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REPORT ON DRUG MISUSE IN PARIS *

by

Dr F R Ingold

* This report was prepared before new government measures were announced in autumn 1986.

INTRODUCTION

This report is the sequel to an initial description of drug addiction and epidemiological approaches to the problem in the Paris region. We have updated that document and now present it in the form agreed by the experts.

The data set out here are not derived from specific research designed to evaluate the extent and evolution of the phenomenon in Paris. There is no scientific body in France which is responsible for the collection and collation of the requisite epidemiological and statistical data.

We shall therefore concentrate rather more on work which has trend indicator research value, since this can elucidate certain aspects of drug addiction in Paris, provide food for thought and offer prospects for epidemiological evaluation of illicit drug consumption at national level.

Generally speaking we use the term “drug user” and keep the term “drug addict” for those users who contact health institutions, regardless of the type of consumption or the products used.

It should be emphasised that the data relating to Paris are not representative of national trends. Since the early 70s, the three regions most affected by drug use have been the Paris region, the south and the east, but it would now appear to have become more widespread in the provinces, including medium-sized towns.

A. DESCRIPTION OF THE CITY

A.1 History of drug misuse

The use of illicit drugs in its current form, by young people, first appeared in the second half of the Sixties. Before then, and particularly in the Fifties, the use of illicit drugs was very limited, concerning only a few morphine or opium addicts from the higher social strata such as artists and ex-colonials.

Up to 1973, drug use was confined mainly to the so-called “psychedelic” products, such as cannabis, LSD and other hallucinogenic drugs. Heroin was also available, but the market was not organised, and the first heroin addicts were therefore a small, very specific group, almost all of whom were known to each other, at least in any one city.

During the Seventies heroin, which was formerly mainly of French origin (Marseille), became more and more readily available and the market was organised, whereas the use of hallucinogenic drugs, and in particular LSD, started to decline. From 1973-74 on a brown, granular heroin started to appear in Paris, of Asian origin and generally imported via Amsterdam. Subsequently, and particularly in the second half of the Seventies, the heroin market expanded still further, the’ product became much more readily available, and its origins were more varied. More widespread heroin use was very marked in the period 1977-82, as is borne out by all the available statistics, the reports from treatment centres and the significant broadening of the age pyramid of addicts seeking treatment. During this period, when the use of heroin reached really epidemic proportions, it also became apparent that users were mostly from the disadvantaged social strata and that the link between delinquency and drug use was becoming stronger. In 1981, a distinctive pink-coloured variety of Chinese heroin appeared. Currently, most heroin (60%) comes from South West Asia.

It is likely that the epidemic trend of the 1977-82 period is stabilising, although this is not immediately apparent from routine statistics. But, the significant factor in the Eighties is the wider use of cocaine, which is now no longer consumed solely by small, socially-favoured groups but is also frequently used by heroin addicts; and it has been available on the street since 1982 and particularly since 1984.

A.2 General policy; legislation

General policy to fight drug abuse in France has been based since 1970 on a close combination of three different aspects: punishment of traffickers, treatment of addicts and prevention. As regards treatment, the government decided in 1970 that there was to be no

rigid policy on treatment and that no particular system should take preference, which is why the therapy network in France is not dominated by the distribution of methadone or by therapeutic communities on Anglo-Saxon lines. In fact, the salient feature of the system is its great diversity which derives from the progressive selection of the most satisfactory experiments in therapy.

a. The law before 1970

The Act of 12 July 1916 provided for the prosecution of persons contravening the administrative regulations on drugs, and in fact facilitated the prosecution of persons using such products inasmuch as they were almost invariably guilty of illegal possession of drugs.

The Act of 24 December 1953 gave judges the option of ordering users of drugs to undergo detoxification if they were found guilty of the "social" use of drugs. This was compulsory treatment subject to penalties, but in the absence of an administrative regulation it has never been possible to apply this provision.

b. The Act of 31 December 1970

This act "relating to health measures against drug addiction and to punishments for trafficking and the illicit use of poisonous substances" introduced a legislative reform with two main objectives: to provide health aid for drug users and to step up punishments for drug trafficking. It is however the health aspect of this law which is given immediate priority in the text, which forms part of the public health code: "Any person making illicit use of substances or plants classified as narcotics shall be placed under the supervision of the health authority." (Article L 355-14 of the public health code)

Health measures

These concern drug users, and particularly users of the following products: opium and its derivatives, LSD, khat, cannabis and its derivatives, cocaine, mescaline, psylocibin and a number of medicines listed in Table B. Three possible situations are envisaged:

– Persons are referred to the prosecuting authorities who may require them to undergo a course of detoxification or to place themselves under medical supervision, without initiating any official action. Continuous contact must be established between the user, the health authority and the Public Prosecutor's Office. The health authority monitors the progress of treatment, and must be kept informed of this by the doctor in charge and report to the court, in particular if treatment is interrupted.

– Persons are referred by the medical or social services to the health authority. After medical examination and investigation, the health authority may require the user to undergo a course of treatment. There is no provision for penalties in the event of refusal.

– Persons apply spontaneously to prevention or treatment services, and they will then be guaranteed treatment and anonymity if they so desire.

Repressive measures

– Trafficking. This is very broadly defined and concerns the production, transport, import, export, possession, supplying, etc of drugs. The measures also cover persons who have facilitated the use of drugs by other persons, who have received or supplied drugs by means of forged or collusive prescriptions and persons who have supplied drugs in full knowledge of the forged or collusive nature of such prescriptions.

The penalties prescribed are imprisonment for two to ten years if the offence involves the import, manufacture, production or illicit export of drugs or a fine of 5,000 to 50,000 Francs, or both penalties. There is also provision for other penalties, such as deprival of civic rights, withdrawal of passport -etc.

The usual criminal procedure is modified. A suspect may be held for up to four days with the written authorisation of the public prosecutor: searches may be initiated at any time of day or night.

– Use. This is punishable by imprisonment for between two months and one year or a fine of 500 to 8,000 Francs, or both these penalties.

For the first offence no official action will be taken if the user submits to the medical treatment ordered by the Public Prosecutor's Office or if he accepts it spontaneously, the person in question is not convicted but must merely supply proof that he has undertaken a course of treatment, and this also applies when that course follows the proceedings. In the case of a further offence, the prosecutor has absolute discretion in deciding whether official action is to be initiated.

– Incitement and encouragement to drug use or trafficking. The prescribed penalties are imprisonment for one to five years and a fine of 5,000 to 500,000 Francs, or both these penalties.

– Other provisions. Minors: increased penalties for persons who have made it easier for minors to use drugs. Foreigners: in addition to expulsion, the courts can forbid entry into French territory. The penalties incurred are doubled for further offences. There is also provision for the confiscation of equipment which has been used for the manufacture of drugs and further provisions concerning public establishments where offences have occurred. Finally, 1986 has seen the definition of a new charge relating to "minor trafficking", under which "persons who have offered or made available drugs to another person for his personal consumption" can be convicted.

A.3 Demographic information

Taking Greater Paris as consisting of the city and the three departments surrounding it, the population according to the INSEE census of 1982 is a little over six million (see table). The level of unemployment among young people under 25 is 14.5%.

A.4 Surveys on drug misuse

There is no survey on drug addiction which can be considered as specific to Paris. Apart from the different results obtained by various treatment centres, there is in fact only one survey on the use of drugs: the "survey of establishments" conducted by the Directorate of Health since 1974. This survey is now being redesigned by the Department of Health in collaboration with the INSERM.

It lists, for the last quarter of each year only, the number of consultations, of drug addicts in specialised institutions, general and psychiatric hospitals and all health establishments. The results are interesting inasmuch as they are the only ones which can lay claim to being representative at national level. Nevertheless, they are very limited both quantitatively and qualitatively. From the quantitative point of view, the inevitable double counts «and the variation from one year to another in the number of establishments involved preclude any rigorous interpretation; by the same token, the fact that this survey is limited to a single quarter further diminishes its relevance. From the qualitative point of view, the administrative nature of the survey makes it impossible to look for indices which might show changes in the use of drugs or the addicts themselves from one year to another.

A picture emerges from the survey of an average addict who visits a health institution at a given point in time. He is likely (see appended tables) to be quite young, aged from 18 to 25, generally male (2.5 men to 1 woman) and mainly using heroin. It is also to be noted that the replies obtained in Paris constitute about one-third of the replies nation-wide.

A.5 Treatment and social care systems/facilities

The institutions specialising in reception, overnight care and treatment have all been set up since 1970, the first of them being the Marmottan Medical Centre which opened in Paris in 1971 and at the time had an experimental status. Previous to this, addicts were dealt with mainly in psychiatric hospitals and a few private clinics.

It is however difficult to describe the health and social system as at present constituted without reference to the concepts which gave rise to it, and in this connection three broad periods can be distinguished.

– 1970-75; experimental action. This period was very rich in experiments of all kinds. In Paris, "medical" initiatives developed (anti-poison centre in the Fernand Widal hospital and psychiatric consultations at the Sainte Anne hospital), some of which were broadly

based on the American “free clinics” of the time (Centre de 1’Abbaye in the Latin Quarter) or were close in philosophy to the anti-psychiatric trend (Marmottan). The great feature of the period was however the extraordinary development of private initiatives involving voluntary and social workers and the Churches (both Catholic and Protestant. In many cases the approach involved taking the patient out of his original environment.

– 1975-80: development of therapeutic follow-up and after-care treatment. The period marked a progressive professionalisation of practitioners in drug addiction. The withdrawal was no longer considered to be the principal phase in the treatment of addicts. The teams involved were much more concerned with follow-up and were starting to investigate the problem of rehabilitation. While the Minister of Health was discouraging the hesitant development of therapeutic communities and attributing an experimental, research status to the use of methadone, the “therapeutic chain” concept was appearing, and residential and after-care urban centres were being established, together with consultations designed to ensure medical follow-up.

– Current trends. The professionalisation of practitioners in drug addiction has increased and has been marked by the foundation of a National Association of Practitioners. There is increased specialisation in certain methods of treatment (eg family therapy) and structures have been set up to admit certain groups of addicts (minors under 18). On the other hand, there is a very definite trend away from specialisation in the medical and social treatment; of addicts. The idea is gaining ground that it is not always appropriate to label a drug user as an addict, and this is leading a number of GPs and non-specialist guidance officers to take on these users, whereas previously they were invariably referred to specialists. Specialised and non-specialised initiatives are concentrating on action to facilitate the social rehabilitation of addicts, and in particular there are “intermediate organisations” providing vocational training and preparing young people to take up employment. It will thus be seen that the institutional system has become increasingly diversified and complex, and the “therapeutic chain” concepts gives only a very incomplete idea of it.

This complexity of the health and social system precludes quantitative description, in terms of the number of beds for instance. There are, however, in Paris and the three surrounding departments a little more than 30 residential reception, treatment and after-care centres which form the bulk of the specialist structures and which work in close co-operation with the general and psychiatric hospitals.

One point should however be emphasised: although these specialist establishments operate independently of each other, they all scrupulously respect the health aspect of the 1970 law: anonymity and free treatment are automatic. On the other hand, the situation as regards co-operation between courts and doctors is more complex and many therapists, particularly in Paris, are rejecting such

co-operation, on the grounds that they should not accept the role of judicial auxiliaries which the law might confer on them. This is why there is no register of addicts, as in the United Kingdom for instance, based on treatment centres and doctors' reports, and there can be no cross-checking of data from different sources.

