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GUIDELINES

MEASURES AND CONCRETE ACTIONS FOR THE PREVENTION OF DRUG-RELATED DISEASES

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Policy Lines for Establishing and Ensuring Observance of Essential Levels of Care

Measures and Concrete Actions for the Prevention of Drug-Related Diseases.

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Measures and concrete actions for the Prevention of Drug-Related Diseases.

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1. The aims of this document

This document aims to clearly define the measures and concrete actions that need to be put into effect in order to promote the prevention of drug-related diseases (those linked to the use of narcotic and psychoactive substances). The measures and actions set forth herein represent the Essential Levels of Care which must be guaranteed to every citizen across the national network of services. This document, therefore, is intended to provide policy lines that will offer an outline of the minimum standard of secondary preventive measures and actions that must be enacted in combination with the use of early outreach services and treatment and rehabilitation programs when working with individuals who use narcotic or psychoactive substances.
This document therefore aims to bring into clear focus the ways in which positive and realistic actions can be taken in order to prevent the risks and reduce the harm linked to the use of narcotic and psychoactive substances and/or the pathologies and deviant behaviours associated with drug use (such as drug-related crime and prostitution).
The document is divided into a series of paragraphs (definitions, basic principles, the goals each action is intended to achieve, measures and concrete actions to be put into effect, etc.) for ease of comprehension but most of all in order to facilitate the subsequent practical application of the instructions it contains.
The information presented herein is to be considered the minimum standard of reference for the creation of a consistent nationwide network of services and intervention actions. Once created, these projects will be put before the Regions and the Public Administration in an attempt to arrive at a concerted plan of actions and interventions to undertake both in the healthcare sector and on a social level.
This document represents one part of a larger project dealing with finding a comprehensive, systemic and sustainable approach to the problem of the use of narcotic and psychoactive substances in our country and provides coordinated and consistent strategies, actions and instructions covering three priority areas of intervention:

1. Primary prevention
2. Treatment of substance addiction and prevention of the pathologies and deviant social behaviours linked to drug use.
3. Rehabilitation and reintroduction

This document therefore represents only one part of the whole spectrum of actions and measures which are meant to be adopted in the fight against drugs and of the options for prevention and treatment which are meant to be made available.

2. Definitions

The use of narcotic substances can lead to a series of risks that go beyond that of addiction. These include the development of pathologies and deviant behaviours linked to drug use (such as prostitution and crime deriving from the need to procure money in order to purchase drugs) which may threaten or seriously compromise the health of drug addicts as well as causing damage to the community as a whole.
The Prevention of Drug-related Diseases as well as the prevention of the deviant behaviours that can result from drug use fall within the realm of projects for safeguarding

the health of the individual and of the community, and is represented by these actions and measures which the regional health and social care systems must put into action in order to prevent and reduce the negative consequences on the health and sociality of the individuals who use psychoactive substances.
In particular, through the adoption of these measures, which must also be entered into the category of actions to safeguard public health, it is hoped to prevent drug-related deaths, the passing and spreading of infections, the entrance of drug-users into criminal networks and prostitution rings and, at the same time, to prevent the discrimination against and stigmatization of drug addicts, as well as facilitate their rehabilitation and reintroduction into society. Let it be made clear, however, that the concept of stigma is unacceptable when applied to individuals who use drugs or to drug addicts, although society's disapproval of the use of drugs (but not of the people who use them) can contribute, together with other measures, to creating a positive preventative aversion in people's minds regarding drug consumption.
All things considers, by adopting these measures, it is therefore hoped to increase the quality of life and the life expectancy of individuals who consume drugs, as well as encourage their integration into society.
These actions must always be taken in conjunction with an offer of intervention and/or treatment of the risk conditions and and/or underlying pathologies (drug use and/or addiction) in the attempt to start individuals early on the path of care and rehabilitation, with the freedom from substance use as the final goal. These measure are to be taken even during the course of already ongoing treatment in order to prevent and reduce possible future negative consequences in case of relapse.
It should be made clear that addiction is to be considered a very real illness, while the recurring habitual use of drugs (in the absence of addiction) can be considered a pathological behaviour which can cause serious damage to the individual, both in terms of health and on a social level.
On the other hand, the occasional non-habitual ("experimental" or occasional, not pre-planned) must be considered a risky behaviour, both because of its potential to evolve into one of various forms of addiction and because of the risks it carries of acquiring various conditions which can compromise the individual's health and relationships with others.

In this context, abstaining from drug use can be, in certain situations, a secondary goal time-wise (even though it must still be achieved), but not a necessary and binding request to be made of addicts if they are to be able to have access to the various types of prevention and measures available to them to help minimize risks and damages.
The general aim is, by putting these actions/measures into effect, to primarily and opportunely help to safeguard, maintain and improve the health and quality of life of individuals who use narcotic or psychoactive substances while at the same time containing the risk of the possible spread of infections linked to the use of narcotic and psychoactive substances within the general population and reducing the overall social and health costs linked to the problem of drug addiction. This is all to be done as part of a comprehensive approach which aims, as has already been stated, to continuously work toward the ultimate unrenunciable goal of complete rehabilitation of the individual and his or her complete freedom from drug use, in full knowledge of the fact that there are people who resist treatment but for whom appropriate treatment options must be found nonetheless.

