation 
centres now one line. Such centres on-line can be found particularly in 
Emilia-Romagna, Lombardy, Tuscany, Piemonte and Veneto. Emilia- 
Romagna has established an on-line network of documentation centres 
“Dip&Doc” which publishes a regular electronic newsletter providing 
information about publications and events and links into the electronic data 
bank. Tuscany is in the process of creating a similar network and already 
has several documentation centres on-line.
In the second group, the national prevention campaigns have always had a 
dedicated web site. At present the web site for the 2001 campaign is still 
available and the new web site for the 2002 campaign is also on-line. Both 
sites provide information about events, about drugs and provide games 
with a drug and alcohol misuse prevention theme. At the local level, there 
have been an increasing number of sites such as, for instance, Il piccolo 
chimico (Modena), Spazio Giovani (Parma), CONT@TTO - SPAZIO 
ADOLESCENTI (Province of Varese), Usi e Abusi (Province of Brescia) 
and Dialoghi di Tossicodipendenza (Piemonte). There is no published data 
about the level of use of these sites for 2001 and it is not, therefore, 
possible to provide any evaluation of their utilisation or to make an 
assessment of their impact. In all cases, however, they are part of an 
overall contribution to prevention rather than stand-alone prevention 
projects.

2.4.2 Research projects and evaluation results
As noted above, there has been no published data from research or evaluation 
reports on other prevention projects. It is, however, difficult to separate out 
youth and community prevention programmes from outreach activities and 
projects aimed at young people in leisure settings or in youth gathering areas. 
Most of these services are provided by the street units (unità di strada) of the
Ser.T. or by private social organisations and include a range of functions such as prevention of drug use, prevention of drug related harm, advice and referrals for specific problems, etc. The discussion has been deferred, therefore, to the section concerned with drug related harm as this appears to be the primary focus of such activities.

2.4.3 Specific training
Although it is known that training is provided to support prevention work, no data has been identified which can offer information about the nature and contents of the training made available.

3 Reduction of Drug-Related Harm

3.1 Role of harm reduction within the national drug policy/strategy

3.1.1 Harm reduction practice
Harm reduction received its first official recognition at the national level through Law 45/99 when it was included as one of the areas eligible for resources from the National Drugs Fund. It has been an important element of some Regional Drug Plans and, given the autonomy of the Regions in the planning and delivery of health care, this is likely to remain the case in the future. The National Drugs Plan adopted in February 2002 has signalled a shift in focus in favour of reducing chronic drug dependence. Whilst this does not in itself deny a role for activities aimed at reducing drug related harm, it places such activities within a total recovery context. It is too early to say how this new emphasis will be reflected at the local service delivery level but it does mark a significant alteration to previous policy.

3.1.2 Range of services
There is a very wide range of services available although there are Regional variations which to some extent reflect local needs and priorities. The more urbanised Regions and the main cities with higher numbers of both drug users and drug dependents tend to include outreach services, mobile treatment units, low threshold services, provision of injecting equipment and activities focused on youth leisure settings such as discotheques and disco bars. The less urbanised areas tend to have part-time services, to use machines for the provision of injecting equipment and have a limited range of services. However, in all Regions during the summer holiday period there is a focus placed on provision of services in the main holiday or weekend leisure settings with both primary and secondary prevention interventions and activities aimed at limiting the likelihood of drug related harm. This is particularly so in the main holiday resorts where weekend and holiday populations can be many times more than the resident population.

3.1.3 Networking between harm reduction professionals
It is not possible to define clearly what a harm reduction professional is within the Italian context. The clearest group would be outreach workers. There have now been two national conferences of outreach workers which have provided a means of sharing experience and exploring different ways of working. The contacts developed through these national conferences are maintained on an informal basis as there is no specific organisation for staff whose work focus is harm reduction. Networking also occurs within the framework of umbrella or co-ordinating organisations such as CNCA, FeDerSerD, ERIT Italia, etc.

3.1.4 Co-ordination of national policy and local practice
As has already been noted, there has been a recent re-focussing of national policy and this has yet to be clearly reflected in local practice. However, Regions have autonomy in the planning and delivery of health services, with
broad guidance provided by the Ministry of Health and established in the National Health Plan. It is possible, therefore, that there will be different priorities at the local level.

3.1.5 Expenditures on specific harm reduction projects

No data is available on expenditure specifically dedicated to harm reduction projects. The National Drugs Fund allocation to Regions may be used to fund such projects, but the extent to which it is used for this purpose will vary from Region to Region, depending on both local priorities and the proposals put forward from public and private organisations. Nationally collated data does not provide a clear distinction between the types of project which have been funded and similar projects in different Regions may be classified in differing ways. It is also the case that in many instances harm reduction activity is part of mainstream activity and is no longer a separate project. In such instances there is no way in which expenditure on such activities can be separated from other mainstream intervention activities.

3.2 Description of specific interventions

3.2.1 Outreach work in recreational settings

This area of activity has been a major focus of local projects financed through the National Drugs Fund. The main attention has been on discotheques and disco bars and the agreement between the State and the Union of Dance Hall Operators has provided the basis for many of the developments. The context has been primarily to make contact with and provide information to irregular users of synthetic drugs. A second strand has been the work of the street units (unità di strada) of the Ser.T. and outreach work to those who use drugs regularly but may not be in contact with drug services. These services are discussed in the following sections where they seem more appropriate.

In terms of interventions in recreational settings, work to provide information to young people attending discotheques, pop festivals or raves is now to a large extent part of the normal activities of both the Ser.T. and private social organisations. There are several different intervention models used. One model is of a direct intervention by a specialist drug organisation with young people who are at risk of exposure to drug use or who may be occasional users. These services may operate within a recreational setting or may be provided close to the setting. A second model is to provide training and information to the staff of recreational settings and to assist them develop capacity to provide interventions with the support of the specialist services. A third model is to provide a wider information and intervention service which includes advice about safer sexual practices, broader advisory/referral services and drug related interventions. These models are not mutually exclusive and different combinations may be applied in different areas.

As has been mentioned earlier, local youth services in many cities provide mobile information and advice units which travel around the locations where young people meet. Data is not available in published form on their work and there is no national data on the number of services operating or on their activities. Some drug services have also developed mobile units aimed at preventing risk behaviours amongst irregular drug users and at providing alternative activities. One example can be found in Verona. The “Life Line Bus” project is a collaboration between the Dependency Department, Ce.i.s of Verona, Il Corallo and the Cultural Department of the Verona Province. The bus travels within the Verona area and provides prevention material, advisory and counselling services in an informal setting, and audiovisual prevention material. Additionally it seeks to gather information and to monitor trends in youth culture, behaviour and drug use and to work with groups of young people exhibiting delinquent or problematic behaviour. Another example can be found in Rome where CeIS of Rome has developed a cyber bus café to travel around
areas where young people meet and provide both recreational activities and advisory/counselling services, including drug prevention. In Catania (Sicily) a mobile “disco bus” has been operating which travels around the Province and presents anti-drug messages in the language of young people through the DJs operating the disco.

3.2.2 Prevention of infectious diseases

Prevention of infectious diseases and prevention of drug related overdoses are both part of the activities of the street units operated by the Ser.T. or by private social organisations. Many such services exist in the cities of Italy although there is limited data available from them. Examples of services which have provided descriptive and/or statistical data include SOS Stazione Centrale in Milan, which is a project of the Exodus Foundation. This service has been operating since May 1990. Its primary objective has been to make contact with marginalized people who collected in and around Milan Central Station and through listening, advice, assistance and support to assist them towards improved health and social circumstances and recovery from their particularly disadvantaged circumstances. In 2001 the service had 13,371 contacts with 1,539 individuals. 4,342 contacts were with 310 drug dependents of whom 239 were male and 71 female. This male to female ratio (3.4:1) is much lower than the ratio for those in treatment with either the Ser.T or with socio-rehabilitative services (5.4 and 6.1 respectively). Of the 310 drug dependents contacted during the year, 167 were new to the service. The available data does not provide information on how many people were being contacted by a helping service for the first time and how many had been in contact with another service. Of the new contacts, the vast majority were homeless and many were referred to a low threshold residential shelter. Referral to a Ser.T. and for methadone treatment was arranged for 59.9% and 41.3% of new contacts respectively. 36.5% required medical intervention of whom 62.3% needed emergency treatment. Another example where data is available is the work of the street unit operated by the Milan Health Authority in co-operation with four private social organisations. The three mobile units which make up the service operate in 8 locations. The service is not available on Sundays and does not operate on Saturday evening. However, the focus of its work is with drug dependents aiming to provide information about HIV and other drug related infections and how they might be avoided, information on drugs and on available treatment options, information on safer sex and the provision of Narcan for administration in cases of opiate overdose. The choice of locations and of times is, therefore, based on identified need and specific objectives, including aspects of community safety and the level of contact which can be achieved with the maximum number of people. Between the 26 May 1999 and 31 December 2000 the service met 4,703 drug dependents (3,575 male and 695 female), 633 of whom were non-Italians. A total of 50,781 contacts occurred with drug dependents. In the period 211,381 syringes, 176,297 ampoules of distilled water, 359,220 sterile swabs and 53,391 condoms were distributed. 89,869 syringes were returned by clients and staff of the units themselves collected a further 2,103. Data from the City of Venice Harm Reduction Project (Tab. 21) shows that between 1998 and 2001 the total number of attendances at different locations rose from 199 to 732 and for the same