A.6 Control systems and resources (lav enforcement)

As far as policing is concerned, repression of the use of and illicit trafficking in drugs is taken care of at national level by the OCRTIS (Office central de repression du trafic illicite de stupefiants). In Paris the Brigade des stupefiants et du proxenetisme has about 140 officers permanently assigned to it.

A.7 Monitoring systems

Strictly speaking, there is no monitoring system. The "Interministerial Mission against Drug Addiction" ("Mission interministerielle de lutte centre la Toxicomanie") is responsible for collating all the statistical and research data, and has recently set up a working party to make proposals for the constitution of statistical and epidemiological evaluation machinery.

B. INDICATORS

B.1 First contact with care centers ("first treatment demand")

Every care centre publishes a yearly report in which information can generally be found on addicts who have come to it for the first time, and the Marmottan Centre has often had this indicative role in the evaluation of trends, reporting the number of new cases, the drugs most often used and other information. At present, it is still, however, difficult to assess to what extent this data is indicative of true trends in Paris. Nor is it yet wholly feasible to make a comparison between the data from the various centres, since the reports rely on very disparate concepts: the numbers of consultations, new cases and cases treated are listed, and it is not always easy to separate them.

The first study on contact with care institutions was carried out in 1981-82 in three different institutions – the Marmottan Centre, the Fernand Widal Hospital and the Association Charonne (F R Ingold, 1983). The object was to assess to what extent it would be possible to use certain data on first contact as an instrument of epidemiological analysis. The results obtained confirmed that these cases conformed to a number of general rules and that detailed examination of them did in fact make it possible to assess trends in the use of drugs in a given place and enabled a retrospective background picture to be built up. In this study we have defined the first contact with an institution for care as being that which occurs for the first time in the life of the subject, whether leading to actual treatment or not, and of course distinguishing it from repeated visits to such institutions.

A number of projects are currently being studied which aim to standardise reports from treatment centres and the Department of Health is planning to develop a new indicator based on first contact.

B.2 Hospital admissions

The number of hospital admissions of drug addicts in the Paris region could be estimated on the basis of the returns from each hospital establishment, since the cost of their stay is borne by the State. Data obtained in this way, however, would probably not be of epidemiological nature. There are plans to carry out a study with an epidemiological dimension to determine the number of drug addicts admitted to specialist and non-specialist hospitals and health centres, and their general characteristics.

B.3 Viral hepatitis

Data relating to cases of hepatitis are not at present seen as an indirect trend indicator mainly because, although hepatitis is a notifiable disease, practitioners do not always report cases as a matter of course.

B.4 Drug-related deaths

Drug-related deaths in Paris are recorded by the Brigade des stupefiants et du proxenetisme. Only deaths covered by a medical diagnosis of overdose of an illicit drug are recorded. Suicides or accidental deaths of known addicts, and deaths from medical causes indirectly linked to drug taking, are not covered.

A study carried out in Paris on recorded deaths (F R Ingold, 1985) showed that the number of such deaths was not indicative of current developments and that most of them were of long-term addicts who had been taking heroin for more than five years and were very definitely marginalised, even in relation, to drug users as a whole. The study suggests that these deaths do not occur randomly among drug users but are linked to certain "risk situations" including long-term heroin use, recent withdrawal (both voluntary and involuntary), and the regular use of psychotropic drugs and alcohol.

B.5 Police arrests

In Paris, all arrests of drug users and traffickers are reported to the Brigade des Stupefiant et du Proxenetisme, but the figures derived from this centralised information cannot be regarded as an indirect trend indicator. This is because they are affected by the way in which data are collected from one year to the next, police manning levels, and whether a clear distinction is made between the number of individuals arrested and the number of arrests. The figures we report must be interpreted in the light of these comments. It should be noted that the police force has been considerably expanded since 1982.

Up to 1983, the figures were classified by product and by offence (use, resale, trafficking) and we opted to use the figures relating to arrests for the use of heroin. The figures have been classified in a different way since 1984 and a distinction is made between arrests per product and arrests giving rise to legal proceedings, thus making it difficult to draw a comparison with previous years. In the histogram showing the number of arrests for use of heroin, we have chosen to use for the years 1984 and 1985 the total figure for arrests for the use or trafficking of heroin.

Finally, with regard to arrests giving rise to legal proceedings, we should point out that since September 1984 orders for therapy in Paris have been made by police officers on the authority of the Public Prosecutor's office.

These data may provide a good picture of the work of the Brigade des Stupefiants et du Proxenetisme, but it is difficult to use them at present to obtain an accurate assessment of trends. It would be a different matter if the data could be processed so as to provide details of the number of new subjects arrested each year, by drug and by charge.

B.6 Imprisonment

Computerised statistics have been available since 1983 on the prison population. Some data therefore relate specifically to the number of subjects imprisoned for offences under the drugs legislation.

It should be borne in mind, however, that the figures relating to these offences cannot be used to describe the population of drug users in prison. In fact it transpires (F R Ingold, 1986) that imprisonment in the case of dependent drug users (in the sense of the classification DSM III) is largely the result of offences other than those defined by the Act of 1970, and theft in particular. Moreover, indictments for trafficking may veil cover subjects who are not drug users.

Our study, which was carried out in 1985 at Fleury Merogis prison, brings out a number of points which make it possible to go further into the penal data:

1) the number of dependent drug users entering prison is about one quarter of the total intake;

2) first imprisonment occurs within three years from the time heroin is first taken, in the great majority of cases; and

3) this drug user population in prison is comparable to that of addicts described in the treatment centres, from the point of view of drug use and social origin.

B.7 Seizures of illicit drugs

Seizures carried out by the customs and police are difficult to interpret since there is a tendency to lump together important seizures (especially at airports) and routine seizures in the street.

It has proved possible to isolate street seizures during routine operations alone for the years 1984-85. These figures are doubtless more indicative of the intensity of drug trafficking and use in Paris than those for major seizures, but not until a few years have elapsed will it be possible to interpret them. They do however highlight the wider use and trafficking of cocaine at street level in 1984, and this trend seems to be confirmed in 1985 (an increase from 103 to 1125 grammes seized).

B.8 Price/purity of illict drugs

In the absence of any continuous ethnographic survey, no precise information can be given about the price of drugs, their purity or trends at street level. In 1986 one gram of heroin may cost from 500-1200 francs, one gram of cocaine costs about 600 francs and cannabis is sold at between 25 and 60 francs per gram. Purity of the products varies considerably depending on where they are bought (on the street or behind closed doors), but heroin is usually about 25% pure. The price of heroin has gradually increased since the end of the 60s when one gram traded at between 50 and 100 francs. It should be pointed out that this was for very pure heroin (from Marseilles); at the beginning of the 80s there was a sharp drop in the price of heroin.

B.9 Data from other surveys

These mainly cover the recording of “drug-related behaviour” in the armed forces, with particular reference to recruitment centres. The survey provides information on the use of drugs amongst young conscripts at national level. The figures for the city of Paris are not available, but they constitute a little more than one-third of all cases. The figures are however debatable in that the concept of drug-related behaviour is somewhat subjective.

In 1982 the number of cases dealt with decreased by 19% in relation to 1981, with little change in 1983 and a considerable increase in 1984.

B.10 Comments on AIDS

It is estimated that 30 to 70% of drug addicts are infected by the AIDS (HIV) virus. At the end of 1986, the number of reported cases of the illness among drug addicts is 120, 10% of the total number of cases (national figures). Plans are being made for the unrestricted sale of syringes in chemist’s shops.

C. ASSESSMENT OF THE USE AND VALUE OF INDICATORS

C.1 Use of indicators in the city

As we have already had occasion to emphasise, evaluation of trends in drug addiction is contingent upon the availability of a very wide range of indicators from as many sources as possible. However, the availability of figures is not in itself sufficient, and their true significance needs to be checked.

The first contact with the health institution should be the most reliable indicator in this field. Apart from information on the number of addicts seeking treatment, it enables an assessment to be made of the general characteristics of people going to treatment centres for the first time. From detailed examination of the available figures it then becomes possible to estimate how long drugs have been used and to obtain an indication of the most commonly used products in the street at the time of the survey, subject to proper compilation of the data.

Our survey carried out from 1981-83 in three treatment centres in Paris confirms this point and also enables us to state that this first contact with treatment centres, at least as far as heroin addicts are concerned, occurs within two years of the first time heroin is taken. This is a very important fact which must be borne in mind, and this first contact should be considered as to some extent indicative of a previous situation. It is however an early indicator compared with most of the others (see appended table).

Police arrests are in the first place a reflection of the activities and resources of the police forces. The gross figures, for example the total number of arrests cannot be used in the epidemiological context. For this it would be necessary to make a detailed analysis of the significance of the arrests and to check exactly which group they cover. It would then be feasible to deduce from the figures an indirect indicator of trends.

Imprisonment is not in itself an indicator of trends, since its extent is conditioned by such factors as the activities of police forces and the attitude of the courts. Nevertheless it does in general cover a group which is different from that regularly monitored in the treatment centres, and a study of it can therefore yield additional information. Thus, our study carried out in Fleury Merogis prison indicated that the use of cocaine is very much more widespread now than it was in the late 70s and early 80s we also confirmed that the type of use is different from that of heroin and that in the majority of cases it began from 1982.

Drug-related deaths are often considered to be a reflection of the seriousness, evolution or extent of drug use in a specific region or country. If this were true, it would have to be accepted that such deaths occur only accidentally and at random amongst users

as a whole. We have seen that this is not so. On the contrary (F R Ingold, 1986), we have checked that these deaths are closely linked to a whole range of factors which together enable a number of high-risk situations to be identified. It therefore follows that there is no direct link between the numbers of such deaths and the incidence or prevalence of drug use.

There is certainly a kind of logical link between the number of users and the number of deaths, and it is inconceivable that they could be unrelated or that they could vary in a totally contradictory manner. In the final analysis, however, several facts have led us to abandon the search for a direct link between prevalence and the number of drug-related deaths:

1) The true figures are not known;

2) There is no strict definition of such deaths, and

3) It is likely that they are in the first place indicative of a type of morbid evolution in the use of drugs amongst certain users.

These various points lead us to think that, in a uniform and continuous series of data, the variation in the figures is more indicative of the situation in the past than in the present: the number of such deaths becomes almost predictable, deriving to some extent from the fast epidemic dimension in the use of drugs, but not necessarily reflecting current developments.

The other indicators also merit discussion, in particular seizures, price and purity of drugs and the activities of the emergency services. The data available to us do not in fact allow a thorough discussion of these various points, and we would here emphasise again the absolute necessity of continuity in the collection of data. It has been observed that certain indicators which are supposed to account for one given fact can easily vary in a contradictory manner over a period of time. A good example of this is the virtually constant growth in seizures of LSD from 1975 to 1982 although the use of this product undoubtedly decreased during the same period. This point leads us to a discussion of the relationships between individual indicators.

C.2 Relationship between indicators

If indeed it is possible to make an epidemiological evaluation of the use of drugs in a specific region or city, such an evaluation can only be reliable if it is based on full knowledge of each of the indicators and if the latter can be associated coherently, with the inevitable contradictions between indicators being catered for and incorporated into a general theoretical concept. However, this concept cannot be really independent of the practical conditions on which it is based; it cannot but be closely linked to the sources of the data, the functioning of which is dependent on the general policy of the fight against addiction. In Paris, as in the rest of France, the main sources of data are potentially those which derive from the health sector, but the latter is so structured that its operational diversity has long since precluded data collection on a systematic, common and continuous basis. Paradoxically, the result is that a very dense and very diversified therapeutic system discourages most efforts to pursue an epidemiological approach at national, or even regional level.