3. A few basic principles

1. *The right of drug-addicted individuals to the cure and Prevention of drug-related pathologies:* recognizing drug addiction as a disease, it is necessary to reaffirm that individuals suffering from this illness must be guaranteed rights equal to those of all other citizens/patients, in particular in terms of the access they are granted to socio-medical care, equality of treatment received and the right to choose their doctor and their place of care. Another fundamental right is that of not being discriminated against or stigmatized as a result of their state of being drug addicts, and this involves a responsibility and precise obligations to that effect on the part of the Institutions in order to guarantee that such discrimination and stigmatization does not occur.

2. *A combination of measures and actions:* there are different measures which are used in the socio-medical sphere to counteract the phenomenon of substance use and its overall consequences, and there are different concrete actions and different services in place to make these measures possible. These measures include primary prevention (mainly targeting people who have not yet used narcotic or psychoactive substances), outreach services, diagnostic care, treatment or health care, secondary prevention (targeting those individuals who already use or are addicted to narcotic or psychoactive substances in order to prevent the development of the diseases linked to the use of such substances and their adverse social consequences) and rehabilitation.

3. *How harm reduction differs from "drug addiction treatment":* when applied to individual cases, the measures taken to reduce harm can be quite varied, but they should not be confused with or seen as being the same as the "treatments or treatment programs", which are, by definition, measures whose primary objective is the curing of addiction through the application of specific diagnostic processes in combination with treatment/rehabilitation programs, which provide the patient with psychological support, monitoring his or her progress and evaluating the outcome. These measures are in fact specifically designed and structured using processes that aim, as much as is possible, to resolve the problem by curing it (with cure clearly intended to mean complete freedom from substance use) and to rehabilitate the drug-addicted patient and reintroduce him or her into society, which is a decisive factor for a full recovery. The measures for harm reduction, applied in specialized doctor/patient relationship contexts, must aim to become a stepping stone to help patients develop the motivation to take the first steps on a successful path using "socio-medical treatments".

4. *Social rehabilitation for drug-addicted individuals:* it musts be remembered that, for drug-addicted individuals who are undergoing pharmacotherapy, social rehabilitation is and must be an integral part of their treatment from the very beginning, and the steps to be followed to reintroduce them into society must begin to be taken during their pharmacological treatment in order to best take advantage of the pharmacotherapy's stabilizing effect.

5. *A necessary concomitance of harm reduction and treatment*: the two types of measures (which are put into practice through different forms of action) – those whose final aim is the actual treatment of the addiction disorder, and those whose aim is harm reduction – can and must coexist in order to ensure that drug addicts'

health can be maintained and/or improved along with their chances of being reintroduced into society. These measures cannot, therefore, be seen as alternative choices. In other words, they are always to be seen as complementary to each other. If a patient should choose not to accept to begin undergoing a treatment (because not sufficiently motivated, at that point in time, to suspend his or her use of narcotic and psychoactive substances) then it can be useful to adopt harm reduction measures with the limited and temporary goal of protecting the patient from exposure to the risk of fatal overdose or to the very serious risks of contracting a disease, while in the meantime working toward stimulating the individual's motivation with the aim of conducting them towards entering onto the paths of treatment and rehabilitation. On this topic this, it is useful and necessary to use as a reference for motivational work the States of Change Model (Prochaska, Di Clemente – 1984) reproduced in this document as an appendix.

6. *Pharmacotherapy and Harm Reduction:* the pharmacological treatment of addiction must, as has already been stated, be considered a very real "medical treatment", and as such its principle aim must be the cure of the underlying pathology, and not a simple harm reduction measure, even though pharmacotherapies can also serve the purposes of harm reduction and of reducing the risks linked to active drug addiction. If these treatments are presented as and considered to be only "harm reduction measures", then patients will lose sight of their primary value as a treatment and as a cure. Moreover, the use of pharmacotherapies or of any other treatment method, even behavioural therapies, if one-dimensional and applied with the sole aim of reducing harm, can lead to the risk of the patient becoming "chronic".

7. *Flexible time-frames for individual needs:* Pharmacotherapies must have as a first, short-term goal that of giving the drug addict the incentive to make contact with outreach services and preventing drug-related risks and harm. The mid-term goal of these therapies is the care and stabilization of the addict's health conditions. Following this, the mid- to long-term goal is the actual treatment of the addiction and the individual's rehabilitation through an integrated addiction treatment process.

8. *Proper professional procedures and contact with the patient:* it must be made clear that pharmacotherapies for addiction and in particular those for opiate addiction must, like all medical treatments, be provided, conducted and monitored according to proper clinical procedures. In Services where pharmacotherapies have been used incorrectly, they have resulted in ineffective and sometimes even harmful treatments. For this reason, it is absolutely fundamental that the Services be in the condition to function with maximum efficiency and effectiveness so that they may know and be able to use all the treatment tools at their disposal in the best possible way and according to proper clinical procedures. Only by expanding the resources available to the Services through a continuing and suitable investment in the training of Services personnel can such an improvement be achieved in a consistent way throughout the country. Indeed, proper clinical procedures provide for a high level of professionalism among Services personnel in order to guarantee, among other things, the proper use of replacement treatments and other forms of intervention and prevention according to different methods which may call for short, medium or long-term application in order to achieve specific goals in treatment and secondary prevention.