<table>
<thead>
<tr>
<th>Harm Reduction Project, Venice</th>
<th>Syringes</th>
<th>Sterile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1ml</td>
<td>2ml</td>
</tr>
<tr>
<td>1998</td>
<td>3756</td>
<td>12585</td>
</tr>
<tr>
<td>1999</td>
<td>10582</td>
<td>15612</td>
</tr>
<tr>
<td>2000</td>
<td>11309</td>
<td>11490</td>
</tr>
<tr>
<td>2001</td>
<td>9764</td>
<td>7033</td>
</tr>
<tr>
<td>TOTAL</td>
<td>35411</td>
<td>46720</td>
</tr>
</tbody>
</table>

Table 21

Drug Situation 2001
period the total number of contacts rose from 3,668 to 4,099. Of these contacts 163 were first contacts, a reduction over previous years and possibly indicative of a diminution in the incidence of problematic drug use. 1ml and 2ml syringes were provided and over the four year period there has been a reduction in the number of syringes distributed and also in the distribution of 2ml syringes as a percentage of all syringes distributed. The return rate of used syringes was 55.1%.

The use of dispensing machines for the provision of sterile syringes is widespread in Italy. This occurs in a wide range of urban settings and may be a useful means of providing sterile equipment when mobile services are not available. Unfortunately there is no published data on the use of these dispensing machines nor is there data comparing the effectiveness of different methods for the provision of injection equipment.

Although not strictly aimed at preventing drug related infections nor at preventing overdoses, the provision of low threshold and drop in services and of first contact/advisory services (Centro Accoglienza) has been an important feature in the overall pattern of drug services. The Centro Accoglienza have in general been operated by private social organisations. They have acted as both a first contact point for entry into a treatment service operated by the private organisation but also as a means of providing advice and referral to other appropriate services including the Ser.T., health and social services. The centres are a common feature for many private organisations and have sought to facilitate access into treatment or to retain contact with people until they are ready to make a more sustained commitment to treatment.

Low threshold services have been to a large extent the equivalent type of service operated by the Ser.T., aimed at drawing drug users into treatment and seeking to remove the barriers which were seen to deter contact with services. Although there appears to be an increase in the number of these services available, there are no reports published recently which describe their activities or report data on their clients. In most instances the data will form part of the returns from the Ser.T. to the Ministry of Health but it is not possible to separate out clients by type of service.

Drop in services are a more recent development by the Ser.T. They in general are intended for both current and former drug users with the aim of providing support, re-socialisation, group work and mutual support. As the name implies, clients can arrive at any time during the opening hours and have the opportunity to be involved in groups, to receive minor medical care, to eat and drink coffee and to find alternative ways of living and social contact without the use of drugs. Many of these services may also provide sterile injecting equipment, Narcan, condoms and information on safer sex and avoidance of drug related health problems. As one example, data is available for a 6 month period from the drop in service operated by the Ser.T. of Ivrea (Piemonte). Between the middle of July 1999 and the end of February 2000 there were 2,581 attendances, at an average of 15.4 attendances per day. A total of 1,609 syringes were distributed and 556 were returned, a return rate of 34.6%. 307 condoms were provided and 60 phials of Narcan. Data is also provided on syringes collected by the service itself. 447 syringes were collected, the majority from empty buildings. The data from the Milan street unit and from Ivrea, show relatively low return rates for syringes of between 25% and 35%.

The Ivrea service actively sought abandoned injecting equipment and itself collected 44.6% of all recovered syringes. The Milan service did not specifically seek to collect abandoned equipment but nevertheless collected 2.3% of all returned equipment. By contrast, the Venice data shows a relatively high return rate, although it is noticeable that there has been a significant reduction in the percentage of returns over time. Overall the data suggests that there is still a potential problem associated with the
abandonment of injecting equipment which may subsequently be re-used or may cause accidental injury.

3.2.3 Prevention of drug-related overdoses

Figure 25 shows the overdose aid card which is widely available. This is credit card size and can easily be carried. In very simple format it provides information about what to do if someone overdoses and where to obtain “Narcan”, which is widely available to counter opiate overdose. Other cards deal with LSD “bad trips” and dealing with ecstasy related emergencies. The street services of the Ser.T., pharmacies and the ambulance services all have Narcan available and it is often provided to drug users in order that it can be immediately administered should an opiate overdose occur. There is little data available specifically on actions designed to prevent drug related overdoses. During the year one study on opiate overdoses was published and this is discussed in the section concerned with evaluation. The only other specific data comes from the street unit of the Milan Health Authority, operated in cooperation with four private social organisations. In the period from 26/05/99 – 21/12/00 4,903 drug dependents were contacted with an average of 10.4 contacts per person. During the same period the street unit assisted 39 overdoses and distributed 761 doses of Narcan. Whilst Milan is the largest Italian city and numerically has the largest number of drug dependents, it might be expected that proportionately similar interventions occur in other large urban settings. Data from the Harm Reduction Project of the City of Venice shows that the number of doses of Narcan and the number of leaflets about its use both rose between 2000 and 2001. The number of doses, at 326, was 90.6% higher than in 2000 but there was a much smaller percentage rise in the distribution of leaflets. The data also shows that in 2001 there were 8 “survival” courses on overdose, 1 on syringe disposal and 1 on safer sex. Similar courses had been provided in 2000. Unfortunately there is no data on the content of the courses, the number of people attending or any evaluation of the courses. However, this is the only data which has so far been identified in Italy on training for drug users themselves.

3.2.4 Users rooms / Safe injection rooms

No user rooms or safe injection rooms operate within Italy and national policy does not favour development of them.

3.3 Standards and evaluation

3.3.1 Professional standards

Professional standards for harm reduction practice is the responsibility of the Region. The Ministry of Health, as has been reported previously, developed Guidelines for Harm Reduction and these are intended to establish basic standards for the delivery of services. At the local level, Regions have responsibility for ensuring that staff have the appropriate skills and qualifications to undertake their professional role. They also have the responsibility for ensuring that training and re-qualification training is available in order that high standards of service are provided.
3.3.2 Evaluation studies
Few evaluation studies have been reported during 2001 although there have been a large number of descriptive accounts of projects provided on Italian web sites and in journals and newsletters. Caslaboni and Saponaro (2001) have reported on the evaluation of the use of computers as a means of conveying drug prevention messages in a selected number of discoteques in Rimini. The messages covered drugs, safer sex, first aid and health problems. A booklet and a computer with dedicated software were the means chosen to convey the messages. The computer software allowed scientific material normally only available in hard copy to be consulted using the interactive language of video games and internet sites. In a one month period the computers were accessed for in depth information on 4,184 questions, 65.3% of which concerned drugs. Questions on ecstasy were the most common (27.4%), followed by cannabis (21.8%) and then amphetamines and cocaine (16.2%). What also emerged from the evaluation was that at each discotheque specific types of information were sought, suggesting that the profile of clients drug use or experience was different for different clubs and that interventions needed to be even more specifically targeted. Verde et al (2001) have reported on a co-operative project between the Ser.T. of Naples (District 1) and a street service. This project facilitated changes in the operation of the Ser.T. to improve accessibility and extend its range of services, with lower thresholds for access and the introduction of harm reduction methodologies. The result was a significant increase in referrals into treatment. A secondary consequence was that those who entered into treatment became advocates for the treatment service with other street users. Ferrari et al (2001) have reported on an analysis of ambulance service attendance at overdoses in Modena during 1997. There were 531 attendances at incidents involving drug dependents, representing 7.6% of all ambulance service attendances. Of the interventions 195 were for opiate overdose and 311 were for drug intoxication. Most attendances were during the summer months, usually at weekends and in the street. The implication was that a high proportion of those requiring an intervention were irregular users. 159 people were assisted following a drug overdose and in 55 cases data was available to provide a possible explanation for the overdose. 67.3% had loss of tolerance, 40% having been released from prison or abandoned a rehabilitation programme. 25.4% were already intoxicated before they overdosed. After the administration of an opiate antagonist, 85% refused to be transported to an Emergency Department. There were 2 deaths despite all resuscitation efforts. 55 people were already known to the Modena Ser.T., two-thirds of whom had interrupted their treatment programme in the previous 6 months or had been released from prison. 4 people were still in treatment with the Ser.T. but with a methadone dose of less than 40mg / day. Overall the evaluation found that attendance at a drug related incident was the third most common form of attendance after trauma, usually related to accidental injury and cardiovascular problems. It was, therefore, a significant demand upon the work of the ambulance service.