Because of this, data deriving from the legal and police sectors still currently provide the most information, although of course they are in no way intended to contribute to scientific or epidemiological objectives.

It can therefore be said that at the present time the relationships and connections between the indicators actually available and potential indicators cannot yet be truly explored.

Be that as it may, we believe that the links which unite or oppose these indicators should not be considered as links independent of each other. Although the use of drugs, and in particular the sum total of its medico-legal manifestations, is a changing reality, varying in quantity and quality from one period to another, the indicators must be seen as yielding information mainly about the various moments in one and the same process. Thus, addiction cannot be described by the traditional iceberg metaphor, unless the latter is conceived as an entity which is very mobile and very variable in shape. Moreover, it would be difficult to see which was the submerged part of the iceberg in Paris since the term merely describes a whole series of unknowns.

Not everything is in fact quantifiable and not everything benefits from being quantified. Discipline requires that the indicators should be defined, but it is also essential to relate then to the environmental data. This is precisely the raison d’etre of the multi-city study, in that it enables us to measure the importance of this fact whilst questioning the feasibility of an immediate national epidemiological evaluation.

D. CONCLUSIONS

Looking back, it can be said that the use of illicit drugs started in Paris at the end of the 60s and increased considerably during the second half of the 70s and the beginning of the 80s. Although it is still difficult to make an accurate evaluation of incidence and prevalence in Paris, we are convinced that the use of drugs, in the case of heroin at least, is tending to stabilise, in Paris at any rate. The number of heroin addicts is undoubtedly still very high, but this is mainly the result of the epidemic growth in the years 1977-82.

The most important change as regards the products used is the very marked increase in the use of cocaine in the last few years as evidenced by the fact that this product is now used by all social classes, some of it being distributed at street level.

The last point concerns the addicts themselves. Overall, users of drugs are definitely older than was the case in the 70s and the present average age is around 25, whereas 10 years ago it was closer to 21-22. This apparent ageing among users is attributable to two separate factors: a) the natural ageing of all users and b) the age of initiation into the use of drugs, which is now much less consistent than previously; subjects are often well integrated socially and aged from25 to over 30.

We have not touched surveys in schools on this point in our presentation because the studies available (F Davidson, M Choquet, 1978-79) do not enable us to deduce any trends. Nevertheless, the studies indicate that the region is quite an important factor: in the Paris region 13.6% of boys and 10.1% of girls had tried a drug at least once, whereas the average for three provincial regions was 7% at the same time. These figures are however difficult to interpret if we attempt to relate them to the chronic and intensive use of the same drugs in the rest of the population.

It is not the object of this report to develop the question of the principles of evaluation, but the preparation of the multi-city study brings us to postulate certain principles which are vital to any scientific work of evaluation. Such work relies on systematic and continuous compilation of data, whether it be in the health institutions or in the other services. Nevertheless, it is also important not to confuse epidemiological research and administrative surveys; the latter are doubtless necessary but they cannot enable a phenomenon to be measured.

The difficulty which inevitably arises for the research worker is the need to define precisely and strictly the object of his study. In the case of drug use, he is confronted with a phenomenon whose legal, medical and social definitions cannot be satisfactorily reconciled. It is therefore essential that he decides on objective reference points which will facilitate interpretation of the various data and enable each of the indicators to be defined.

It is not the function of these indicators to estimate numbers of drug users. Each one shows only a particular aspect of developments amongst all users, and an isolated indicator therefore has no value in itself. Only by bringing these indicators together can trends in addiction be evaluated, by means of a kind of triangulation and assuming a good knowledge of the various possible trajectories of drug users. This is why a sound evaluation is not limited to recording the medico-legal consequences of drug use, which as everyone knows are always out of date. It can only consist of applied research, and this is clearly borne out by the activities of the experts in our group, in connection for example with the progressive forsaking of drug use (phenomenon of "maturing out" or "spontaneous cure" amongst drug users), addicts' perceptions of health institutions or the process of dependence, ie the dynamic and collective dimension of the use of drugs.

It is thus conceivable, at least so far as Paris is concerned, that one of the results of this study may be to adduce arguments in favour of a national evaluation of the use of drugs, which could be achieved on the basis of assessments at regional level. It is clear that although evaluation work must conform to strict methodological criteria, it must also take into account practical realities, ie all the historical and environmental facts which impart specific meaning and identity to the use of drugs.

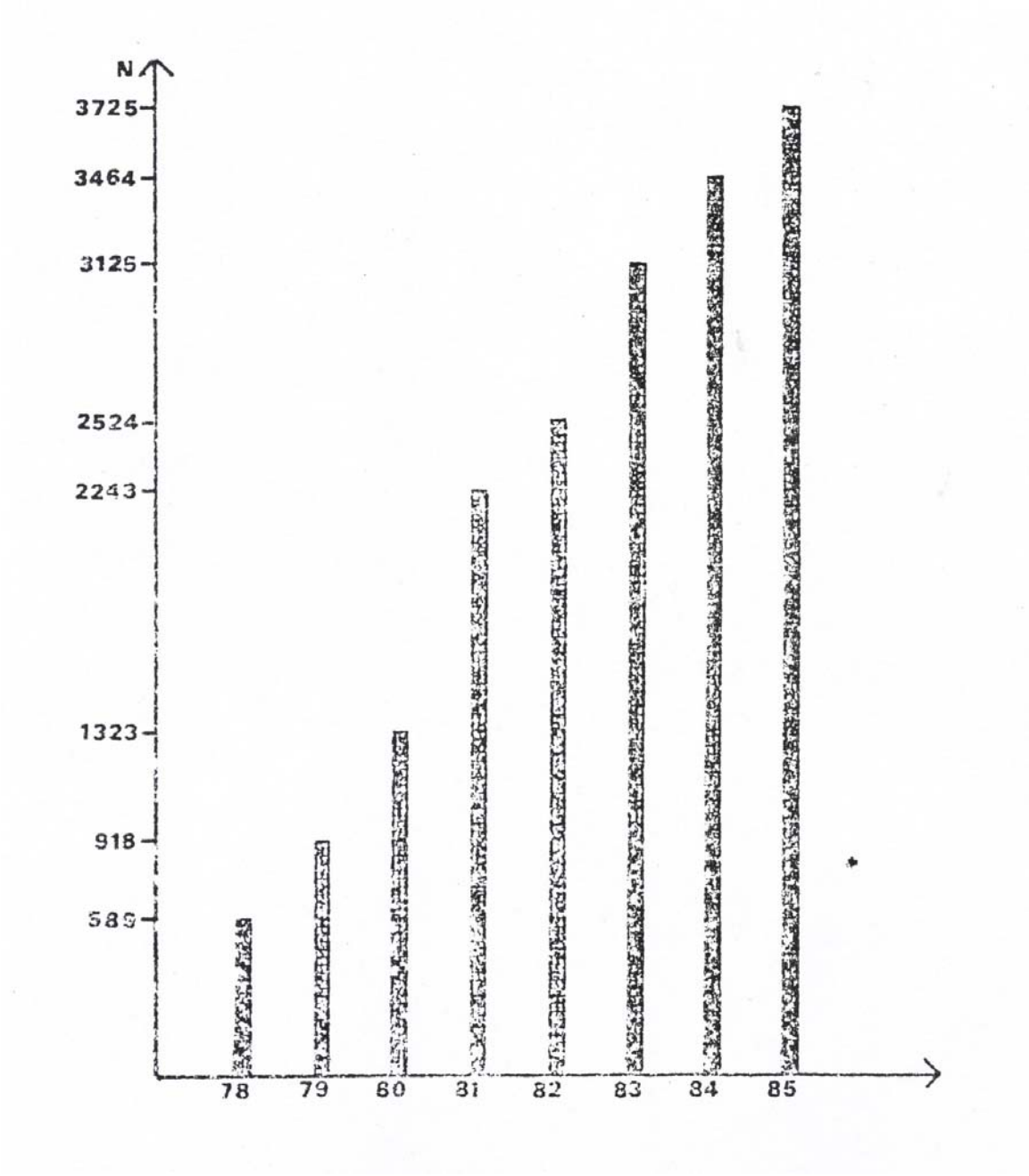
The actual concept of evaluation should thus make reference to both large-scale quantitative surveys and micro-epidemiological and ethnographic studies; the latter do in fact provide more than mere additional information and integrate this activity into the field of the humanities.