9. *The risk of an inability to follow proper clinical procedure while managing out-patient treatments:* it is necessary to the avoid the risk that Services fall back on using inappropriate at-home out-patient treatments with substitutive drugs, even for long periods of time, not for therapeutic/rehabilitative reasons (as is provided for in proper procedures) but as sometimes happens because of a lack of human resources in treatment Services. An at-home substitutive drug treatment cannot be justified by a lack of personnel. The inappropriate application of substitutive drugs which may take place in some Services stems from many and various causes, which could be eliminated through the combined effort of the Regional Health Authorities and the Services personnel so that all available treatment tools, including substitutive therapies and out-patient replacement treatments can be applied appropriately, case by case, for clear rehabilitative purposes. Out-patient replacement therapies, moreover, should be used most of all to support and motivate the patient on the path toward normalization once he or she has already started to take steps toward reintroduction into the workplace, which calls for a greater freedom of movement and for the ability to plan his or her life more around his or her job than around the hours when access is available to SerT facilities. It is clear that out-patient substitutive treatment can only be used under the condition that there is no simultaneous drug use and provided that the patient respects the program for reintroduction into society and/or the workplace that he or she is following. It is also admissible in the case of grave illness.

10. *The risk of a patient becoming chronic:* a problem often witnessed today is that of many patients becoming chronic. It is a problem that remains unsolved and is much debated by experts around the world. It remains a serious problem, not least when attempting to organize and design treatments, and it must be analyzed and faced, beginning by attempting to understand what are the true causes that come into to play and what solutions can be effectively and quickly put into action. Nevertheless, it cannot be forgotten than drug addiction has a tendency to lead to relapse and therefore manifest itself as a chronic condition. Unsuitable maintenance therapies, a lack of contact with the patient and an inappropriate falling back upon out-patient substitutive treatments and a professional tendency and attitude which are evidently far from being based upon proper clinical procedure are, with every probability, jointly to blame when many patients become “chronic”. There is, therefore, a need to carry out a serious and impartial analysis of the problem of patients becoming “chronic” in order to come to the best solutions to this problem. These solutions will have to be strategically aimed toward a medium to long-term future in terms of the reorganization and reorientation of the Addictions Services System. It must be made clear that pharmacotherapies are not “in and of themselves” the cause of a patient becoming chronic. By the term chronic what is meant is the continuing use over time of narcotic substances (at the same time as the treatment is being undergone), but most of all continuing deviant behaviours such as engaging in criminal acts and prostitution linked to the need to procure funds for the purchase of drugs, the persistence of a non-independent condition and an incapability to provide for oneself through work. More than pharmacotherapies, it is the absence of a continuing, well-structured and concomitant support program targeting the psychological aspects and designed to rehabilitate and reintroduce the subject into society that create the conditions necessary for the risk of becoming chronic, as defined above, to manifest. This aside, it must not be forgotten that there are patients who resist rehabilitative treatments and that these have the right to be assisted through the use of the appropriate treatment tools. Substitutive therapies,

therefore, if well managed, can lay the foundation for patients' risk and harm reduction and encourage rehabilitation by creating conditions which are favourable for carrying out integrated treatment programs whose aim is to give the patient social independence and free him or her completely from the use of narcotic substances.

11. *Incompatibility with primary/universal prevention efforts:* Lastly, another very important aspect that regards the application of the concepts of harm reduction is that which concerns "demand reduction". On this topic, it must be made clear that, by "demand reduction", what is broadly intended is the reduction of the number of people who create the demand for narcotic and psychoactive substances by using them. In this group of people, however, there are two important sub-groups: the first group (the largest of the two) consists of subjects who already use and continue to use and create a demand for narcotic and psychoactive substances; on the other hand, the second group, which is more interesting from the point of view of observation of the phenomenon and of monitoring its evolution, consists of first-time drug users, the so-called new users. When keeping this distinction in mind, it becomes clear that harm reduction is a measure that can be used to reduce demand and the use of this approach is positive, advisable and appropriate (in the manner and according to the concepts set forth above) in particular when dealing with those who already use narcotic and psychoactive substances. However, it is extremely unadvisable and counterproductive when used as part of primary prevention efforts aimed at those (the young and very young) who have not yet made use of narcotic and psychoactive substances and could infer the message that a controlled use of narcotic and psychoactive substances is permissible and possible, while in reality it is clearly unacceptable and dangerous. Therefore, the use of the harm reduction concepts in primary/universal prevention efforts targeting young people who have not yet used drugs is to be considered decidedly unadvisable. For this target group, it is much more appropriate to provide information aimed at raising awareness of how risk perception is lowered by the use of legal and illegal substances – this in order to control the spread of HIV, HCV, HBV and sexually transmitted diseases.

4. Objectives of the measures and actions for the Prevention of Drug-Related Diseases

In these types of efforts there are a series of priorities which the projects must respect and they are ranked as follows:

1. Early outreach: creating conditions that enable early outreach project feasibility
2. Reduction of mortality: create actions based on the causes of mortality.
3. Reduction of disability: create actions targeting the causes of disability
4. Increasing quality of life: create actions that target the causes of psychosocial maladjustment and of discrimination.