3.3.3 Training
As noted above, training of staff and ensuring that they have the necessary skills and qualifications is the responsibility of the Regions. The Departments of Pathological Dependency have responsibility, within their strategic and implementation plans to make provision for training. In general Regions directly provide or commission the provision of training related to the needs of the Regional Plan. Harm reduction training may form part of this overall package but will vary from Region to Region. There is no common training programme although some training courses are open for attendance by staff working in a different Region.
A second element of training concerns the training of those working in youth leisure and recreational settings. As has already been mentioned, the national prevention campaign included training for discotheque staff and sports directors. At the more local level, most projects concerned with the use of synthetic drugs and young people attending discotheques have included training or information sessions with staff of the discotheques as part of their activities. There has also been an increased focus on work with sports facilities because of increased concern about the use of performance drugs in these settings. No recent data is available on the amount of such training or the contents of the courses provided.

3.3.4 Major research projects

The major research projects in this area are the VeDeTTE Study, co-ordinated by the University of Turin and the Lazio Region and work on rapidly identifying new drugs or new drug using practices co-ordinated by the National Health Institute. Publication of data from both studies is awaited. The VeDeTTE Study involves 119 Ser.T. 12,373 clients have been recruited to the study. It is a longitudinal research following clients over time and has as its primary objective an evaluation of the effectiveness of methadone treatment. As part of this work it has collected data on drug related morbidity and mortality and has also collected socio-demographic data as well as data on treatment approaches. The National Health Institute research, which is linked to the early warning system of the EMCDDA, has established a network of informants at the local level to act as observers and to report on trends and emerging patterns and also to provide an alert where new circumstances require attention. The research has had to overcome a number of technical difficulties, not least the legal problems surrounding the acquisition and analysis of street substances. However, work is progressing to resolve some of the problems and it is hoped that the research will provide better qualitative data on local trends and diversities. Other major research and evaluation projects include an evaluation of harm reduction projects, an evaluation of the time lag between the onset of dependency and seeking treatment, identification of a primary and secondary prevention strategy aimed at the youth population, evaluation of methodologies for intervening with drug dependent prisoners and drug using sex workers. In total, some € 1.48 million has been committed to these projects during the last three years.

4 Treatments

As has already been reported, the major development in treatment strategy has been to place priority on a reduction of chronic dependence, including dependence on methadone, recovery from dependence within a residential treatment setting and insertion or re-insertion into training or employment. This major theme of the National Drugs Plan was adopted in February 2001 and the funding priorities for the National Drugs Fund have only recently
been published. It will not, therefore, be until next year that the effect of the new priorities will be observed at the service delivery level.

4.1 "Drug free" treatment and health care at the national level

4.1.1 Objectives and definitions of drug-free treatment

Drug free treatment is primarily aimed at achieving and sustaining long term abstinence from drug use. Within this definition, treatment with opiate agonists and short-term methadone treatment aimed at achieving detoxification are considered to be drug free treatments as both have the objective of achieving abstinence. Also included in this definition are residential rehabilitation services, day rehabilitation and psycho-social interventions in both public and private treatment services without the use of maintenance drugs.

4.1.2 Criteria for admission

It is extremely difficult to offer clear criteria for admission into drug free treatment services. The vast majority are operated by independent private socio-rehabilitative organisations and they each operate their own systems for admission. Moreover, there are differences between the criteria for admission into a treatment service and criteria for admission into a specific programme. For instance, many private socio-rehabilitative organisations use their 'first contact' programme, commonly called "accoglienza", as a means of assessing treatment needs and determining the appropriate programme.

For treatment services using antagonists or short term (under 3 months) methadone to achieve detoxification, the criteria for admission are the same as for admission to substitution or maintenance programmes. The difference is essentially in the assessment of treatment needs based on age, length of dependent drug use and mode of administration, as well as on psycho-social factors such as motivation, social and employment circumstances, etc.

For rehabilitation services and psycho-social interventions two different criteria may apply. For the former, the presence of a wish to change, even if this does not represent a strong commitment, or pressure to participate in the programme either as a result of legal proceedings or from the family or employers may be sufficient basis for admission into the preparation (accoglienza) phase. For the latter, a second criteria may apply, that drug treatment is inappropriate, for instance where cannabis, cocaine or synthetic drugs are involved.

4.1.3 Availability, financing, organisation and delivery

The census carried out four times a year by the Central Directorate for Documentation of the Ministry of the Interior shows that on 31 December 2001 there were 835 residential, 233 semi-residential and 234 non-residential socio-rehabilitative services operating in Italy. At the time of writing there is no data on the number of places available in the different types of service. Table 22 shows the distribution of the services by type of service and geographical area.

<table>
<thead>
<tr>
<th>Socio-Rehabilitative Services - 31/12/2001</th>
<th>Residential</th>
<th>Semi Residential</th>
<th>Non-Residential</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>455</td>
<td>114</td>
<td>117</td>
<td>686</td>
</tr>
<tr>
<td>Centre</td>
<td>181</td>
<td>61</td>
<td>38</td>
<td>280</td>
</tr>
<tr>
<td>South</td>
<td>144</td>
<td>44</td>
<td>61</td>
<td>249</td>
</tr>
<tr>
<td>Islands</td>
<td>55</td>
<td>14</td>
<td>18</td>
<td>87</td>
</tr>
<tr>
<td>TOTAL</td>
<td>835</td>
<td>233</td>
<td>234</td>
<td>1,302</td>
</tr>
</tbody>
</table>

Table 22 Source: Ministry of Interior

The largest number of services is in the northern Regions. This is expected as these are also the Regions which have the largest numbers of problematic
drug users and the highest urban densities. The data on clients attending these services is less clear. The census for 31 December shows that there were returns from 92.8% of all relevant services. This represents a reduction in the percentage of replies compared to 2000. There was also a reduction in the number of services available from 1,335 in 2000 to 1,302 in 2001. Nevertheless, the number of people attending the services was slightly higher in 2001 than for the same period in 2000 (19,397 and 19,289 respectively). This would suggest that occupancy levels were higher overall for 2001 and that the number in treatment with these services was also higher.

The classification of services used in Italy does not allow a full appreciation of the types of programme available. Residential services may include detoxification, crisis intervention, rehabilitation, preparation for social re-insertion and vocational training services. Semi-residential services are all those which require attendance for a substantial part of the day, usually five days a week. The may include day therapeutic programmes, assessment centres, vocational training and harm reduction services. Non-residential services are ones which may involve attendance by appointment or may have open access but where attendance is voluntary. In either case full time daily attendance is not required. Semi-residential and non-residential services may be provided in combination with methadone treatment from the Ser.T. Residential treatment in general does not involve the Ser.T. except where residential detoxification or crisis intervention is being undertaken.

Socio-rehabilitative services are required to be registered with the Region and are subject to Regional regulations on the minimum expected standards, on staffing levels, qualifications and training. These regulations vary from Region to Region and the only common base is the Regulation agreed by the Permanent Conference for Relations between the State and the Regions of 5 August 1999 which provided the broad basis for the standards. A registered service is entitled to receive payment from the local health authority for clients referred to them by the Ser.T. Normally there is fixed amount paid per week with a standard rate for residential therapeutic communities, residential pedagogical/rehabilitation services and for semi-residential services. Additionally, services may have an agreement with the Ministry of Justice to provide treatment services as an alternative to punishment or as an alternative to imprisonment. They may also have an agreement with the Prefecture for provision of services to those referred for unlawful possession of a listed drug. In such cases, they will receive payment for clients referred through the criminal justice system separately from payment for clients received through the Ser.T. Non-residential services are in general financed through project funding from a range of different sources. There is no mechanism at either national or Regional level to identify the total amount of funding available from public and private sources.