APPENDIX I

DATA

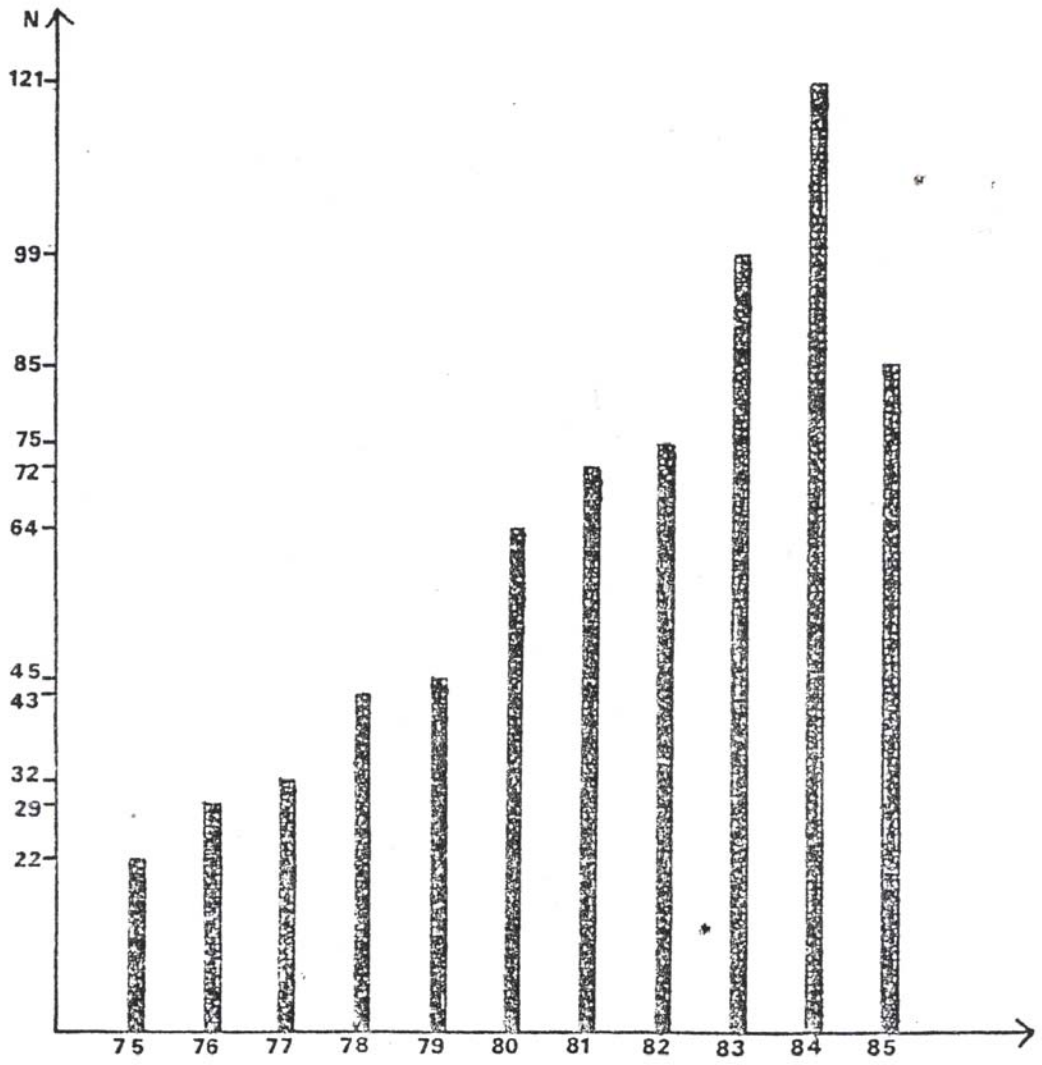
NUMBER OF INTERROGATIONS FOR USE OF HEROIN

PARIS



NUMBER OF DRUG-RELATED DEATHS

(overdoses) PARIS



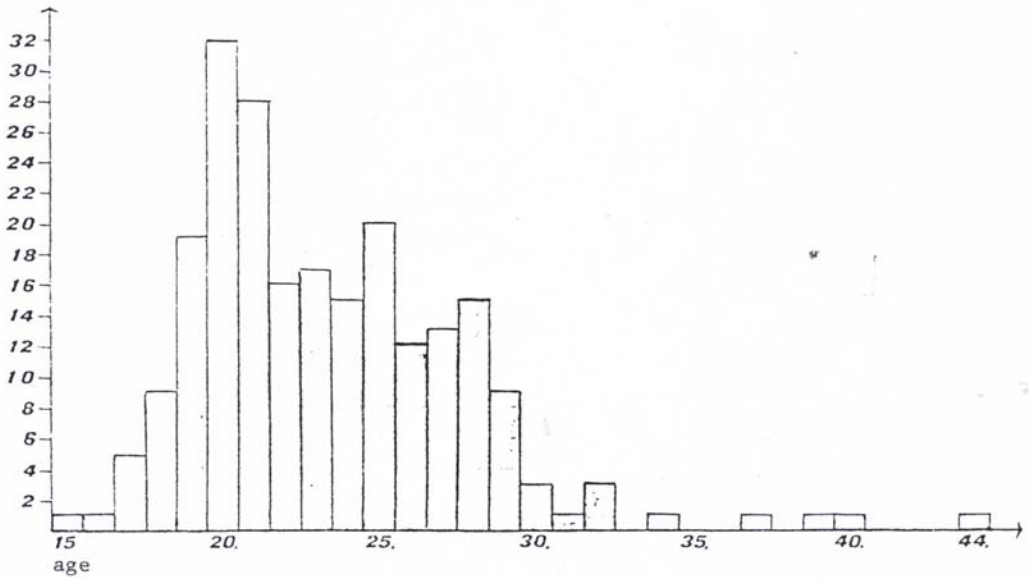
AGE at 1 January	BOTH SEXES		INCL. ARRIVALS IN. COMMUNE AFTER 1974	MALE	FEMALE
	Total	%			
TOTAL	2188960	100.0	802680	1015500	1173460
0 – 4	97260	4.4	56880	49620	47640
5 – 14	200100	9.2	76700	104100	96300
15 – 24	306600	14,2	161760	144160	162440
25 – 34	423940	19.4	266160	212940	211000
35 – 44	293920	13.4	112760	150180	143740
45 – 54	253800	11.6	58660	122380	131420
55 – 59	132600	6.1	21280	58620	73980
60 – 74	293820	13.4	33680	115300	178520
75 *	186610	8.5	14800	58200	128420

PARIS

A distinction should be made between inner PARIS, PARIS and its inner suburbs (three departements in the centre) and the PARIS region (lie de France). The population of PARIS decreased by *5.57,* between 1975 and 1982 and was 2.188,960 in 1982. Its area was 105 km^2.

PARIS and its inner suburbs has a population of six million, and the lie de France ten million.

The rate of unemployment amongst young people under 25 is 14.5% of the active population in the same age group in PARIS. In the lie de France it is 16.6% (Source: Institut National de la Statistique et des Etudes Economiques, INSEE)



Addicts sent to prison

(Fleury-Mérogis, Paris 1985)

Source: Institut de Recherche en Epidémiologie de la Pharmacodépendance (IREP)

COUNTRY	NUMBER	%
Algeria	21	39
Morocco	10	18
Tunisia	10	18
Portugal	3	5
Senegal	2	4
Zaire	2	4
Belgium	1	2
Spain	1	2
Holland	1	2
Ivory Coast	1	2
Switzerland	1	2
Vietnam	1	2
TOTAL	54	100

Addicts sent to prison

Nationality of foreigners

(Fleury-Merogis, PARIS 1985)

Source: Institut de Recherche en Epidemiologie de la Pharmacodependance (IREP)

Structure by sex and age

SEX / AGE	MEN		WOMEN		TOTAL	
	Number	%	Number	%	Number	%
14 or under	85	1.1	56	1.6	141	1.2
15-17	503	6.2	384	11.2	887	7.7
18 and 19	920	11.4	366	10.7	1,286	11.2
20 and 21	1,323	16.4	518	15.1	1,841	16.0
22 and 23	1,443	17.9	528	15.4	1,971	17.1
24 and 25	1,170	14.5	384	11.2	1,554	13.5
26-29	1,433	17.8	459	13.4	1,892	16.5
30-39	960	11.9	436	12.7	1,396	12.1
40 or over	232	2.9	300	8.7	532	4.6
Age unspecified	231	2.9	80	2.3	311	2.7
Total	8,300	102.9	3,511	102.3	11,811*	102.7

* This table does not cover the 766 persons whose sex was not specified.

Survey on drug addiction in establishments.

4th quarter, 1982

Service des Etudes Statistiques Informatisees (SESI),
Ministere des Affaires Sociales et de la Solidarity Nationale.

Nature of substances used

Substances	1982: MEN		1982: WOMEN		1982: TOTAL*		PREVIOUS (%)		
	Numbers	%	Numbers	%	Numbers	%	1980	1979	1977
Heroin	4,421	34.7	1,413	26.7	5,842	32.4	37.0	25.5	19.2
Cannabis	2,041	16.0	621	11.7	2,665	14.8	17.8	21.0	23.4
Alcohol (in association)	1,077	8.5	392	7.4	1,476	8.2	5.0	5.0	7.2
Barbiturates	572	4.5	392	7.4	964	5.3	4.3	5.5	5.7
Other hypnotics	205	1.6	233	4.4	440	2.4	0.3		
Tranquillizers and neuroleptics	571	4.5	543	10.3	1,114	6.2	2.6	4.0	2.5
Other opiates	669	5.3	215	4.1	886	4.9	7.5	9.5	11.8
LSD	489	3.8	96	1.8	585	3.2	4.5	6.5	7.6
Trichloroethylene	243	1.9	171	3.2	415	2.3	1.4	**	**
Cocaine	310	2.4	95	1.81	405	2.2	3.5	3.0	2.9
Anti-depressants	166	1.3	205	3.9	371	2.1	0.3	**	**
Stimulants	176	1.4	78	1.5	254	1.4	3.3	3.5	6.2
Ether	142	1.1	109	2.1	253	1.4	1.3	1.5	2.1
Other substances	732	5.8	398	7.5	1,136	6.3	4.6	4.0	3.8
Unspecified substances	913	7.2	332	6.3	1,248	6.9	6.8	11.0	7.6
TOTAL	12,727	100.0	5,293	100.0	18,054	100.0	100.0	100.0	100.0

* Including sex unspecified.
** Trichloroethylene and anti-depressants not listed separately in 1977-79.

Survey on drug addiction in establishments.

4th quarter, 1982

Service des Etudes Statistiques Informatisees (SESI),
Ministere des Affaires Sociales et de la Solidarity Nationale.

Numbers of addicts accepted in the three main regions involved
and the rest of France since 1977

	1977	1978	1979	1980	1982
ILE DE FRANCE	2,118	2,390	2,402	4,278	5,323
– including PARIS	1,339	1,542	(*)	2,186	2,616
RHONE-ALPES	317	543	925	839	987
PROV.-ALPES-COTE D'AZUR	466	560	667	497	1.139
OTHER REGIONS	1,650	2,209	2,652	2,299	5,128
WHOLE OF FRANCE	4,551	5,702	6,646	7,913	12,577

* not available.

Survey on drug addiction in establishments.

4th quarter, 1982

Service des Etudes Statistiques Informatisees (SESI),
Ministere des Affaires Sociales et de la Solidarite Nationale.

	1975	1976	1977	1978	1979	1980	1981	1982	1983
Number of deaths in FRANCE	37	59	72	109	117	172	141	164	190
Number of deaths in PARIS	22	29	32	43	45	64	72	74	99
Proportion aged 25 and under in FRANCE	–	86%	66%	68%	73%	68%	73%	70%	64%
Proportion aged 25 and under in PARIS	68%	65%	65%	62%	54%	50%	73%	65%	70%

Number of drug-related deaths in Paris and in France: proportion of subjects , aged 25 and under.

Source: F R INGOLD, Mission interministerielle de lutte centre la toxicomanie, 1984.

AGE	I	II	III	IV	V	VI
15 to 19	15%	21%	5%	41%	10%	19%
20 to 24	48%	44%	4858	39%	25%	40%
25 to 29	31%	31%	34%	14%	35%	23%
30 to 34	4%	4%	9%	6%	30%	17%
35 and over	2%		3%			

Addicts sent to prison
(Fleury-Meropis. PARIS 1985)
Source: Institut de Recherche en Epidemiologie de la Pharmacodependance (IREP)

I. Addicts imprisoned

II. Addicts imprisoned (first offenders only).

III. Deaths. Paris region, 1983.

IV. Persons interrogated. OCRTIS report, 1983.

V. Persons regularly followed up. D ROSCH, “Who are the addicts we treat?” INSERM report, 1983.

VI. Persons requesting treatment. Survey on drug addition in establishments (4th quarter, 1982).

HEROINE		CANNABIS		COCAINE		DIVERS		TOTAL	
T.	US+T.	T.	US+T	T	US+T	T	US+T	T	US+T
804	2451	287	3154	73	56	3	7	1167	5668

Paris, 1985
Arrests for drug use (US) and trafficking (T)
Source : OCTRIS, 1985 report

APPENDIX II

DEFINITIONS

Drug addict. A “drug addict” is a regular user of drugs, ie products listed as dangerous substances. In practice this definition is widened to include those who take medicines other than for medical reasons and other products such as volatile solvents. In this report the term drug addict is used more specifically for individuals who approach specialist medical institutions for help.

Drug dependence. Drug dependence is understood as the biological, psychological and environmental process which reveals itself in a particular type of controlled or uncontrolled use of drugs, medicines and other substances usually having psychotropic properties. Drug dependence may become apparent through individual reactions of tolerance and addiction towards these substances; its progression may show up in serious effects on the health and it is bound up with a complex of individual, biological and psychological factors, together with social, environmental and economic factors.

Drug. Drugs are poisonous substances listed in the table of narcotics. In particular they include opium and its derivatives, cocaine, cannabis and its derivatives, together with other substances and medicines (listed in Table B). By extension, some products are regarded as drugs, such as certain organic solvents whose sale is restricted (sale to minors prohibited).