There are, therefore, a series of specific objectives which professionals in the prevention sector must work towards in order to create favourable conditions for the health and the sociality of drug-addicted individuals:

Objectives

1	Early outreach for drug users and/or individuals with drug dependencies in order to shorten the time spent outside of the programs provided by the social and healthcare Services as much as possible.
2	Prevent and reduce the risk of death as a result of overdose.
3	Prevent and reduce the risk of contamination and the spread of infectious diseases linked to drug addiction such as HIV, viral hepatitises, TB and sexually transmitted diseases, among the population of occasional users (alcohol, ketamine, etc.) as well.
4	Prevent and reduce the risk of drug and/or alcohol related road accidents.
5	Prevent and reduce the risk of accidents at home and in the workplace.
6	Prevent and reduce the risk of temporary or permanent disability linked to substance use and to psychiatric co-morbidity.
7	Preventing and reducing the social risks linked to substance use: Marginalization, discrimination, stigmatization. Introduction into criminal networks Incarceration Loss of positive social networks Prostitution School drop-out and loss of learning potential Loss of employment and productivity
8	Prevent and reduce the hardships and the negative consequences faced by the family members of drug-addicted individuals.
9	To promote awareness on the part of the drug addict of the problem and of the need to seek treatment.
10	To encourage individuals to begin treatments that aim to put an end to addiction.
11	To make drug addiction therapies consistently available throughout the prison system as well, with particular regard to "*custodia attenuata*" (T.N. special prison programs designed to treat and cure addiction while addicts are incarcerated).

5. The conditions under which certain measures are not applicable

To avoid confusion and misunderstanding, it is necessary to clarify that there are spheres in which the application of certain approaches and techniques for the Prevention of Drug-related Diseases is clearly unadvisable.

As has already been stated, harm reduction is unadvisable in the sphere of primary prevention, in other words, in the projects and efforts which target individuals who have not yet begun to use drugs or who are experimenting with drug use in a casual manner. Using means of communication and sending messages about minimizing the risks and harm resulting from drug use could easily result in misinterpretation on the part of the young target group of non-drug users. Messages about minimizing risks could actually be interpreted by the "naïve" target group as indirect messages saying that the use of drugs is "acceptable and tolerable", especially if reinforced by the idea that "if it is done in a certain way" drug use can be less harmful and therefore the target group could see the correlated risks as "acceptable". It is absolutely necessary to avoid such misunderstanding and misinterpretation on the part off the "naïve" target group, since such perceptions could encourage the onset of risky behaviours and an underestimation of the gravity of the problem on their part.

6. A few specifications regarding substitutive drug treatments, in particular from the point of view of preventing drug-related diseases

The basic principle is that the use of medical treatments for drug addiction, as for any other illness, must follow the principles of "science and conscience", such that the doctor accepts the responsibility of his own decisions in accordance with his own professional judgement, but within the realm of scientific evidence, sustainability and social acceptableness of his or her decisions.
"Substitutive drug therapies" fall within the sphere of "medical treatments" and must therefore be managed as such. Such treatments are primarily "measures whose primary goal is harm reduction", although in some situations and environments they can (and are hoped to) have a secondary preventive effect and therefore reduce the diseases and dangerous conditions associated with drug use.
The primary goal that "treatments" in addiction clinics hope to achieve is therefore that of freeing the individual from drug use and encouraging his or her complete reintroduction into society.
The primary goal of "harm reduction", on the other hand, is to prevent the onset of the diseases related to drug use or to minimize their consequences. In this context, and in certain situations and conditions, substitutive therapies can also become "harm reduction" measures.
In any case, the two approaches can be complementary, with one, as a rule, following the other and differing in their time-frames (the former being short-term, the latter mid- to long-

term), but they cannot be considered as alternatives to each other or be used independently of each other or in non-coordinated fashion.
The use of substitutive drugs such as methadone or buprenorphine, which serve to curb heroin use and reduce the number of fatal overdoses it causes (not to mention of the related crimes and of the behaviours that lead to a high risk of disease contamination), is useful in the context of the prevention of drug-related diseases whenever proper clinical procedures deem it suitable and in combination with motivational intervention and psycho-social support, but never as the sole alternative to live-in treatment programs.
Substitutive drugs can be used, for limited periods of time, in the sphere of Drug-related Disease prevention for the following purposes:

- To encourage and motivate drug-addicted patients who are in early treatment phases.
- To achieve a short-term reduction of the risks of overdose, withdrawal, contracting diseases or, in the case of pregnancy, obstetric/gynaecological complications and neonatal withdrawal syndrome.
- As a stepping stone on the way toward more structured, mid- to long-term paths of treatment and rehabilitation.

These types of pharmacotherapies aim to quickly and for a limited time reduce the risks and harm linked most of all to withdrawal symptoms, and are sometimes provided in less structured environments, such as from mobile units. Their principal characteristics are as follows:

- Rapid accessibility.
- Usually short-term.
- Always provided in combination with motivational counselling.
- Do not include out-patient treatment when administered in less structured environments, such as from mobile units, since it would not then be possible to ensure the possibility of emergency or periodic checks or to maintain an enduring relationship with the patient.
- Dosage that will ensure the containment of withdrawal syndromes when the drug is taken, usually about 20 mg of methadone or that equivalent, and in any case not more than 40 mg or that equivalent (control of abstinence symptoms).
- Prodromal in more structured treatments and as a supporting treatment in the mid- to long-term.