Psycho-social treatment provided by the Ser.T. may be a stand alone treatment or it may be in combination with substitution or maintenance treatment. In 2001 there were 130,862 people in treatment with the Ser.T. alone. Of these, 72,042 received psycho-social treatment, 68,233 received medium or long term methadone treatment and 27,606 received detoxification treatment with short term methadone, clonidine, naltrexone or other pharmaceutical. The total number of treatments, therefore, was 167,881 for 130,862 people.

4.1.4 Evaluation results, statistics, research and training

As noted above, it is difficult to identify the exact number of drug free treatments as opposed to the number of treatments in a particular setting. However, it is a reasonable assumption based on the available data that residential and semi-residential treatment services in the socio-rehabilitative sector provide drug free treatments based on the definition given earlier.
From the Central Directorate for Documentation data, the number of people in residential treatment on 31 December 2001 (12,170) was less than the number in such treatment on the same day in 2000 (12,777). For the same dates there was a slight increase in clients of semi-residential services in 2001 (2,032 to 2,107) and a much larger increase in clients of non-residential services (4,480 to 5,120). This data seems to confirm what appears to be a long term trend for a reduction in the use of residential services, which largely accounts for the reduction in the use of drug free treatments, whilst the number of substitute or maintenance treatments has continued to increase. There must, however, be some reservations about the available statistics, which only provide data for utilisation on a particular day. There is no national data available on total admissions into drug free treatment or on programme completions / premature departures. It must be assumed that admissions were higher than one day figures but without improved recording and data collection there is no means of identifying effectively the true extent of drug free treatment utilisation.

Mele et al (2001) have reported preliminary results on a study of retention rates for heroin dependents referred to a therapeutic community by the Ser.T. of Taranto in 2000. In the year 97 men and 3 women were referred, accounting for 112 admissions – one person being admitted on 4 separate occasions, one on 3 separate occasions and seven on 2 separate occasions. 56 people were referred for the first time, 23 had one previous referral, 8 had two previous referrals and the remaining 13 had at least three previous referrals. Almost half the referrals (48) had been in treatment for less than three years, with 19 having been in treatment for 10 years or more. By 30 November 2001, 27 people were still in treatment, 24 having been in continuous treatment and 3 having returned after leaving prematurely. The vast majority of people left treatment within 2 months of admission, and nearly all early leavers departed voluntarily (76), with only 9 leaving for other reasons (imprisonment, agreed departure and expulsion). The evaluation which is still continuing provides valuable data about the circuit of treatment between the streets, the Ser.T., the therapeutic community and prison.

Bricolo et al (2001) have reported on a residential methadone detoxification programme carried out by the Comunità San Francesco di Monselice in cooperation with the Ser.T. of Padova. 102 people (84 men and 18 women) were admitted to the programme which involved a three month gradual detoxification in a structured residential community. 61 men and 12 women completed the programme and transferred on to naltrexone. Observed withdrawal symptoms were minimal and were dealt with either through psycho-social interventions by the staff of the community or, where necessary, through symptomatic treatments. The conclusions from the study were that significant improvements in detoxification treatment were achieved when this was undertaken in a structured and secure residential environment with intensive psycho-social interventions rather than in the semi-residential or non-residential setting.

Angius et al (2001) estimated that around 1,400 people were resident in Piemontese therapeutic communities each day in 2000. They also estimated that the total number of places available was 1,469. Of 1,903 clients in treatment with residential communities in 2000, at the end of the year 891 (46.8%) were still in treatment, 422 (22.2%) had completed treatment, 490 (25.7%) left prematurely and 100 (5.3%) were transferred to another community or imprisoned with one death being recorded. For semi-residential communities there were 136 clients, 16 (11.8%) of whom were still in treatment at the end of the year, 47 (34.6%) had completed treatment, 32 (23.5%) had left prematurely and 41 (30.1%) transferred to another service or were imprisoned. For both types of treatment the vast majority of premature departures occurred within 6 months, with a higher drop out rate for semi-residential (93.9%) than for residential (78.8%) communities. Monteleone and Lanzafame (2001) report on treatment approaches used in the therapeutic
communities for polydrug users operated by II Sentiero in Catania. The
research covered a four year period and amongst other things identified
changing psych-social traits and the presence of significant psycho-pathologies
prior to the onset of problematic drug use. These findings led to important
changes in staff training and skill development and in the educational and
therapeutic interventions. Further details about clients of drug free treatment
services can be found in the Annual Report of CeIS of Reggio-Emilia (CeIS
Reggio-Emilia 2002) and in a report from the Centro di Solidarietà di Belluno
and Cooperativa Sociale Integra (CeIS Belluno 2002).

The major research work being undertaken with regard to drug free treatment
is an evaluation of the quality of therapeutic communities, co-ordinated by the
Emilia-Romagna Region and carried out by Emme & Erre. Preliminary results
from this study have very recently been published and the full report is
expected to be available shortly.

Training for staff working in drug free treatment settings is the responsibility of
the individual organisation providing the service. They must ensure that the
qualifications of staff meet the requirements of the Region and that their
continuing training needs are met in order that their knowledge and skills are
updated. In practice, there are three basic groups of drug free treatment
provider. One group consists of national organisations which have services
operating throughout the country, for example, Comunità Incontro, Fondazione
Exodus, Comunità Emmanuel and Saman. A second group of service
providers operate multiple services in a Province or Region, for example, most
organisations operating under the general title of Centro di Solidarietà,
Associazione Papa Giovanni XXIII, Gruppo Abele. The third group consists of
local independent organisations which commonly work in close association
with other public and private services in the area. The first two groups usually
organise their own training programmes and very often are contracted to
provide training for private and public services by public authorities. The third
group usually receives training input from the Ser.T. or private organisations.
The Departments of Pathological Dependency also arrange short training
courses which are open to all those working in the dependency sector. In
essence, throughout Italy there is a substantial amount of training available for
all those working in the sector. What is less available are evaluations of
training.

4.2 Substitution and maintenance programmes

4.2.1 Objectives

There are several different objectives which might be pursued in the provision
of substitution and maintenance programmes and there is no single model.
Broadly, the objectives have been defined in the Guidelines for Harm
Reduction Interventions developed by the Ministry of Health and described fully
in the last National Report. These see the purpose of substitution or
maintenance programmes as drawing and retaining people in a treatment
centre, reducing the likelihood of high risk behaviour and creating a more
stable situation for interventions aimed at directing the client towards long term
abstinence. Whilst the national guidelines are explicit about the objectives, it is
probable that there are different objectives operating at local level which are
clinical assessments of the appropriate objective for a client. It is not clear
whether there are explicit general objectives or implicit assumptions about the
purpose of a particular treatment modality at the local level.

4.2.2 Criteria for admission

As with the objectives, there is little data about the criteria for admission into a
substitution or maintenance programme which are used at local level. The
definition of such programmes is that there is provision of a pharmacological
intervention, usually methadone administered orally, on a medium (3 – 6
months) or long term (over 6 months) basis. Admission to such programmes usually follows unsuccessful detoxification treatment, continued use of street drugs and/or continuing high risk behaviour. However, there is at present no data which can allow a full classification of the criteria which are applied. It is hoped that data from the VEdette Study and from the evaluation of the quality of the Ser.T. will provide further information.

4.2.3 Availability, financing, organisation and delivery

There are 555 public drug treatment services – Ser.T. – managed within the framework of the national health service. The Ser.T. operate within a Department for Pathological Dependency at the Provincial level and are responsible to the relevant Regional Department. This may be the Regional Department of Health, of Health and Social Policy, of Social Services – there are a number of different titles which are used, depending on the size of the population resident in the Region and whether there is justification for a small number of generic departments or a larger number of topic focussed departments. In heavily urbanised Provinces, the Ser.T. may be operational at district level. In less urbanised Provinces it is not uncommon for the Ser.T. to operate from a number of different locations, providing many local services which operate for limited hours. The general aim has been to increase accessibility for people with drug problems. This has become of greater importance given the wider spread of problematic drug use into smaller urban settings. The staffing of the Ser.T. has moved gradually towards a more health oriented service (Fig. 27) with the percentage of staff who are doctors or nurses/health assistants rising whilst their has been a reduction or stabilisation in the percent of staff who are educators or social workers. However, as data was not available on the balance between full time staff, part time staff and those contracted to provide specific services as required, nor on the type of service in which staff operated, it is possible that the non-medical staff are more actively involved in treatment interventions.