APPENDIX III

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REPORT ON DRUG MISUSE IN ROME

by

Mr U Avico

INTRODUCTION

During recent years, drug abuse in Italy has developed in many ways in the different regions, both as regards territorial distribution and approaches to research and intervention. As a result, the phenomenon has been characterised in Italy by various interventions at national and local level.

The over-dramatisation of the problem by the mass media has not always been consistent nor justified; in fact it has been at the origin of a series of extempore actions which have sometimes worsened the situation.

Nevertheless the phenomenon in Italy can be compared with that in other European countries.

A. DESCRIPTION OF THE CITY

A.1 History of drug misuse

In the second half of the sixties attention was drawn towards the drug phenomenon in the Rome area. So-called “soft” drugs and hallucinogens, whose use was confined to restricted social spheres, were mostly referred to.

At the beginning of the seventies the first cases of morphine and opiate users were recorded, brought about by the influence of oriental culture related to the habits of the people of the Indian sub-continent (Pakistan, India, Nepal). A deep change in this situation was registered in 1974/75 when the market was cleared of soft drugs and morphine itself to give way to heroin, which was pushed by means of “marketing” systems.

In its initial phase – the recruiting of users and the creating of the market – the use of heroin went along with various forms of social protest and the rejection of established schemes, patterns, rules and traditions. Sometimes heroin users identified themselves, with political and/or cultural movements.

A.2 General policy; legislation (see also Appendix I)

As a consequence of such change and with the help of the most qualified technical and scientific services, made aware of the risk connected with the new form of drug habit, the parliament rapidly approved the Act No. 685 of 22 December 1975, still in force, that greatly changed the previous one and envisaged new strategies for coping with the problem. Some of the chapters of the new law have remained for the most part unapplied (see Appendix I) so that up to the present time it is not possible to evaluate its effects.

Apart from indirect/direct interventions against drug trafficking (such as the “Antimafia” Act No. 532/1982 and the Act No. 646/1982 dealing with “Preventive Detention”) the action of the government concerning drug addicts was oriented toward programmes for the complete eradication of drug abuse in the long term and toward strategies aiming, in the short term, at curbing the phenomenon by controlling it, thus reducing its most dramatic consequences.

In its interventions, the government was always aware of the basic rights of society and of the individual (the right to medical care; individual freedom; the right of each doctor to freedom of decision; etc). It has also taken into account all the technical and scientific know-how and all the experiences at international level (distinguishing between the various kinds of drug abuse and addiction in relation to their dangerousness; criteria concerning detection of drug abuse and its treatment; protection of drug addicts regardless of their condition; distinguishing between an addict and a pusher, etc).

Because of the strong differences existing among the various regions of Italy they have been granted a certain autonomy. As a consequence, apart from the availability of “ad hoc” facilities and personnel which varies from region to region, there have often been also strong differences in operative strategies and methods from one region to another.

The main public initiatives were therefore aimed at:

a. the assessment of the phenomenon from the following points of view;

- quantification of the extent of the problem at national and regional levels;
- analysis of social aspects, and of service delivery;

b. the introduction of new treatment modalities for the detoxification of addicts in order to reduce illicit drug use and improve access to the public service;

c. the improvement of pharmacological support in emergency care (Naloxone injections) for the most critical cases, in order to reduce the increasing number of drug-related deaths.

Thanks to these measures, the strengthening and the wider diffusion of services and most of all the general use of Naloxone, a rapid drop in the increase in drug-related deaths has been brought about (see Figure 1)(1). +73% (the yearly average for 1978-79-80), +15% (1981), +6% (1982), +2% (1983).

It is important to examine figures for drug-related deaths' in the light of health services provided.

Extra funding has been provided for many special initiatives taken by the government, the parliament or local authorities. Other preventive measures have been taken by voluntary movements at local level in order to protect the young people who are the most exposed to the risk, and to hinder the pushing and trafficking of drugs, in close co-operation with the police force.

The following acts directly or indirectly concerning drug abuse are at present in force at national level:

– Act No. 685/1975: Drugs and Psychotropic Substances;Manufacturing, Prescribing, Retail of licit; Abuse of licit/illicit; Addict's Detoxification; Rehabilitation; Prevention.

– Act No. 833/1978: National Health Service: Decentralisation at regional and local level of the services provided.

– Act No. 532/1982: So-called "Antimafia Act": it allows for property and bank investigation, under certain conditions and with proper guarantees, these measures tended to the relatives of the person strongly suspected of connections with the Mafia.

– Act No. 646/1982: envisages that, during detention before trial, persons in particular circumstances (such as drug addicts) can be allowed to stay in therapeutic communities or other similar facilities, or granted home arrest.

– Act No. 297/1985: Urgent measures for fighting against drug abuse: Partial changes to the Act No. 685/1975 on Drug Abuse, to the Penal Code, and to the prison system; co-ordination of all activities assigned to the Prime Minister; simplifying of the procedure for examining seizures; extra allocations.

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(1) See Appendix II.

Under Italian legislation, treatment of and assistance to drug addicts are placed under the responsibility of each region and of the local Health Units (in Italian: USL). Each USL is generally responsible for a number of citizens not in excess of 200,000 irrespective of the area covered. Each region decides on procedures for applying a national Act in its territory.

Also to be mentioned are several regulations and guidelines relative to:

– methods for detecting the different degrees of addiction to narcotics and analgesics, and heroin;

– safe treatment of pregnant drug addicts and their unborn children;

– methods (including questionnaires) for collecting data regarding drug addicts who are being treated;

– use of Naloxone injections during crises induced by an overdose of heroin;

– qualifications and requirements of the personnel involved in the treatment of "heavy" drug addicts.

As regards indications for future activities and relevant priorities, and taking into account the analogy between Italian and European problems, the activities promoted by the Pompidou Group have kept pace with those developed in Italy.

Utmost efforts must be made in the field of primary prevention, by defining ad hoc interventions whose long term results offer an advantageous cost/benefit ratio.

Other important aspects of the Italian legislation are: the introduction of the concept according to which a drug addict commits no crime if he/she is in possession of small quantities of a drug. This small quantity is calculated in relation to the physical and psychological condition of the person (this is a guarantee for the addict and also allows for the prosecution of non-addict traffickers even if they are in possession of a small quantity of a drug).

A.3 Demographic information

The municipality of Rome and other smaller municipalities form the area of the Province of Rome. This together with four other Provinces forms the Latium Region (Regione Lazio).

The geographical size (catchment area) and the number of inhabitants, as well as distribution by sex and by age range, are shown in Tables 1 and 2.

It seems that unemployment trends constitute a factor of interest as regards the spread of drug abuse, particularly unemployment among young people (although the absolute figures are also unreliable).

It is to be noted that the unemployment rate has constantly risen since 1980, particularly for the potential working population aged 14-29.

When taking into consideration all income-producing activities, it seems that the official figure concerning the unemployed is an underestimation of the real situation, partly due to the increasing unlawful presence of various forms of so-called “black labour” (unregistered).

As regards the various kinds of occupation, the field of services is the most extensive. For the Province of Rome, it represents *75%*, of the added-worth, as compared with the national average of *25%*.

A.4 Surveys on drug misuse

The data reported here relate to the city of Rome and its surroundings; the data from services operating in other areas vary greatly in their the aim and sometimes show characteristics which are the opposite from those for the region of Rome. Of all the available data, we only report here those which are relatively reliable. We do not report here those data which are clearly unreliable for various reasons such as collecting methods, an ideological bias of the data collector and/or clearly resulting from the questions used in data collecting or from the lack of direct knowledge of the problem, etc. Although there are no particular conditions under which a certain group of addicts can be excluded from treatment, the drug addict’s treatment services are at present generally neither equipped nor sufficiently competent to deal with certain forms of addiction such as addiction to alcohol, barbiturates, etc, which may be better coped with by “ad hoc” voluntary associations (eg Alcoholics Anonymous) or in hospitals equipped to treat such cases.

As concerns the directly measured prevalence rate of opiate users in Rome, we observe (Tables 3, 4) that:

– the prevalence rate confirmed the same trend (14.1 per thousand in 1982) lower than the national average (16.7 per thousand), as that shown by the previous survey TO.DI (12.9 per thousand and 15.4 per thousand respectively in 1980);

– there was a lover prevalence rate among those of secondary-level education (10.3 per thousand) as compared to those who had not completed compulsory schooling (79.4 per thousand);

– a similar result emerged from the data concerning occupation (students, 6.5 per thousand, as compared to the unemployed + employed, 25.4 per thousand);

– the same significant trend was shown again concerning tobacco smokers (20.7 per thousand smokers) and non-smokers (5.4 per thousand);

– a less significant finding emerged for consumers of alcohol (20.1 per thousand) compared with the non-drinkers (10.9 per thousand).

– As far as cannabis users are concerned, the same trends and/or characteristics as for the opiate users were recorded in Rome and in Italy (Table 5), for example;

– a strengthening of the attitude against drug abuse among those of secondary education level (81.2 positives to the cannabinoid test per thousand for those of secondary education level, compared to 191.8 per thousand for those of primary education level and those who had not completed compulsory schooling);

– a nearly halved prevalence among students (65.1 per thousand) as compared to the employed + unemployed (118.1 per thousand);

– a similar significant association with tobacco smokers (119.7 per thousand smokers) as compared to the non-smokers (44.1 per thousand);

– no difference emerged concerning the association with alcohol consumption.

Additional addict profiles, even roughly sketched, can be influenced by the ideology, bias, cultural background of data-collecting staff members. Within these limits it is possible to give a summary of the situation on the basis of sociological research carried out in 1982. According to this research, the characterising elements of the addicts of the Rome area were:

i. place of origin in socially disturbed areas (mostly in suburban areas of Rome);

ii. lack of or feeble influence exerted by traditional basic social structures (family, school, youth organisations);

iii. a bad family situation both from the cultural point of view and from the point of view of human relationships among family members;

iv. a tendency to be easily pushed towards drug use/abuse by Organised criminal gangs which, especially for girls, use the same methods which allow them to drive many girls towards prostitution.

Other elements which can be added to those above are a mood of disillusionment/dissatisfaction with their average condition and a refusal of the life parameters offered by the society they are forced to live in.

The profiles which emerge from the SAT's (1) data do not refer to all existing addicts because a certain number of them (eg those who have more money and/or opportunities) resort to other services (privately run facilities, etc) and thus they cannot be officially recorded.

Moreover, for various reasons findings concerning addicts who use other substances that cause a different degree of dependence (psychotropic stimulants including cocaine, hypnotic sedatives, minor tranquillizers, alcohol, tobacco, etc) and cannabis users are not available at the moment. *

This sociological survey produced estimates which exaggerated the phenomenon. The overestimation was caused by repeated recordings of the same addict, by the nature of the questions used for the survey and by the inaccuracy of both the classifications and definitions adopted.

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(1) Drug addicts' treatment services.

Special consideration must be given to drug-addicted convicts. In Rome there are two prisons in which the extent and characteristics of drug abuse are different. This stems from the different background of the convicts and from a different kind of relationship between the prison and the Territorial Health Facility. The only available data on the phenomenon come from the census carried out at the end of each year. These data show that there were, out of approximately 3,500 convicts, 425 male addicts and 53 female addicts as of 31 December 1982, and 422 male addicts and 63 female addicts as of 31 December 1983. Such figures, however, are clearly unreliable for estimating the real extent of the problem for the following reasons:

– the recording as drug addict is carried out either on the basis of an explicit statement by the subject at the moment of his/her arrival or on the basis of certain persisting physical and psychological conditions; thus it comes about that at least a certain number of them are also recorded at the Health Service of his/her place of origin (not necessarily in Latium).