Measures/actions to be undertaken in order to meet set goals	Details	Principle areas to be targeted	Success indicators
Information programs (1-10)	• Provide information to the population at highest risk (young people) on the harm and risk caused by the use of narcotic and psychoactive substances. This project should be considered as supplementary to the Drug Related Illness projects.	• Permanent placement of informative materials (posters, brochures, website). All the materials to be marked with an logo that is easy and inexpensive to reproduce, and able to be systematically reused by the mass media and/or in conjunction with "Quality of Life" efforts (as is the red ribbon that symbolizes HIV+ solidarity) • High-risk schools • Health and medical centres • Pharmacies • Doctors' offices • Youth Information centres • Dance clubs • Discotheque bars	• N. of projects and extent of coverage throughout the country
	• To provide information to drug addicts who are not currently undergoing treatment and to occasional consumers about the existence throughout the country of both public drug addiction services (Ser.T) and private services (Non-profit organizations) and make such services easily accessible, even if that means accompanying individuals there or showing them the way.	• Places where drug-addicted persons and even occasional users meet and socialize. • Prisons	• N. of drug addicts informed / t_{std} • N. of occasional users informed • N. of new entries into addiction services linked to the information campaign / t_{std}
	• To provide information about the risks linked to substance use and provide information on how to modify or avoid	• Mobile Units • SERT (Public Drug Addiction	• N. of drug addicts informed / t_{std}

Measures/actions to be undertaken in order to meet set goals	Details	Principle areas to be targeted	Success indicators
		Services)	
	• drug abuse behaviours.	• Reception Centres • Drop-in centres	
	• To provide information on the heightened risk conditions during: periods of suspension; while simultaneously consuming alcohol or other substances; when using drugs in isolated areas which are hard to reach on one's own – as well as providing information on how to minimize adverse effects.	• Mobile units • SERT • Reception Centres • Drop-in centres	• N. of drug addicts informed / t_{std}
Early outreach programs	• To facilitate contact with drug-addicted individuals and also with occasional drug users through low-threshold approaches: ○ Approaching drug-addicted individuals and also occasional drug users by sending prevention personnel onto the streets and into the venues where drugs are consumed by using mobile units ○ Setting up and managing drop-in centres, working with public and private assistance and recovery Services, and providing places where drug addicts can have basic needs fulfilled (with the exclusion of drug and alcohol consumption) such as taking care of their personal appearance and hygiene, getting the food they need to survive and having shelter from the cold). This effort also aims to improve the quality of life of individuals who use narcotic and psychoactive substances while at the same creating a chance to establish first contact. ○ Adaptation of admission procedures for public services • To put accompaniment programs into effect for those	• Entertainment venues, places where drug-dealing goes on, rave parties, informal gathering places	• N. of drug addicts contacted through: mobile units and drop-in centres • N. of mobile units – N. of working hrs. per week • N. of mobile units – N. of projects / drug addicts contacted • N. of Drop-in centres - N. of working hrs. per week • N. of Drop-in centres - N. of projects / drug addicts contacted • N. of individuals accompanied/total n. of contacts made

Measures/actions to be undertaken in order to meet set goals	Details	Principle areas to be targeted	Success indicators
	individuals on their way to receive public services. • To develop nationwide training programs for law enforcement professionals (including the Penitentiary Police Corps) that focus on how to relate to those in need of assistance in order to better direct them toward accepting consensual treatment, and also to establish emergency support and counselling networks and services through the creation of 24hr telephone hotlines.		
Distribution of clean syringes and replacement of used ones, distribution of kits containing sterile materials and life-saving drugs **Distribution of condoms (HIV prevention)**	• To begin campaigns and to make deals with pharmacies nationwide to cooperate in the effort to make sterile syringes readily available to drug-addicted individuals. • To provide for the replacement of used syringes with clean ones in an attempt to curb the spread of diseases caused be syringe sharing and to reduce as much as possible the number of used syringes left lying in inappropriate places. Also, in situations where it is not possible to distribute new syringes, to teach users to sterilize those that have already been used. There is to be a simultaneous distribution of sterile materials (gauze pads with disinfectant and distilled water) and life-saving drugs (naloxone) to be used in case of overdose (to be distributed to drug-addicts' families as well). • To distribute condoms for the purpose of reducing the incidence of communicable diseases and to teach people how to use them properly.	• Permanent community-based assistance points for drug-addicted individuals • Mobile units • SERT • Reception Centres • Drop-in centres	• Established cooperative deals with pharmacies • N. of syringes – distributed – replaced • N. of drug addicts trained in the disinfection of syringes and the proper use of condoms. • N. of condoms distributed • A change in the incidence of overdose and of the number of diseases linked to intravenous drug use and/or sexually transmitted diseases diagnosed.
Training to acquire preventative skills	• To use specific training to help drug-addicts as well as occasional users develop the knowledge and skills they need to carry out the following activities. Also, to introduce peer support with properly trained and carefully selected peers (although the peer support technique should be avoided during syringe disinfection training, as this activity	• SERT • Prisons • Drug treatment clinics • Mobile Units • Reception Centres • Drop-in centres	• N. of drug addicts who participated in the training • Levels of knowledge acquired • Levels of skill acquired in the areas of • disinfection