Regions have autonomy in the delivery of health care services and determine priorities in line with local needs. They are guided by the national health plan prepared by the Ministry of Health and approved by Parliament and by specific health legislation or regulations and by specific guidelines which might be issued through the Ministry. The funding of treatment services for people with drug problems is from the general allocation to Regions for all healthcare provision, as well as from local taxation and from projects financed through the National Drugs Fund. Few Regions have detailed information available about expenditure on drug treatment.
4.2.4 Substitution drugs and mode of application

The most widely used substitute drug is methadone. Of the 130,935 people reported as receiving treatment directly from the Ser.T in 2001, 73.2% received a pharmacological intervention. This represents a steady reduction in the percentage of clients receiving this type of intervention, falling from 80.9% in 1998. For those who do receive a pharmacological intervention, figure 28 shows the percent in receipt of such interventions by year and type of pharmacological intervention provided. As can be seen from this, there has been a steady increase in the use of long term methadone whilst the use of other types of pharmacological intervention have remained stable or declined. Taken together, the data would seem to suggest that:

- There has been a reduction in the use of pharmacological treatments over the last four years,
- This reduction is greater than reduction in the number of people with primary opiate dependence and
- Long term (over 6 months) methadone treatment is focused on clients who have not proved amenable to shorter term interventions.

With much smaller numbers involved, there has also been a small increase in the percentage of clients in socio-rehabilitative settings who are receiving a pharmacological intervention, from 22.4% in 1998 to 24% in 2001. Again, this has involved an gradual increase in long term methadone prescribing and a reduction in the percentage receiving other types of pharmacological interventions. It is not entirely clear how this should be interpreted. The most likely explanation would be that there has been an increased use of residential treatment and crisis intervention services with the aim of stabilising the drug intake of chronic opiate users, who subsequently become outpatient clients receiving long term methadone. Those receiving short term methadone or other types of pharmacological intervention are more likely to be undertaking detoxification prior to admission into a therapeutic community.

Very little descriptive or qualitative data has been produced describing the operations of the Ser.T and only more generalised statements are available. Normal practice in most Ser.T is for an assessment of new clients and where a pharmacological intervention is considered appropriate, the initial aim is to stabilise the client on appropriate medication without him/her resorting to illicit drug use. Initially the prescribed drug is consumed under supervision and subsequently it may be collected from a designated pharmacist. The long term aim is to achieve abstinence from the continued use of listed drugs.

Prescribed drugs for the treatment of dependency are only available in oral form.
4.2.5 *Psycho-social counselling*

As with substitute prescribing, little descriptive or qualitative data is available on psycho social counselling within the Ser.T. The type of counselling available is categorised as psychological support, psychotherapy and social work interventions. It is not possible, from the available data, to know how many people receive this type of intervention without pharmacological interventions, how many may transfer from pharmacological to non-pharmacological interventions and vice-versa and how many are in receipt of both types of intervention simultaneously. The form for reporting the data seeks to avoid double counting and requires the primary intervention only to be recorded. The sole occasion where a client may be recorded for both types of intervention is where they constitute two distinct treatment episodes. It is very likely that clients receiving a pharmacological intervention are also in receipt of psycho-social interventions, but no specific data is available. What is clear and might be expected, is that clients directly treated by the Ser.T. most commonly have a pharmacological intervention whilst clients who are in socio-rehabilitative services or in prison predominantly receive psycho-social interventions. The data indicates that of clients who receive a psycho-social intervention, around 52% have social work support, 34% psychological support and 13% - 14% have psychotherapy.

4.2.6 *Diversion of substitution drugs*

There is little data about diversion of substitution drugs and the available information suggests that it is not a major problem. There are some anecdotal reports of illicit methadone being readily available in some cities, but there is no documented support and specific research would be necessary to determine the actual situation.

Substitution prescribing is normally undertaken by the Ser.T. or by a general medical practitioner working in co-operation with the Ser.T. There is normally visual supervision of consumption for new clients of the Ser.T. and this is ended once the client is considered stable on the maintenance dose. With the additional control of non-repeatable daily prescription, the opportunities for diversion are limited.

From the available data, in the last four years referrals to the Prefect for unlawful possession of methadone has never exceeded 150 referrals in the year and in 2001 there were only 113 referrals. The second measure might be the percentage of clients of the Ser.T. with secondary drug use who report use of methadone. In the last four years, the highest percentage was 2.4% in 1998. In 2001 only 2% of clients of the Ser.T. had methadone as a secondary drug.

Taken together this data suggests that there is very limited diversion of methadone and that it is not a drug of choice for those seeking drugs on the illicit market.

4.2.7 *Evaluation results, statistics, research and training*

Much of the epidemiological data has already been dealt with in Part 2 of this report and will not be repeated here. Table 23 provides the key data. As mentioned earlier, the major research project concerned with the evaluation of substitution treatment is the VeDeTTE Study (Evaluation of the effectiveness of treatment for heroin addiction), commissioned by the Ministry of Health and co-ordinated by the Department of Public Health, University of Turin and the Public Health Agency of the Lazio Region. The study involved 119 Ser.T. in 13 Regions and recruited 12,373 clients into the study over an 18 month period. In the same period, 24,602 people were in treatment with the Ser.T. Of those recruited, 10,454 had valid data available for analysis. The study population, therefore, represented 42.5% of the treatment population. Figure 29 shows the distribution of clients by Regions. Some data from the study is now
becoming available although this is still primarily quantitative rather than qualitative. 1,249 people were new clients, 1,981 were re-entering treatment and 7,224 were in treatment already when recruited to the study. For all the Regions, around 10% of clients had their first treatment within the last year. There were, however, greater variations between the Regions when length of time since first treatment was started with between 20% and 30% having started treatment over 10 years ago. As might be expected, almost 50% of new clients began treatment less than one year ago whilst almost 30% of clients already in treatment when recruited to the study had started treatment over 10 years ago. The preliminary data appears to suggest that those already in treatment are less likely to use illicit drugs and more likely to be abstinent. However, all available data is preliminary and no published qualitative analysis has become available to date. Auriemma et al (2001) have reported on an evaluation of treatment outcome for 347 patients enrolled into a buprenorphine programme in two Naples Ser.T. There were 318 males and 29 females receiving daily sublingual buprenorphine at dosages between 2 and 12 mg. Some 50% of those recruited to the therapy dropped out, 62% of whom entered a methadone treatment programme and 38% of whom were lost to treatment. Those who remained in treatment showed improved psycho-physical and quality of life measurements. They also had a significant reduction in the use of illicit opiates and cocaine both during treatment and at a two month follow-up. 17% of those recruited to the buprenorphine treatment completed successfully. The study appears to confirm other work which found buprenorphine treatment was a valuable tool in drug treatment. Vigezzi et al (2001) have reported on alcohol use amongst methadone maintenance clients. The study was undertaking because of reports that such clients tended to have increased alcohol consumption. 160 clients receiving methadone maintenance were randomly selected. The mean age was 32 and 72.5% were male. A structured questionnaire was administered and the findings suggested that methadone maintenance treatment led to a slight reduction in alcohol intake. Of the 160 clients, 98 regularly consumed alcohol and 15 reported that use of alcohol started after they began methadone maintenance. 11 people reported increased alcohol use, 21 decreased alcohol use and 61 no change in their level of alcohol use. 62 people in the study did not consume alcohol at all. Di Carlo et al (2001) have reported on an evaluation of the Abruzzo Region

<table>
<thead>
<tr>
<th>New</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31042</td>
<td>32398</td>
<td>31510</td>
<td>32920</td>
</tr>
<tr>
<td>Continuing</td>
<td>108905</td>
<td>110551</td>
<td>115636</td>
<td>117407</td>
</tr>
<tr>
<td>Male/female ratio</td>
<td>6.3:1</td>
<td>6.2:1</td>
<td>6.4:1</td>
<td>6.4:1</td>
</tr>
<tr>
<td>Mean age new M.</td>
<td>28.0</td>
<td>28.2</td>
<td>28.5</td>
<td>29.1</td>
</tr>
<tr>
<td>Mean age new F.</td>
<td>27.1</td>
<td>27.6</td>
<td>27.7</td>
<td>28.2</td>
</tr>
<tr>
<td>Mean age continuing M.</td>
<td>31.2</td>
<td>31.6</td>
<td>32.0</td>
<td>32.4</td>
</tr>
<tr>
<td>Mean age continuing F.</td>
<td>31.1</td>
<td>31.4</td>
<td>31.8</td>
<td>32.0</td>
</tr>
<tr>
<td>Primary drug heroin</td>
<td>85.6</td>
<td>83.6</td>
<td>82.7</td>
<td>81.4</td>
</tr>
<tr>
<td>Primary drug cocaine</td>
<td>3.2</td>
<td>4.3</td>
<td>5.3</td>
<td>5.7</td>
</tr>
<tr>
<td>Primary drug cannabis</td>
<td>7.6</td>
<td>8.0</td>
<td>8.0</td>
<td>8.2</td>
</tr>
<tr>
<td>Primary drug other</td>
<td>3.6</td>
<td>4.1</td>
<td>4.0</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Table 23  Source: Ministry of Health

Figure 29  Source: Studio VeDeTTE

Drug Situation 2001
system of services for dependencies. A specific part of this evaluation considered methadone based treatment. The study had three phases: recruitment, 1st follow-up after two months, 2nd follow-up two months later. 617 clients were recruited to the study. The data showed that there was improved physical health, family relations, awareness of abuse behaviour, care of self and educational/professional conditions for clients whilst undertaking methadone treatment. The indications were, therefore, that methadone treatment could provide a means of improving health and personal relations and reducing risk behaviours.