– the census carried out at the end of the year can have missed those convicts who have been granted special home leave and who have been spending Christmas holidays out of prison.

For these and other reasons (also related to the fact that drug addiction is not considered as an offence) we think that the presently available data are not sufficiently reliable.

In order to assess the reliability of certain data collected through questionnaire-based surveys, it is to be recalled that a pilot survey carried out in a prison in Northern Italy in 1982 showed that, on the basis of urine tests, there were 19 opiate abusers out of 92 convicts, while, when directly asked about the problem, 78 out of 101 convicts declared themselves to be drug addicts (Drug and Prison -meeting organised by the Council of Europe – Messina, December 1982). The number of addicts estimated by direct determination, as far as the Latium is concerned, exactly matches the treatment demand. This is in accordance with the fact that regulations do not impose limitations or create difficulties for treatment requests from drug addicts.

As regards the definition of criteria for the assessment of the effectiveness of different facilities, it is to be noted that the public treatment centres, contrary to the therapeutic communities should not strictly limit the access to treatment, especially regarding the addict's purpose to break drastically all his/her ties with "narcotics" since this is the first contact an addict can have with public institutions other than the police or the judiciary. The residential communities often refuse the term "therapy", in that they refuse to consider drug addiction as a "disease", this might also correspond to the reality of the phenomenon with which they come into contact. In most cases, as a condition of entry, they require almost complete detoxification or in any case the clear aim of the subject to break all his/her ties with "narcotics".

A.5 Treatment and social care systems/facilities

The territory and the population of the municipality of Rome are distributed among 20 USLs (Local Health Units). Connected to these there are 28 drug addicts treatment services (known in Rome as SAT).

These services are distinct from the emergency rooms which operate only in hospital facilities. Twenty-two of them have been taken into consideration. The figures concerning trends following 1980 in Latium and in Italy appear in Table 8.

In the province there are nine therapeutic communities. Some are run by the local public authorities, others are run by private citizens (religious, voluntary). The figures for addicts treated by public services and therapeutic communities in 1984 are reported in Table 9.

In-patient detoxification is generally carried out in hospital.

Quick, or gradual out-patient treatment or maintenance, rehabilitation training, psychological therapy should be carried out under the SATs jurisdiction.

Drug free and group therapy programmes are carried out in residential communities. A certain lack of co-ordination has arisen between the communities and the SATs.

Some of the SATs are annexed to hospital facilities (hospital services), others are self-run (social services). From the administrative point of view they are controlled by the Local Health ‘ Unit (USL). Since they are regional facilities (Latium region), they operate within the framework of the National Health Service.

Each SAT serves a single catchment area or a portion of it. Some of the tasks, including data analysis (analytic determination, etc) are jointly carried out by a group of Local Health Units.

The municipality of Rome has an office which co-ordinates the activity of all the SATs. This office is headed by the City Counsellor for Health Matters.

During the last two years the action of this office has reduced operational differences existing among the various SATs. There are still some management and programming problems deriving from the varied composition of SAT staff and the lack of job continuity of many SAT workers.

Even though the SATs are formally ready to deal with any sort of drug addiction, they focus all their efforts on heroin addicts. Heroin abuse is presently regarded as the most dangerous form of drug addiction. The new kind of form which has recently been elaborated by the Central Health Administration shows that the Health Authorities intend to define the various parameters and concomitant factors which are to be taken into account when making a viable global individual assessment of the phenomenon, as far as the different forms of drug addiction are concerned.

The services provided by the SATs are free of charge, since the SATs work within the framework of the National Health Service. Only residents in an appointed geographical “catchment” area can apply to the local services. Nevertheless, due to the obvious population mobility in a city like Rome and to the seasonal immigration, some SATs also provide services for non-resident addicts.

To protect the anonymity of the addict, the regional health code number of the citizen can be recorded instead of his/her full name, address, etc.

The treatment is agreed upon by staff members and the addict him/herself after detecting his/her state of addiction (to opiates). Detection methods have been recently regulated by the Ministry of. Health in order to avoid that subjects who are not yet physically dependent on heroin are inappropriately treated with analgesics-narcotics (Methadone, Morphine (1)). Statistics on the amounts supplied in 1980-83 are provided in Tables 6 and 7.

Treatment with agonistic drugs normally lasts less than three weeks; only in particular cases a prolonged treatment is allowed. Treatment can be repeated. The substitutive drug is generally administered in gradually decreasing doses in order to reach a drug-free condition. At the same time the addict undergoes a psychological therapy through counselling which takes place once or twice a week. Urine tests are periodically performed to detect any possible use of an illicit drug. In most cases a positive test is not considered a sufficient reason to exclude a person from a treatment programme, since one of the most important targets of the programme itself is the establishing and strengthening of a contact with the addict and his/her breaking loose from all the ties to illicit trafficking in order to be able to start other forms of treatment (family, group, community treatment). Table 9 shows the data relative to the number of .subjects treated by the SATs and by therapeutic communities in 1984 (15 September). The corresponding data of previous years were clearly exaggerated since the same subject was included several times by different operative services.

These guidelines are not uniformly applied because of the different “motivations” of staff members, their ideology, their cultural background, and because of the varying operative capacity of the services in relation to the number of addicts who need treatment. All staff members usually show a sufficient degree of co-operative spirit. However there are strong differences in the way various staff members fulfil important tasks such as the assessment of each individual problem, the collection of preliminary information, therapy controls, planning of individual programmes and the respect of the prescribed terms. The practical outcome of these differences is that the best staff members are forced to be less accurate in their controls or to limit the time they can devote to each single person because of the high number of persons they have to deal with or to reduce the number of persons they can assist. In all cases the overall quality of the service is clearly compromised.

As regards “less dedicated” staff members, it is clear that, even though they have to deal with a smaller number of persons, they will in any case provide a service of insufficient quality. Such differences do not allow the continuity of treatment from one facility to another since an acceptable follow-up from effective to less effective facilities (or vice versa) is not possible. Even though envisaged by regional regulations, anonymity does not seem to be of much importance for most addicts. This consideration induced other regions to provide for recording of personal data concerning addicts.

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(1) The “experimental use” of morphine by injection ended on 31 December 1985.

A.6 Control systems and resources (law enforcement)

Police activities concerned with drug trafficking are carried out in Rome as in the whole of Italy, by various structures: the Civil Police (under the Ministry of the Interior), the "Carabinieri" (Military Police; under the Ministry of Defence), the Finance Guard (Custom Officer under the Ministry of Finance). Specifically in the metropolitan area the following departments are concerned:

– Narcotics Section – Flying Squad (Civil Police) (Squadra Mobile -Sezione Narcotici);

– Drug Enforcement Operating Unit (Reparto Operative Anti-Droga -ROAD) (Military Police);

– Fiscal Police Main Group (Nucleo Centrale Polizia Tributaria (Finance Guard).

The municipal police also assure administrative duties, and meet certain obligations related to commercial tasks, to traffic control etc.

The nationwide activities are jointly carried out under the central command, the Drug Enforcement Main Service (Servizio Centrale Anti-Droga).

As for available data, aggregated per area, the most useful concern the "small quantity" seizures as compared with larger quantities.

The mean seizure weight per person charged with trafficking was over 0.5kg in Rome, and 0.38kg in Italy in 1983 (about the same weight per person charged, 0.37kg, being recorded in Rome and in Italy in 1984)(Table 11).

Less than one hundredth the above weights are considered to be "small quantities". Less than one half the mean seizure per person has been recorded in Rome: 1.35 and 0.94 grammes, as compared with 3.53 and 2.15 grammes in Italy, in 1983 and 1984 (Table 12).

Supplementary interesting trends (1983-84) resulted from the pharmacological composition of the seizures (Table 10):

– an increase in opiates and heroin in Rome, in accordance with a corresponding increase in Italy;

– an increase in cocaine seizures, in accordance with an increase in global stimulants in general;

– a diminishing increase in hallucinogenic and hashish seizures as compared with the marked increase in marijuana.

A.7 Monitoring systems

The collection and circulation of information occurs in Italy as follows: each Local Health Unit (USL) sends a continuous flow of data to the regional competent authorities where all the data are assembled and assessed. Every six months a report based on these data should be sent to the Ministry of Health.

The following tasks are normally fulfilled by the USL drug services: diagnosis, admission to in-patient treatment, dealing with applications for first treatment and subsequent treatment, the planning of individual treatment programmes, etc until the end of the treatment of the person. It is allowed that the treatment, after being agreed upon and authorised by the SAT, is carried out by the family doctor. It cannot however be excluded that a certain number of cases of treatment remain unrecorded.

The following specific variables are routinely recorded (at first level).

a. Primary and secondary drug (associated with the former)

b. Personal data (age, sex, health code number, address)

c. Previous treatment, related and/or concomitant diseases.

Although the questions included in the questionnaire are extremely detailed and specific, there are often misunderstandings due to the different cultural background of the staff members who use it both within the same facility and from one facility to another.

At the first level (USL), information could usually be available in a relatively short time (weeks). At the second level (regional level) it could be available within months. At the third level (Ministry of Health), information has been made available every six months to one year on average, only by half of the regions. This method, however, did not give good results.

A permanent Drug Abuse Monitoring Department has been recently created at the Ministry of the Interior. This monitoring department demands the most important information directly from each USL and is able to work out useful quarterly assessments. The following essential data are concerned: the number of public services, the number and sex of addicts under treatment, the kinds of treatment, pharmacological or non-pharmacological, the number of residential therapeutic communities, the number and sex of subjects under treatment, the corresponding figures relative to the provinces, regions and to the whole country. These figures have proved to be reliable.

B. INDICATORS

B.1. First treatment demand

When dealing with this indicator one must bear in mind that addicts are hindered in no way from seeking the aid of the public service (anonymity if he/she requests it; counselling; pharmacological and/or other support; confidentiality towards relatives, including the parents even when a minor is concerned, if the minor expressly requests it; no heavy control of treatment stages nor restrictive clauses in general). Moreover the addict possessing a small quantity of a narcotic drug (see under “legislation”) is “unpunishable”.

Because of such broad availability of treatment particularly for new (unknown) addicts, it is thought that a very large proportion of addicts apply at least once to the services and seek further treatment for the “first” time in different services.

Aware of its importance, all the treatment centres record data on first treatment demand. Obviously several “multi-recordings” of individuals have occurred during the past years, particularly in some larger urban areas. Some positive aspects included the opportunity tp contact many different addicts, to acquire a useful training, to offer first-line treatment to individuals needing to gain trust in such institutions.

After 1984 a more rigorous (centralised) monitoring system was tentatively set up by the Ministry of the Interior and there was more coherence in the data collected.

The great majority of demand for treatment came from heroin addicts. Nevertheless, some change is taking place in the philosophy of the public structures towards the phenomenon and various (non-opioid) addicts and others needing help are now among those coming forward.

The figures available for “treatment demand” and for the “addicts under treatment” are nowadays more coherent than in the early 1980s. The respective figures are contained in Tables 9(a) and 9(b).