Measures/actions to be undertaken in order to meet set goals	Details	Principle areas to be targeted	Success indicators
	can trigger cravings): ○ Disinfection of syringes and paraphernalia ○ Proper use of condoms ○ Emergency first aid for a person who has overdosed ○ Identifying factors that increase risk (resuming substance use after a period of abstinence, etc.)		• condom use • emergency aid in case of overdose
Continuing Care (1,7,10)	• To put concerted and concordant efforts into action (through the use of shared steps and protocols) aimed at preventing and managing the risk of overdose for drug addicted individuals who are making the steps: • From prison to freedom • From drug treatment clinics to the outside world • Out of in-prison drug treatment programs	• Prison • Drug treatment clinics • Families of incarcerated drug addicts or of drug addicts living in drug treatment clinics	• The existence of protocols • N. of drug addicts informed • N. of overdoses in the groups at risk • N. of patients admitted into in-prison treatment programs.
Establishing early warning systems	• To create an extremely fast regional information network linked to and coordinated with the Focal Point - EMCDDA national early warning system established by the Department of Antidrug Policies (National Early Warning System – NEWS) that would make it possible to be aware, in almost real time, of the appearance within the country of new, particularly dangerous substances • To take steps to ensure the timely reporting of noteworthy news and/or send out alerts picked up locally to the national system. • To ensure that warnings are duly received within the local jurisdictions and set up and organize early response efforts to safeguard the health of drug-addicted individuals • To see to the direct distribution of early warning information to the emergency healthcare providers as well as to communities of users, consumers of public drug services, incarcerated drug addicts and to the mobile units in contact with users	• Regional jurisdictions • Head offices of the Department of Antidrug Policies • Prisons • SERT • Mobile Units • Law Enforcement Authorities • Reception Centres • Drop-in centres	• N. of warnings sent • N. of warnings received and acted upon • Extent to which warning information was spread in relation to the number of points targeted by the effort

Measures/actions to be undertaken in order to meet set goals	Details	Principle areas to be targeted	Success indicators
Emergency first aid	• To organize training programs for drug addicts (focusing on the development of concrete prevention skills and not only on raising their level of knowledge) that aim to provide them with the basic skills needed to provide emergency first aid in the event that a fellow drug addict should overdose.	• Mobile units • SERT • Drug treatment clinics • Prisons • Reception Centres • Drop-in centres	• N. of courses organized • N. of participants
Naloxone distribution	• Distribution of ampoules of naloxone hydrochlorate to patients and to the family members of drug addicted individuals for emergency first aid in case of heroin overdose.	• Mobile units • Drop in centres • SERT	• N. of ampoules distributed • N. of ampoules used
Programs for reducing fatalities and disabilities linked to driving under the influence of alcohol or drugs	• Information and educational campaigns in the places where drugs are consumed and in entertainment venues through commercials, posters, on site testing and breathalyzer tests. • To enact programs using suitably trained personnel to give rides to individuals who are in obviously altered states when leaving night clubs and similar venues. • Stationing law enforcement officers in discothèque parking lots to make drivers undergo voluntary tests before they start their cars. • Testing on the roads with the collaboration of law enforcement authorities and healthcare organizations (SerT) – putting the “Drug on street” protocol into effect.	• Schools • Driving schools • SERT • Discothèques • Rave parties • Places where law enforcement authorities are stationed to carry out testing on the roads	• N. of activities carried out in targeted locations • N. of people accompanied • N. of voluntary tests carried out • N. of positive test results • N. of on-road tests carried out • N. of positive test results
Women and drugs	• To set up special points of contact and reference that women can easily get in touch with through services such as publicized information hot-lines. • To set up programs which include: ○ Counselling and information on the particular risks which women are exposed to and their specific vulnerabilities: (the risks associated with prostitution,	• SERT • Drug treatment clinics • Reception Centres • Drop-in centres • Prisons	• N. of female drug addicts contacted • The existence of special programs for women • N. of drug-addicted prostitutes entering treatment programs to cure addiction and free them

Measures/actions to be undertaken in order to meet set goals	Details	Principle areas to be targeted	Success indicators
	violence, unwanted pregnancies; how the use of narcotic and psychoactive substances can affect the unborn child, etc.). ○ Training to develop awareness and assertiveness. ○ Programs to help start women on the path toward freedom from the exploitation to which prostitution subjects them. ○ Gynaecological care and prevention of sexually transmitted diseases. ○ Care during pregnancy and birth. ○ Programs and concrete assistance to support mothers in managing and caring for their children.		from drugs • N. of female drug addicts given gynaecological examinations • N. of female drug addicts receiving care during pregnancy

8. How and in what contexts these programs can be successfully put into effect and under whose responsibility they fall

The actions listed above must be inserted into permanent programs and efforts for which ongoing sustainable organizational and financial support is foreseen and provided.

The real application of these measures and actions will have to be monitored to check that they have been put into place and that their application is ongoing, said monitoring including gathering data on their effectiveness and efficiency using the success indicators listed above.