4.3 After-care and re-integration

4.3.1 Links with national strategy and legislation

As has already been stated, after-care and social re-integration or specifically targeted in the National Drugs Plan adopted in February 2002. The legislation which provides for maintenance of employment and support of a drug dependent employee whilst undertaking drug treatment was described fully in the National Report for 1999. In summary, article 124 of the Presidential Decree 309/90 establishes the rights and duties of employers and employees where an employee is drug dependent or where an immediate family member is drug dependent. Circular 164 of 6 December 1991, issued by the then Ministry of Labour, provides operational guidance for both employers and employees. A drug dependent employee has the right to return to work within three years if entering a therapeutic treatment programme. A family member has the right to unpaid leave to participate in the treatment programme where this is necessary. The National Drugs Plan has indicated a need to further improve these legislative and regulatory arrangements, but has not specified the changes which are required. It has, however, proposed that drug dependents should be included in the "disadvantaged" category of paragraph 1, article 4 of law 381/91. This change would facilitate the employment of drug dependents within the work of social co-operatives, providing additional mechanisms to gain skills and re-enter the labour market.

4.3.2 Objectives, definitions and concepts

The overall objectives of after-care and re-integration are to assist the drug user to return to social relations and employment without recourse to illicit drug use or other harmful behaviours. The definition of after-care and re-integration, therefore, at the national level at least, is that it represents the final step in the treatment process aimed at achieving and maintaining long-term abstinence from use of listed drugs. There may be variations in the definitions used at local level, but at policy level there is no disagreement with the nationally defined objective. There are more variations at local level on the concepts of after-care and re-integration. This is primarily related to whether after-care and re-integration is focused on abstinence from all listed drugs, including drugs which might be prescribed in drug treatment, or focused on abstinence from the use of street drugs whilst continuing to receive substitute drug treatment, or focused on abstinence from problematic drug use. There has been little written about different definitions and concepts of after-care and re-integration. It is not possible, therefore, to say precisely what definitions are most commonly applied. It is, however, usual for after-care to be concerned with relapse prevention, support groups, social programmes and family support. There may also be early intervention programmes where there is a relapse. Re-integration is usually concerned with education or vocational training and supported housing to assist the drug user to return into the community.

4.3.3 Accessibility for different target groups

After-care and re-integration is primarily targeted at those who have undertaken a therapeutic treatment programme. This may have been within a
residential therapeutic community or within a therapeutic day programme. It may also be targeted at drug users who have achieved stability on substitute drug treatment with improved physical health and social functioning, where they are in a position to re-enter employment or education. Most therapeutic treatment services provide after-care and assist in the re-integration of clients.

4.3.4 Organisation, financing, managing, availability and delivery
Theftapeutic treatment services are most commonly provided by private social services, although there are also such services offered by the Ser.T. Like any service for drug dependents, they must be registered with the Region in order to receive public funding. Services may be financed from a range of different sources. Where the after-care and re-integration programmes can be seen as part of the overall therapeutic programme, specifically the re-entry phase of the programme, this may be financed by the local health authority, the Ministry of Justice or the Prefecture. Educational support services may be financed by project funding from the Province or Commune. Vocational training is most commonly financed through project funding from the Region, the National Drugs Fund or the Ministry of Employment and Social Policy. There has also been substantial funding through the European Commission for vocational training programmes. This is discussed more fully in the key topic.

As noted above, most therapeutic treatment services provide after-care and re-integration services. However, there is no national data available on the extent of these programmes, in so far as they are part of the normal rehabilitative activities. It is not possible, therefore, to say whether they are sufficient to meet identified need although they are widely available in some form.

The core of after-care and re-integration delivery is the re-entry phase of a therapeutic programme where the client begins to spend more time outside the programme whilst continuing to live within a supportive environment. Within this phase aspects of relapse prevention will be developed and ways of managing risk situations will be explored. Depending on the size of the organisation managing the service the re-entry phase may be located away from the main therapeutic treatment centre. A number of organisations have also developed social centres which are available to those who have or have had drug problems. The aim of these centres is to offer a safe environment for socialisation, education and training. Education and vocational training tends to be more ad hoc because of its project funding base. Many therapeutic services have developed their own vocational programmes in which clients learn specific skills as part of the rehabilitation programme. For example, San Patrigano near Rimini is famous for its breeding of champion show-jumping horses and produces wine from its own vineyards. Comunità Incontro produces prosciutto, olive oil and wine. Other organisations produce small leather goods, pottery products, furniture, etc. These activities aim at both providing clients with new, marketable skills whilst also producing products which can promote the work of the organisation and produce an income for it. Delivery of the programmes tends to be split between therapeutic staff providing the support services and skilled practitioners, with therapeutic competences, providing the training/educational inputs.

4.3.5 Statistics, research and evaluation results
There is limited data available on utilisation of after-care and re-integration services or on research and evaluation on these services. To avoid duplication, the available material is discussed fully in the key topic “Social Exclusion and Re-Integration”.

4.3.6 Training
Little information is available on this topic. What data is available has been reserved for presentation in the key topic.
5 Interventions in the Criminal Justice System

5.1 Assistance to drug users in prison

5.1.1 Abstinence oriented treatments

The majority of treatment interventions for drug users in prison are abstinence oriented aimed at using the opportunity to focus on continued abstinence on release from prison. Figure 30 shows the type of intervention provided for drug using prisoners over the last 4 years. There has been a continuing increase in the number of people receiving treatment whilst in prison with an upward trend for both psycho-social and pharmacological treatments. However, the use of pharmacological treatments has been increasing more rapidly. There is little data available on the contents of non-pharmacological treatments. However, within the broad categories for this type of intervention, in 2001 35.1% received psychological support, 62.3% social work intervention and only 2.6% psychotherapy. In the four year period 1998 – 2001 there has been a slight increase in the percentage receiving psychological support and a small decrease in the percentage receiving social work intervention, but these changes are not significant.

The National Drugs Plan has proposed that increased attention should be given to drug dependent prisoners through the expansion of abstinence oriented services. To this end it has proposed that drug dependent prisoners, where they are eligible according to the regulations, should have the right to enter a rehabilitation programme guaranteed as an alternative to imprisonment. It has also proposed that specific structures should be created within the ambit of the Prisons Administration of the Ministry of Justice, managed in collaboration with private social organisations, as a preparatory phase for admission into a drug free rehabilitation programme. As has been noted in Part 1 of this report, the guidance for use of the National Drugs Fund reflects the key topics highlighted in the National Plan. However, it will not be until 2003 that information about these developments will become available.

5.1.2 Substitution treatment

The steady increase in the use of pharmacological interventions coincides with the increasing role of the Ser.T. in the provision of health care and drug treatment to drug dependent prisoners. Figure 31 shows the pharmacological interventions provided over the last four years as a percentage of all pharmacological treatments provided. As can be seen from this, there has been a gradual reduction in the percentage of short term methadone interventions and upward trends in the provision of both medium (3 – 6 months) and long term (over 6 months) methadone interventions. The use of other drugs has shown considerable fluctuations. These include symptomatic treatments and the use of buprenorphine. It is not entirely clear how this data should be interpreted. The most probable explanation is that detoxification and
symptomatic treatments are provided to people who are not eligible for alternatives to imprisonment or continued detention and to those who intend to enter a drug free therapeutic programme. Continuing substitution treatment is provided to prisoners who are awaiting trial and may not receive a prison sentence, who are imprisoned for a short time or who are already known to the Ser.T. Although this seems to be the most likely explanation, further exploration of this area is necessary to provide more definitive data. Given the continuing increase in non-Italian drug dependent prisoners as a percentage of all drug dependent prisoners, it is also possible that they are more likely to receive detoxification or symptomatic treatment given the problems of providing longer term community based treatment for this population.