Availability, accessibility and rapidity

The data on treatment demand are available at regional level and at ministerial level (Health, Interior). They appear a few months later in a widely circulated quarterly bulletin. As for validity, they can be considered as a measure of the extent of the addict population but not of the user population.

A supplementary consistent proportion of addicts needing help refer to Therapeutic Communities. The figures are included in Table 9.

Here it is important to stress the great differences between the public services and the therapeutic communities as regards both the entrance criteria and the rules governing treatment (more strictly binding in therapeutic communities).

B.2. Hospital admissions

The hospital admission of addicts in Rome refers almost entirely to emergencies related to dramatic episodes. The vide availability of services (services available per geographical area and per head of population) means that addicts do not resort to a strictly medical structure, disliked by drug users.

B.3. Viral hepatitis

As regards hepatitis, the A-, B-, nA-nB hepatitis cases can all be. related to drug abuse, mainly the hepatitis B.

In the specialised hospital a serological diagnosis is currently carried out on all in-patients including heroin addicts and others using substances intravenously.

The specific diagnosis of the various types of hepatitis (A, B, nA-nB) have not been included under the hepatitis item in the compulsory recording form for infectious disease.

The official statistics collected by the National Institute of Statistics (ISTAT) are available only some years later. A very quick system exists on voluntary basis, at the Biostatistics and Epidemiology Department of the Istituto Superiore di Sanita. This monitoring system (SIRMI) provides broad statistics on several infectious diseases only one month later. Nevertheless reference to the addict condition is not made.

Data on the prevalence of infectious disease among addicts can be obtained from research (see the survey carried out at the L.Spallanzani Hospital, 1973-80, Table 14) or from a survey not supported by serological tests carried out at the Services for Addict Treatment (broad comprehensive data are available for 1984; Table 13).

Both the statistics are useful from the health point of view; but their significance is poor as concerns use as an indicator for estimating drug users' prevalence.

B.4. Drug-related deaths

There is only one source of data on drug-related deaths, at national and local level. The criteria are the same all over Italy. The following bring about classification as drug-related death:

– death diagnosed by a physician as being drug-related (overdose, fatal intoxication, etc);

– the concomitant presence of objects used in connection with the drug addict's habits (syringes, spoon, cotton, etc);

– presence of other signs and/or indications of a drug abuse habit;

– intelligence data connecting the episode with the drug abuse habit.

Data are gathered daily by the Italian Drug Enforcement Administration and are currently available in one week.

The annual figures refer mainly to heroin addicts; these figures would be more related to the prevalence of "heavy" addicts than to users as a whole. In other words (a) an increasing rate of drug-related deaths can imply a stabilisation of the user population or (b) a levelling in drug-related deaths can occur at the same time as an increasing rate of prevalence of users.

Even if the data have some failings they can be considered yearly comparable.

The annual trend recorded in Rome and in Italy (figure 1) shows an anomalous peak in 1984 to be ascribed rather to a temporary change in trafficking strategy than to a change in the pattern of addiction itself.

B.5. Police arrests

Data on police arrests in strict sense (in Italian: fermo di polizia) for offences against the Drug Act are not available when the first formal action is not followed up by imprisonment. Data on reported individuals from the police are comparable with the police arrests.

Such figures would vary according to the criteria of the local police staff as well as the District Attorney: their autonomous independent judgment does not allow for a common background for statistical evaluation.

Figures concerning police reports (as above) and the corresponding imprisonment for drug-related offences carried out in Rome are reported in Table 15.

B.6. Imprisonment

Different sources of imprecision affect data on the imprisonment of addicts and/or subjects convicted of an offence against the Drugs Act, as referred to in Section A (time of survey; imprecision of the ascertainment of drug addiction; etc).

Of most significance would be the differences emerging from data on seizures (kg, no.) and persons charged with drug trafficking (Tables 11 and 11(a)) and those possessing a "small quantity" (Table 12). Rome and Latium, as compared in Italy, represent 18% the weight of seizures and 16% the number of seizures, 11% and 38% the Italian and foreign persons connected with the former (drug trafficking and passing on of drugs). As for the latter (possession of a "small quantity"), Rome and Latium represent 2.3% of the weight of seizures and *5.8%* the number of seizures, and 6.2% and 1.5% the Italian and foreign persons involved.

B.7. Seizures of illicit drugs

As regards the seizures there is a remarkable difference between the average seizure weight per individual, charged with drug trafficking (over 1/2 kg) and the average weight for those possessing "small quantities" (about 5 mg).

From an epidemiological point of view annual seizures seem unsuitable as an indicator for the estimation of drug abuse, as concerns either absolute weight or number.

A further doubtful factor is the nature (transit and/or producer and/or consumer) of the state/region concerned. This aspect obviously differs according to the drug concerned, so that the respective seizures correspondingly take on a different meaning (ie heroin seizures have different implications in Yugoslavia (transit only), in Italy (transit, consumer, small producer) and in the United States (consumer only).

B.8. Price/purity of illicit drugs

Here we refer to the purity of the street drug (heroin)(its active concentration).

The purity of the street drug has decreased during recent years to *5-7%* (1984); the concentration range differed from one metropolitan area to another, being slightly different from the national average.

During the last year the purity slightly increased from *5%* to about *6-7%* (1st semester 1986).

A common “street drug dosage” (so-called “quartino”) ranges from 50-200-300 milligrams as raw drug (about 5-7%), and the price ranges from 30,000 to 50,000 Italian Lire.

The price per gramme of 10% heroin (or over) ranges from 150,000 to 220,000 Lire per gramme. This is the starting drug for further preparations (“quartino” as above).

B.9. Survey data

Several research studies on drug abuse have been carried out by public structures in Italy from 1980, either in the form of surveys or in the form of experimental research. Work has been carried out on epidemiology, monitoring indicators, treatment with agonistic drugs, addiction testing, sociological surveys of a general nature and those involving specific population samples or specific localities.

a. The first research study (project TO.DI) was carried out by the Istituto Superiore di Sanita (ISS) and the National Research Council on a sample of males from the general population (young male draftees, 1980 and 1982, 17,000 and 36,000 respectively).

The methodology employed included chemical clinical tests for opioids and polidrugs (1980, 1982) and for cannabis (1982), and the administration of a simple questionnaire.

Besides an indication of the prevalence of opiate use (15.4 per thousand and 16.7 per thousand), and of cannabis use (80 per thousand) in Italy and its regions, other interesting findings were as follows:

– the important role of the higher educational level as a preventive factor as concerns opiate use;

– the strict association of tobacco smoking with opiate use;

– the poor significance of any connection between alcohol drinking and opiate use;

– the high possibility of estimating the submerged portion of users (about three times the number of addicts).

– Further application of the project TO.DI methodology concerned

– the measurement of the prevalence of opiate users among prisoners (approximately *21%)* in a medium-size prison.

b. The use of morphine injections in experimental treatment of addicts was authorised from the end of 1980.

The most significant results were:

– the voluntary shift of some of these addicts from morphine to methadone treatment;

– the average decrease in the manufacturing and prescribing of morphine (Tables 6 and 7).

c. The ISS survey, referred to above, on the prevalence of hepatitis, involved approximately two thirds of addicts under treatment by the public services. Irrespective of the serological diagnosis, it resulted that approximately 48% were affected by A, B or nA-nB hepatitis according to the anamnesis, 29-30% being affected[1]'by ' B-hepatitis.

Since however hepatitis cases (A, B, n-A, n-B) were included in the survey, regardless of their relationship with the drug misuse, the data were obviously overestimated.

d. A sociological survey (CENSIS), based oh the opinion of several specialists on the phenomenon and its trends, gave a picture of the national and regional situation as it was perceived by the services.

Irrespective of the quantitative estimations provided, and of the vague definitions used, the information obtained allowed for development in several interconnected fields.

B.10. Other indicators; emergency data; comments on AIDS

Emergency data

The emergency rooms in the Rome area are located in main hospitals, each of which is attached to a Health Unit (see A.3 above). Only a minimal number of emergency room cases per emergency room concern drug abuse related episodes. From these episodes only figures related to the fatal ones are currently available. Figures on cases with a successful (non-fatal) outcome could be assessed by means of an "ad hoc" survey (to be carried out in each emergency room); nevertheless unreliable data would emerge, because no widespread recording system (ie similar to DAWN) is at present operating, involving several units.

AIDS and drug addicts in Italy

In June 1983 a surveillance system was set up in Italy at the Istituto Superiore di Sanita, Department of Epidemiology, Rome. From January 1982 to 30 June 1986, 286 cases of AIDS matching the CDC/WHO definition were identified in the country; of those only six involved non-Italian residents.

The epidemic started in the second half of 1982 with cases concerning Italian homosexuals with frequent contacts with the USA: in June 1983 there appeared to be few cases of AIDS among heroin drug addicts. Up to the present time the proportion of drug addicts among Italian cases of AIDS increased continuously reaching 60% in June 1986 (Figure 2). Of 286 cases 142 concern heroin drug addicts, 18 homosexual drug addicts and 18 children born from heroin-addicted mothers; thus overall drug addiction contributes to 178/286 cases (62% of AIDS cases in Italy).

This epidemiological aspect seems to be peculiar to Italy; in fact, of the 2,006 cases of AIDS notified in Europe up to 31 December 1985 only *17*, (including Italy) concern drug addicts. Only Spain seems to share the Italian high proportion of DA AIDS cases.

The Italian epidemic of HTLV-III infection in drug addicts is confirmed by the preliminary results of a national screening for HTLV-III of those individuals: out of 3,425 drug addicts screened in the first half of 1986, 1,375 (40.1%) were positive to HTLV-III antibodies. Similar studies on a smaller scale carried out on; 1,982 sera of drug addicts shoved a proportion of positives below 5%.

The explanation for a high proportion of AIDS cases among Italian drug addicts is still a matter for discussion: although groups of Italian homosexuals, recently investigated, tend to have living habits comparable with those of other similar European groups, it is likely that a smaller proportion of this social group is exposed to a high number of sexual partners. On the other hand, Italian drug addicts tend to have risk habits that expose them to blood transmitted infections, as confirmed by HBV studies.

Still the problem needs clarification and suitable epidemiological studies are in operation for this purpose.

C. ASSESSMENT OF THE USE AND VALUE OF INDICATORS

C.1. Use of indicators in the city

No formal method has been devised for the use of available indicators in order to estimate periodically prevalence and/or ‘incidence of drug users in Rome.

The major sources of information are:

– the figures on addicts in treatment at the public services and persons in therapeutic communities;

– the figures on drug-related deaths;

– the figures on offences against drug legislation;

– the figures on seizures (number and weight) (per drug);

– the figures on first treatment demand (suitable data collection was made as from 1985).

A double level of co-ordination exists at municipality and at regional level.

D. CONCLUSIONS

It is necessary to separate the epidemiological statistical data from those aimed at monitoring the phenomenon as far as individuals or certain specific problems are concerned.

As regards the epidemiological/statistical aspects, only data referring to a large number of inhabitants and to large geographical areas can be of some significance. In this case “continuous” monitoring seems superfluous, since it cannot provide clear elements for tracing the trends of the phenomenon. By superimposing interventions and contributions which often contrast with one another, the sound assessment of the global situation as well as the consequences of the effectiveness of legislative and/or administrative measures taken by the authority (national, inter-regional) could be hindered.