The responsibility of planning these programs for the prevention of drug-related diseases falls to the Regional Authorities and the Public Administration, who will have to provide for the organization within each individual Health Authority by inserting these efforts as part of the normal activities of the Departments of Addiction Services (where these already exist) or of the SERT (Public Drug Addiction Services), with heavy involvement on the part of certified private service providers.

9. Assessment

It is important that success be assessed through the observation of 5 primary areas of interest:

1. The existence or absence of the actions, programs and services that have been provided for within the healthcare services agencies (Departments of Addiction Services/SERT), making it obligatory to provide these things in order to be certified by the healthcare authorities (whether the service is managed directly by the public Operation Units or outsourced to certified organizations).
2. Level of success in relation to the needs of each local community area, judged by the number of specific individual services provided (allocative efficiency) in relation to need.
3. Actual effectiveness of the actions.
4. Costs and sustainability of the measures put into effect, taking into consideration as well the percentage of the total budget set aside by agencies for addiction services.
5. Costumer satisfaction and social acceptability of the various efforts undertaken from the points of view of local administrations and of the general population.

Assessments must be carried out by two separate entities: one by the party responsible for the organization and providing of the service (self-assessment) and the other by a third party (third-party assessment). These assessments must be based on the same parameters, which should be parallel and able to be compared to one another.

10. What is asked of the Central Administrations and of the Regions and Autonomous Provinces

In order to ensure that what has been set forth here does not remain simply a declaration of intent, it is necessary to define the specific duties and roles of which will have to be taken on by the various entities in order to make the policy lines set forth here operational in each local area.
To this end, it is deemed necessary to set forth the specific details as follows.

Department of Antidrug Policies	The Regions and the Public Administration

• Interministerial coordination
• To encourage agreement between:
  ○ Central governments
  ○ The Regions and the Autonomous Provinces
  ○ Non-profit organizations
  regarding the policy lines
• Define the policy lines and the Essential Levels of Care to be proposed and agreed upon with the Regions and the Autonomous Provinces.
• Reach an agreement with the regions about how to apply said policies.
• To enact formal measures according to the procedures set forth by the State-Regions Conference
• To promote and support the application of the policy lines in the individual Regions
• To monitor the proper application of measures within the boundaries of each single Region
• To enact corrective improvements as necessary
• To assess the success of policy application based on the real results achieved and to put agreed upon solutions into effect in case of failure to carry out the policy or to reach the goals set forth
• To set up a Third-party assessment system
	• To make concerted arrangements with the Central governments and Non-profit organizations
	• Contribute to the technical definition of policy lines and Essential Levels of Care
	• To formally assimilate policy lines through the procedures set forth by the State-Regions Conference
	• To apply these policy lines through appropriate planning on regional levels
	• To check that the programs and efforts decided upon have been put into effect and are ongoing in each individual Health Authority
	• To provide regular and suitable reports on efforts undertaken and their results
	• To take part in the monitoring process by communicating the information necessary to carry out a proper assessment of activities within the agreed upon time-frame
	• To propose modifications and improvements to be integrated into the system as necessary

In the interests of being able to carry out a proper assessment of the application of the measures/actions set forth herein and of the roles, duties and responsibilities they entail, it is seen as necessary and essential to involve a “Third Party” as part of a project to provide support to the Department for Antidrug Policies, the Regions and the Autonomous Provinces in their monitoring and assessment of the Policy lines. This Third Party should be chosen from among the highest level Organizations qualified and certified in providing support for the realization of complex systems such as those of a socio-medical type.

11. ADDENDUM (by the Department of Antidrug Policies)

IMPORTANT NOTE: this part of the document is to be considered an "ADDENDUM" prepared and defined solely by the Department of Antidrug Policies. Its contents were not formally circulated to the advisory group, although most of them agreed that this note should be inserted.
An explanation of the three measures listed below must be provided in order to clear up misunderstandings with Regional Governments regarding their legitimacy, their organizational feasibility and the treatment and prevention opportunities they can offer. This is due to the fact that this Department is of the opinion that it does not want to focus discussion on these issues nor to consider allocating resources to these measures as it does not hold them to be of a high priority nor even feasible under Italian law. Indeed, they could drain limited resources which could otherwise be allocated to other efforts that are more effective and feasible and which are aimed at inserting individuals into treatment programs.
It must therefore be clearly explained that the actions below are to be excluded from any Drug-Related Disease prevention programs for the following reasons:

ACTIONS	EXPLANATIONS AND REASONS
Pill testing	• This method cannot be applied in Italy due to the existence of laws which prevent its use. It consists of analyzing the contents of pills in the places where they are consumed in order to provide information on the "substance quality" and its estimated dangerousness. This type of action is unadvisable, as reliable "on site" laboratory tests to determine the toxicological characteristics of substances do not exist. Moreover, new and as yet unidentifiable substances are continually being produced. Lastly, it is also necessary to consider the unpredictability of the reaction any given individual may have to a substance. A "reassuring" test result could give the user a false sense of safety regarding the abuse of the substance, which is often mixed with alcohol with unforeseeable consequences. We must also take into consideration the fact that it is unclear what happens to the substances which are found to be "of bad quality" during pill testing. They probably will not be disposed of, as the user will, in all likelihood, pass them on to other users who are ignorant of the test result in order to make back the money spent in order to buy new drugs. With regard to the problem of identifying particular substances or their extremely dangerous variants, it is therefore held to be more important and certainly more suitable to put a nationwide early warning system into effect, with warnings being communicated to drug users as well. This system represents a valid and more reliable solution to the problem than pill testing, in that it uses much more reliable laboratory methods.
Controlled Heroin Distribution	• The issuing of heroin from designated facilities for therapeutic purposes, with patients having access 3 or 4 times a day in order to self-inject heroin, is an action which cannot be enacted under Italian law. There is not a high need for this based on the very small percentage of subjects who might take advantage of such facilities (not greater than 3%) and, considering the experiences of many other countries which have shown, over the course of many years, that this type of treatment, which requires that heroin be injected 4 times per day, is usually abandoned by patients of their own free will within 4 to 6 months. Moreover, the large expense involved in providing patients access 4 times a day could be seen as a misappropriation of funds required for other levels of treatment, and