5.1.3 Harm reduction measures
No harm reduction measures are carried out within the prison system of Italy. As part of the counselling and support offered to drug using prisoners, it is not unusual for them to be warned of the dangers of a return to drug use, especially at the level of use prior to imprisonment or through injection. However, there is no specific data on the contents of counselling, nor on the types of risk behaviour most common amongst newly released drug using prisoners.

5.1.4 Community links
The transfer of responsibility for the health care of prisoners to the Ministry of Health and thus to the Regions and local health authorities has increased links with community services. Figure 30 shows clearly the continuing increase in the number of drug dependent prisoners in treatment with the Ser.T. However, the involvement of the Ser.T. is not uniform throughout the country. The Department for Prison Administration of the Ministry of Justice has noted that there are a number of problems including misunderstandings between the prison and local health authority, inadequate planning on the part of the Ministry of Health, the absence of clear directives from the Regional Health Departments
In addition to the contacts with the local health services, a large number of private socio-rehabilitative organisations are also involved in work with drug dependent prisoners. These contacts vary from maintaining contact with an individual already known to the organisation through the provision of psycho-social support services to providing assessment and rehabilitation services for drug dependent prisoners as an alternative to detention or in preparation for release from prison. As has been described in previous reports, for many years it has been an objective to encourage drug dependent offenders into therapeutic treatment both as an alternative to a prison sentence and as an alternative to continued detention. The active involvement of community services, especially therapeutic communities, has therefore been promoted.
These services are registered with the Ministry of Justice and are financed by the Ministry for prisoners in their care.

5.2 Alternatives to prison for drug dependent offenders

5.2.1 Objectives, organisation, funding and professional resources

The overall objectives of alternative to prison are to provide community supervision and support to avoid re-offending and to assist a long term prisoner return to the community. For drug using offenders, the specific objectives are to engage the offender in a therapeutic programme to achieve abstinence from illicit drug use with the ultimate objective of full rehabilitation from all drug use.

The Directorate General for Alternative to Prison Penalties (Direzione Generale dell’Esecuzione Penale Esterna) of the Ministry of Justice is responsible for coordinating and overseeing the work of the Probation Service (CSSA - Centri di Servizio Sociale per Adulti). The Probation Service at local level supervises offenders and works closely with both the Ser.T. and private socio-rehabilitative services where these are providing specialist interventions for the offender. A parallel structure operate within the Juvenile Justice System, with a separate probation service for young offenders (USSM - Uffici di Servizio Sociale per Minorenni). Where an offender is assigned to the Probation Service, the funding for treatment in a therapeutic programme is paid by the Ministry of Justice. In 2001 the Ministry of Justice allocated € 973,521 to the Regional Offices of the Prison Administration for social re-insertion projects, such as re-insertion into work and vocational training for drug and alcohol dependent persons under probation supervision. This does not represent the full extent of funding but is indicative of the level of activity.

The two probation services are professionally staffed with qualified practitioners who also receive both continuing training and ad hoc training programmes on specific topics. They are also able to draw on the expertise of staff in the Ser.T. and in therapeutic training programmes.

5.2.2 Accessibility to alternative measures

There are two types of alternative measure available in Italy. Substitute sanctions are decided by the judge as a replacement for imprisonment at the same time as s/he passes sentence. The intention is to avoid offenders receiving short sentences from going to prison. Community measures are granted by a specific judicial authority, the Supervisory Court, during the execution phase of a penalty, at the offender's request. The following substitute sanctions are available:

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

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

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

The range of community measures available is substantial. For drug dependents, the specific measures available are assignment to the Probation
Service and Suspension of the Penalty. They are also eligible to all the other general community measures or concessions. Drug using offenders may be ineligible for community measures for a variety of reasons, but where they satisfy the criteria for a particular measure or concession, they have the right to apply for it. What is less clear is whether all drug using offenders who are eligible for alternative measures can in practice access the necessary treatment services. The National Drugs Plan foresees the need to develop additional resources and guarantee a right of access to therapeutic alternatives to imprisonment. This might suggest that whilst the legislative framework is satisfactory, the implementation arrangements remain inadequate.

5.2.3 Information strategies
The availability of substitute sanctions and alternative measures is widely known, the arrangements having been in place for many years. There are no specific information strategies to alert drug using offenders of the availability of substitute sanctions or community measures. However, the various parties involved in the judicial process – defence lawyers, supervising magistrates, judges etc. are all aware of the options and there is a common objective of placing a drug using offender within a therapeutic programme wherever possible as an alternative to detention in custody.

5.3 Evaluation and training
5.3.1 Evaluation results
No evaluation results with regard to the treatment of drug using offenders in prison nor concerning substitute sanctions or community measures for drug using offenders has been published recently. There are some articles providing commentaries or descriptive accounts of activities which can be found on Italian web sites, for instance Progetto Teseo carried out by the Ser.T. of Padova in the Veneto Region contains a description of the project and a number of interesting articles, but no published results.

5.3.2 Statistics and research
The Ministry of Justice has produced substantial statistics on drug using prisoners and on drug users assigned to the Probation Service. More detailed data is available about drug using juvenile offenders. It should be noted that this data refers to drug using offenders as the definition of dependence used in the statistics is not based on a clinical assessment but includes clinical assessments, self-declarations, prison staff assessments and observations. The Prisons Administration of the Ministry of Justice estimates that between 40,000 and 50,000 drug using adult offenders pass through the prison system every year. On 31 December 2001 there were 15,442 prisoners assessed as having a drug problem, representing 27.9% of the total adult prison population on that date. There has been a very substantial change in the pattern of prison admissions over time (Table 24). It is also noticeable that for both Italian and non-Italian drug using offenders there has been a major change in their offending. Table 25 shows the category of

<table>
<thead>
<tr>
<th>Changes in the Percentage of New Admissions to Prison by Category</th>
<th>1992</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italian non-drug users</td>
<td>55.4</td>
<td>46.3</td>
</tr>
<tr>
<td>Italian drug users</td>
<td>30.1</td>
<td>21.3</td>
</tr>
<tr>
<td>Foreign non-drug users</td>
<td>10.4</td>
<td>24.9</td>
</tr>
<tr>
<td>Foreign drug users</td>
<td>4.2</td>
<td>7.8</td>
</tr>
</tbody>
</table>

**Table 24** Source: Ministry of Justice

<table>
<thead>
<tr>
<th>Changes in the offences for which drug users are detained in prison</th>
<th>1992</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italian Drug offences</td>
<td>56.9</td>
<td>45.4</td>
</tr>
<tr>
<td>Non-drug offences</td>
<td>43.1</td>
<td>54.6</td>
</tr>
<tr>
<td>Foreign Drug offences</td>
<td>67.0</td>
<td>59.1</td>
</tr>
<tr>
<td>Non-drug offences</td>
<td>33.0</td>
<td>40.9</td>
</tr>
</tbody>
</table>

**Table 25** Source: Ministry of Justice
offence for which drug users were detained as a percentage of all offences for which Italian drug users and foreign drug users were detained. For Italian drug using offenders, there has been a reversal and now non-drug law offences predominate. For foreign drug using offenders the change has not been so dramatic but a similar trend can be seen. As the data refers to offenders detained in prison, this might suggest that these are the more serious offences or are ones where preventive detention is considered necessary. It is also possible that Italian drug using offenders have acceptable accommodation for release either awaiting trial or to take up a non-custodial alternative. By contrast, foreign drug using offenders may not have residency and may also have problems of communication, making it difficult for them to be released pending trial or to take up an alternative to prison.

The statistics on adult offenders assigned to the Probation Service show that nationally 26% (6,863) of all assignments were drug using offenders. This is a 1% drop from 2000 although an increase in the number of assignments. There are significant differences between areas of the country. In the northern Regions around 35% of all assignments are of drug using offenders whilst in the southern and island Regions drug users represent only 15% of assignments. This difference is considerable and cannot be explained solely by different levels of offending or seriousness of offences. It suggests that access to community measures is more restricted in the southern Regions and this may reflect a paucity of therapeutic services. It might also reflect less acceptance of treatment as an alternative to punishment for drug using offenders within the judicial system. Further investigation would be necessary to understand the reasons for such substantial variations.

In 2001, 1,116 drug using offenders passed through the Juvenile Justice Service of whom 76% were Italian and the vast majority were male (95.3%). 15.1% of drug using juvenile offenders were aged 14 – 15, 66.2% aged 16 – 17 and 18.7% aged 18 or over. The balance between Italian and non-Italian drug using offenders changes substantially between the age groups. Only 58.3% of offenders are Italian in the 14 – 15 age group whilst for the 16 – 17 age group it is 78.2% and for the 18 or older group it is 85.6%. It is likely that this reflects a higher likelihood of detection for this group. This seems more certain as 65.8% of all non-Italian drug using juvenile offenders are from Africa and this rises to 75% in the 14 – 15 age group.

In terms of patterns of drug use, 46.5% were occasional drug users, 43.9% regular users, 9% drug dependent and data was not available on 0.6% of young offenders. Cannabis was the drug most commonly used (70.1%) but 12.4% reported use of opiates and 9.7% use of cocaine.

Young offenders may go to an assessment centre (CPA – Centri di Prima Accoglienza), a youth prison (IPM – Istituti penali per minori), be assigned to the youth probation service (USSM) or sent to a community which has a convention with the Juvenile Justice Service COM – Comunità ministeriali). In 2001, 15.7% (580 people) of all admissions to the CPA were drug users, as were 15% (329 people) of admissions to the IPM and 10% (43 people) of admissions to the COM. By contrast, only 2.9% (398 people) of all assignments to the USSM were drug users. It is not clear why there should be such an apparently high level of use of custody for drug using young offenders. It may

| Allocation of drug using young offenders by year and nationality |
|--------------------------|-----------------|-----------------|-----------------|-----------------|
|                         | 1998            | 1999            | 2000            | 2001            |
|                         | it | Non-it | it | Non-it | it | Non-it | it | Non-it |
| CPA                     | 43.5 | 60.2 | 43.9 | 52.3 | 43.3 | 51.5 | 41.7 | 46.8 |
| IPM                     | 25.4 | 33.3 | 22.8 | 39.2 | 22.3 | 41.4 | 19.7 | 38.7 |
| USSM                    | 31.1 | 6.4  | 33.3 | 8.4  | 28.1 | 4.0  | 35.4 | 11.2 |
| COM                     |     |      |     |      | 6.3  | 3.1  | 3.1  | 3.3  |

Table 26 Source: Ministry of Justice
reflect a number of factors. First, the relative seriousness of the offence. Second, if the offender has no residency or accommodation, it may not be possible to permit release to a community measure. Third, if the offender cannot communicate in Italian, the use of community and therapeutic alternatives may be limited. The latter two factors may be particularly important as a non-Italian young offender is twice as likely to be held in a youth prison as an Italian young offender and 3 Italian young offenders are assigned to the USSM for every one non-Italian assignment (Table 26).

5.3.3 Training
Training for work within the criminal justice system operates at different levels. The Higher Institute of Prison Studies (Istituto Superiore di Studi Penitenziari) has responsibility for the training of senior staff and works in collaboration with universities, national research institutes and with local public and private organisations as appropriate. In particular, it has a number of projects funded through the National Drugs Fund aimed at identifying training needs (Project Val.O.RI), training strategy (Project PANDORA) and training evaluation (Project F.I.T.T.). Continuing training of staff is decentralised and is the responsibility of the Regional Prison Administrations. They have focused on two specific areas during 2001. First, they have undertaken work aimed at developing a more integrated system for work with drug using offenders. These have included both staff working within the prison system and staff from the Ser.T., local public services and private socio-rehabilitative organisations. An example is Project Teseo, which concluded at the end of 2001. Its training module involved 10 training sessions spread over the year for 100 people working for the prison system and in the Ser.T. The box shows the titles of the training sessions. The introductory session presenting the project overall has not been included. Each is hyperlinked so that the documents (in Italian) can be directly accessed. Within the Juvenile Justice Service the particular focus has been on training of staff on developments and new problems, especially those related to misuse of synthetic drugs. There has also been continuing training to support the provision of health education within the Service.

<table>
<thead>
<tr>
<th>Project Teseo Training Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of crimes and punishments: guidelines on detention</td>
</tr>
<tr>
<td>Alternatives to Prison: Analysis of successes and failures</td>
</tr>
<tr>
<td>Drug dependents in prison: Special treatment units or diversified custody?</td>
</tr>
<tr>
<td>Health in Prison: Problems arising from HIV infection and abstinence syndrome</td>
</tr>
<tr>
<td>Work within and outside the walls: Special treatment units and other possibilities</td>
</tr>
<tr>
<td>Treatment programmes in alternative measures: Parent and child relationships</td>
</tr>
<tr>
<td>Non-Italian Prisoners: Possibilities for rehabilitative interventions</td>
</tr>
<tr>
<td>Alcohol and Prison: from treatment to alternative measures</td>
</tr>
<tr>
<td>The prison team and local services: the flow of information and working together</td>
</tr>
</tbody>
</table>

6 Quality Assurance

6.1 New trends and developments
There have been no significant new trends or developments during the year. Under an agreement approved on 5 August, 1999 by the Permanent Conference for Relations between the State, the Regions and the Autonomous Provinces, minimum standards were established for the accreditation of private services for drug dependents and for public services. The standards cover the requirement to be registered with the relevant local authority, the physical standards of the accommodation/building, the provision of explicit details about the services offered,
ethical issues, staffing levels, qualifications and training, administrative reporting, monitoring, evaluation and data submission. Each Region was responsible for approving regulations at the local level to implement the national agreement. There has been a process occurring of local consultation, the development of draft regulations, debate of the drafts through to final approval of the regulation. This has inevitably taken time and the main activity has been a gradual implementation of the local regulations in the context of further changes arising from devolution to the Regions of full responsibility for planning and provision of health care, assumption of responsibility for the health care of prisoners and changing arrangements for the delivery of prevention, drug treatment and rehabilitation services.

6.2 **Formal requirements**
The formal requirements for quality assurance are determined at Regional level and vary from Region to Region. There is no common quality assurance system outside the minimum standards which have been described in previous reports (National Report Italy 2000). The minimum standards which have been adopted do not necessarily represent quality assurance procedures and an increasing number of services are applying to receive the ISO mark as a means of ensuring that quality procedures are operated within the service.

6.3 **Criteria and instruments**
As noted above, there are no national criteria other than those providing for minimum standards and Regional procedures vary considerably with few having any true quality assurance criteria or instruments. An exception is the Veneto Region where a substantial manual on quality management has been produced (Serpelloni [ed.] 2002). This multi-author publication is available in both hard copy and electronic form (http://veneto.dronet.org/database/vis_bibl/bib_zip/tqm.zip) and covers both theoretical and practical elements. It is not known to what extent this manual is used within the Veneto Region or how many organisations or Regions have used it either in its entirety or as a basis for developing their own quality systems.

6.4 **Application of quality assurance procedures and results**
There have been few publications or reports on quality assurance or quality standards. Two articles (Di Carlo et al, 2001, Bruni et al, 2001) have reported on the perceived quality of drug services. Sareri (2002) has reported on an evaluation of the quality of a therapeutic community. Di Carlo et al (2001) were evaluating the treatment system of the Abruzzo Region and the evaluation of perceived quality was a specific study within this wider evaluation. Data was collected on both the Ser.T. and the therapeutic communities operating in the Region. The qualities evaluated were location, cleanliness, level of comfort, opening hours and organisation of the service, the availability and professionalism of the staff and the adequacy of the proposed treatment programme. For the Ser.T., most of the responses were that the situation was alright with higher satisfaction levels for the availability and professionalism of the staff and for the adequacy of the therapeutic programme offered. For the therapeutic communities satisfaction levels were slightly better in all areas than for the Ser.T. This may, however, reflect the fact that clients were resident in the communities and were present for a more limited and concentrated time at the Ser.T. Bruni et al (2001) evaluated perceptions of quality of the residential and day therapeutic communities in the Macerata Province (Marche Region). A formula was used to identify the level of satisfaction (index quality). Clients expressed greatest satisfaction with the individual and group psychological and psychotherapeutic services, and lowest satisfaction with the family psychology service and the organization of community life. The general analysis showed that the users perceived the quality as being discreet (average = 0.66 on a scale of 0 - 1). It was concluded that the index could provide community staff with indicators of aspects of
their intervention that could be improved. Sareri (2002) reports on some of the difficulties associated with general models for evaluating quality when they are applied to a therapeutic service. He then reviews the use of two modified evaluative tools, the Treatment Perceptions Questionnaire and the Evaluation of Satisfaction with the Service. Both of these proved valuable instruments for identifying areas where improvements could be made. However, the key observation was that the instruments were static rather than dynamic procedures and were more evaluative than quality assurance tools.