		this must be taken into consideration.
Self-administration rooms	•	Italian law does not allow for the enactment of such an action. It would require the establishment of places where patients are permitted to self-administer narcotic and psychoactive substances which they themselves have purchased while under the supervision of qualified medical and paramedical personnel. This action goes completely against the national strategy and basic principles of the Department of Antidrug Policies. The Department instead deems it necessary to prioritize the investment of resources exclusively in parallel activities such as first contact projects carried out by mobile units, drop-in centres, first reception centres and low-threshold pharmacotherapies. We therefore propose, as an alternative, to enact rapid reception policies and the use of pharmacotherapies to motivate drug users to initiate contact and to enrol in treatment and eventually free themselves from drug use with higher-threshold and longer-term treatment programs. Additionally, there has been concern and disagreement over what the opening of such rooms would mean for and how it would affect drug-addiction services personnel, the local and regional administrators and planners, and what effect it would have on public opinion. At the moment, most Regional Systems are able, if given the proper direction, to create effective efforts for first contact and to motivate users to enrol in treatment programs (this being the primary objective), and the opening of such rooms could cause attention and funds to be diverted toward less expensive solutions which, instead of being seen as an addition to existing programs could, for purely budgetary reasons, run the risk of supplanting the pre-existing programs, thus creating groups of patients who are monitored but not properly managed from a therapeutic standpoint.

12. Essential Bibliography

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14. "Drug Dependence Treatment - Training package", UNODC (2008)
15. EU Drugs Action Plan for 2009-2012 European Council , December 2008
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13. Annexes:

Annex 1: The Stages of Change Model (Prochaska and Di Clemente – 1984)

The Stages of Change	Characteristics	Techniques
Precontemplation	Not acknowledging that any change needs to be made: "Blissful ignorance".	• Validate lack of readiness. • Clarify: decision is theirs. • Encourage re-evaluation of current behaviour. • Encourage self-exploration, not action. • Explain and personalize the risk. •
Contemplation	Ambivalent about making a change: "sitting on the fence". Not considering making a change within the next month.	• Validate lack of readiness. • Clarify: decision is not theirs. • Encourage evaluation of pros and cons of behaviour change. • Identify and promote new, positive outcome expectations.
Preparation	Some experience with making a change and the individual is trying to change: "Testing the waters". Planning to take action within 1 month.	• Identify and assist in problem solving regarding obstacles. • Help patient identify social support. • Verify that patient has underlying skills for behaviour change. • Encourage small initial steps.
Action	Individual practices the new, changed behaviour for 3 to 6 months.	• Focus on restructuring cues and social support. • Bolster self-efficacy for dealing with obstacles. • Combat feelings of loss and reiterate long-term benefits.
Maintenance	Continued commitment to sustaining new behaviour. Post-6 months to 5 years. .	• Plan for follow-up support. • Reinforce internal rewards. • Discuss coping with relapse.
Relapse	Resumption of old behaviours: "Falling from grace".	• Evaluate trigger for relapse. • Reassess motivation and barriers. • Plan stronger coping strategies.

Annex 2: full text of an e-mail sent by the Office of National Coordination of Therapeutic Communities (Coordinamento Nazionale Comunità di Accoglienza – CNCA) to the Department for Antidrug Policies (Dipartimento Politiche Antidroga – DPA) on 23 June, 2009 at 11.27 p.m.

"To the National Antidrug Department

Having acknowledged receipt of the final version of the document on the prevention of drug-related diseases, received by us on June 11, 2009, while we favourably noted the quality of some of the technical data on harm reduction which the group had compiled in the course of its work and which were presented in the document, we nevertheless hold that some points regarding the premises on which the document is based and the conclusions it draws remain insufficient and unacceptable.
Therefore, while we continue to remain at your disposal to effect a technical-scientific assessment which would allow the technical data to become part of the Essential Levels of Care, we are nonetheless unable to adhere or subscribe to this document in its entirety".

Riccardo De Facci
Leopoldo Grosso

Annex 3: text of a letter sent by the Italian League for the Fight against AIDS (LILA), on July 6, 2009 at 12:51 p.m.

"Omitted...Therefore, while recognizing that other suggestions put forward by us have been taken into consideration, for all of the reasons detailed above, we are unable to agree with this document in its entirety."

Alessandra Cerioli
National President

Massimo Oldrini, Damiano Maggio
Harm Reduction sector