On the contrary, a system of “continuous” monitoring of the phenomenon which emphasises individual problems (family, psychological, unemployment, cultural, economic, social) can provide useful elements for the assessment of local situations and can help the authorities to take effective measures at the local level (municipality, province and, partly, region). Useful information, supported by experimental data, will be provided in consequence of multiannual research performed in Rome (and in other areas) by means of a monitoring system set up by a CNR team (1).

As results from available data, the use of common indicators for estimating the diffusion and extent of the drug abuse phenomenon fails, even when the trend of a same indicator, apparently objective, is considered (see drug related deaths, seizures, addicts notified and/or treated, etc).

The use of periodic cross research in general/specific population samples by means of direct standardised methods, free from questionable considerations, provides a basis for calibrating other available indicators, without altering the various provisions, rules and criteria prevailing.

The availability of several methods, the short time required to perform such a survey, the relatively unskilled expertise required, provide a highly favourable profit/cost ratio for such a strategy.

More detailed study of data recorded by medical and social care facilities is tied to so many local factors that it is very difficult to give indications which can be equally useful to other Western European states.

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There is the possibility of resorting to more detailed studies in relation to particular regional situations. For example:

a. the incidence of infectious disease related to or induced by drug abuse differs from country to country in relation to the different regulations concerning the availability, with or without medical prescription, of sterilised syringes.

b. different degrees of enforcement of certain measures exist when these involve professional categories (doctors, chemists) who are not equally rigorous in their application.

The setting up of a surveillance system for monitoring infectious diseases among addicts and/or drug addiction among hepatitis patients could be a feasible aim in European countries.

To give an example, no further substantial changes in the system at present in use in Italy should be necessary. Some specific sub-items could be included for the hepatitis item in the data collected on infectious diseases. A systematically accurate recording of the various hepatitis-types would be provided.-

According to the type of information, there are different tithe ‘ intervals between the event and the collection of the information (eg deaths are recorded and communicated daily). Data analysis and assessment should be regularly carried out by each region every six months.

Additional information can occasionally be obtained without altering information recording procedures. The carrying out of further analysis depends on the information and the type of analysis. Not all regions are able to provide it.

The following proposals and/or points of view have occasionally hindered the focusing of the interventions on the most dangerous aspect of the phenomenon (heroin use):

– the classification of heroin abuse together with all the other forms of abuse (from alcohol to psychotropic drugs);

– the subordination of the fight against the diffusion of heroin to the fight against all forms of social outcasting;

– the taking into account of only the toxicity of substances in evaluating the risks connected with their use, purporting that the use of pure heroin, that is heroin at pharmaceutical grade, might reduce the number of diseases, not taking into account the effects of drugs expressly added (“street heroin”) in order to contrast with its undesired secondary effects.

It must be borne in mind that according to Italian legislation possession of a “small quantity” (especially of addiction producing drugs, like heroin) is a non-punishable offence. The fact that offences concerning the illicit use of drugs are chargeable in different ways means that larger seizures can be effectively distinguished from smaller seizures. Thus it can be useful to calculate the “mean amount seized” by taking into account the drugs seized and the number of traffickers charged (only for large seizures). This indicator would represent the other face of the phenomenon, differing from the “average small quantity”.

At present, the aim of the framework of public services and therapeutic communities in the Rome area is to change and improve their efficiency by means of the support of several “first line centres”. The purpose of these centres is to distinguish the quality of intervention to be planned for each aid request according to his/her own needs and conditions, not only as concerns the drug addiction. Thus it will be possible to avoid loading the services with those cases in need of treatment as out-patients or of other forms of aid.

A further aim seems to be to find ways of detecting cocaine abuse cases at an early stage and to improve measures and interventions for their treatment and/or their prevention.

The present lack of treatment demand at the public services gives rise to other strategies for epidemiological estimation (indicator dilution technique; snowball technique; etc). Useful contributions could be expected from widescale research planned.

There are other indications of a changing pattern of opiate abuse towards a better self-controlled misuse, aimed at avoiding the risk of overdose.

The decreases in drug-related deaths, in treatment demand, and in other indicators, seem to be consequent signs of this evolution.

The most beneficial effort against drug abuse remains prevention, a great many factors of which are unknown or unverified.

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- Department on Documentation, Ministry of the Interior;
- Central Department on Narcotic Drugs, Ministry of Health;
- National Institute on Statistics, ISTAT;
- Office for co-ordination, Local Health Units and Addict Facilities, Rome.

The following experts and researchers provided data for this report:

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APPENDIX I

NOTES ON LEGISLATION

Legislation on drug abuse in Italy

The penal provisions of the law on trafficking and abuse of narcotic and psychotropic drugs are included in Italian Act No. 685/1975, as well as in a few articles of the Criminal Code. The following matters are covered:

a. Cultivation, manufacturing, import/export, etc (Act No. 685/1975; art. 71);

b. Possession, conveyance, purchase, sale, distribution (Act No. 685/1975; art. 72);

c. Quantity (small or large) concerned. Only the "small" quantity is defined, in relation to the "unpunishable" criterion. (Act No. 685/1975, arts. 72, 73, 80, 98);

d. Drug, as "hard" or most dangerous (roughly in accordance with the Single Convention – except cannabis – and Schedules I, II, III of the Convention on Psychotropic Substances) and as "weak", "soft" or less dangerous (roughly including cannabis and substances under Schedule IV of the Convention on Psychotropic Substances) (Act No. 685/1975; art. 12).

According to Italian legislation a drug addict is not punishable if he or she is in possession of small quantities of a drug. This small quantity is calculated in relation to the physical and psychological condition of the person (this is a guarantee for the addict and also allows for prosecution of non-addict traffickers even though they may be in possession only of small quantities of a drug).

However, it must be stressed that, although objective tests are available which allow for the detection of the state of dependence, (ie naloxone systematic test), this concept has rarely been enforced. On the contrary, it has been applied in a different way, that is, without taking into account the state of dependence of the person. This misapplication of the legislation has given the impression that drug trafficking is legalised or tolerated.

Information on the offences and crimes, the criminal categories and the corresponding fine or length of imprisonment is given below:

	SANCTIONS	
	Imprisonment (years)	Fine (millions, Ital, lire)
A. Person having no licence sentenced for manufacturing, or supplying; related activities		
concerning “hard” drug	4-15 (18)	6 (20)-200
concerning “soft” drug	2-6	4-100
B. Person * sentenced for any illicit activity concerning “small” quantities		
“hard” drug	2-6	0.2-16
“soft” drug	1-4	0.2-12
concerning “large” quantities	6-25**	
“hard” drug	3-10	9-326**
“soft” drug		9-166**
C. Person forming part of		
1. Criminal association		100-400
- as promoter, organiser etc	over 15***	20-100
- as member	3-15	
2. Armed association	over 20***	
- as promoter, organiser etc	over 5***	
- as member		
D. 1. When several aggravating circumstances concur	not over threefold the maximum penalty	
2. When several attenuating circumstances concur	not less than a quarter the minimum penalty	
E. Person who possesses or detains a “small” quantity of “soft” or “hard” drugs (such “small” quantity being not greater than the quantity needed by the addict, taking into account his particular condition)	not subject to sanction***	

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* who acts in an illicit way towards minors, invalids, addicts, etc or commits crimes as the organiser or member of a criminal association:

** plus 2/3 the penalties included, when aggravating circumstances concur;

*** not more than 30 years;

**** even though it remains an offence.

APPENDIX II

DATA

Table 1

Demographic data on population, age 17-29, in the catchment area concerned, relate to Latium and Italy

Data from Census 1981 – National Institute of Statistics (ISTAT)

	Sq. Km.	Males	Females	Total
Italy	301,267	5,308,400	5,254,650	10,563,050
Latium	17,202	434,203	437,646	871,849
% (Italy)	5.71	8.18	8.33	8.25
Rome, province	5,352	320,500	328,833	649,333
% (Latium)	31.11	73.81	75.14	74.48
Rome, munic.	1,508	252,078	261,392	513,470
% (Latium)	28.18	58.05	59.73	58.89
% (Italy)	0.50	4.75	4.97	4.86

Table 2: Population living in the province of Rome, by sex and by age range, 1971 and 1981

AGE RANGE	1971		1981	
	MALES	FEMALES	MALES	FEMALES
0 – 4	153,982	146,292	104,621	98,898
5 – 9	160,027	151,893	139,270	133,133
10 – 14	135,503	129,638	153,317	147,028
15 – 19	121,464	118,638	160,546	154,602
20 – 24	129,459	130,701	140,974	136,701
25-29	119,617	128,059	126,691	129,732
30 – 34	134,723	144,131	129,094	137,650
35 – 39	126,974	135,305	119,701	129,992
40 – 44	125,902	131,040	129,255	140,919
45 – 49	116,675	125,428	119,569	130,188
+ 50	370,504	454,422	460,081	573,999
TOTAL	1,694,830	1,795,547	1,783,119	1,912,842
GENERAL TOTAL	3,490,377		3,695,961	

Source: National Institute of Statistics – ISTAT

Table 3

Opiate users (n), per age range, educational level, occupation; indications concerning tobacco-smoking and consumption of alcohol

Distribution (Prevalence rate x 1,000) in Rome and in Italy (young men (N) from 15 urban areas). 1982.

Project To.DI.2.

ACE RANGE:	18 and under			19 – 25			Total		
	N	n	Rate	N	n	Rate	N	n	Rate
Rome, prov.	3.664	47	12.8	160	5	31.2	3,838	54	14.1
Italy	32.272	517	16.0	3,921	85	21.7	36,252	604	16.7

EDUCATIONAL LEVEL:	No-Schooling			PRIMARY			SECONDARY		
	N	n	Rate	N	n	Rate	N	n	Rate
Rome, prov.	10	0	–	214	17	79.4	3,605	37	10.3
Italy	282	7	24.8	2.756	90	32.7	33,137	506	15.3.

OCCUPATION:	EMPLOYED			UNEMPLOYED			STUDENTS		
	N	n	Rate	N	n	Rate	N	n	Rate
Rone, prov.	1,200	26	21.7	337	13	38.6	2,301	15	6.5
Italy	15,530	236	18.4	3,629	141	38,9	17,093	177	10.3

TOBACCO SMOKING: Cigarette/day	1 – 9			10 – 19			20 – 29			30			Non-Smokers		
	N	n	Rate	N	n	Rate	N	n	Rate	N	n	Rate	N	n	Rate
Rome, prov.	427	6	14.0	1.382	20	14.5	324	16	49.4	41	3	73.2	1664	9	
Italy	3,545	50	14.1	7,723	151	19.5	4,421	213	48.2	794	56	70.5	19,769	134	

ALCOHOL. Drinkers	DRINKERS			Non-Drinkers		
	N	n	Rate	N	n	Rate
Rome, prov.	1,494	30	20.1	2,193	24	10.9
Italy	11,947	242	20.2	24,007	359	14.9

Table 4: Multiple drug users, among opiate users

Distribution (percentage, %) per drug, in Rome and in Italy (young men) from 11 regions.

1982. Project TO.DI.2.

	Opiate + 0 substance		Opiate + 1 substance		Opiate + 2 substance		Opiate + 3 substance		Total Users	
	n	i	n	i	n	i	n	i	n	i
Rome, prov.	24	44.4	25	46.3	5	9.2	0	–	54	100
Italy	248	41.1	284	47.0	67	11.1	5	0.8	604	100

Opiate + 1 Substance

	Opiate + THC		Opiate + Barbitur		Opiate + Cocaine		Opiate + 3 Amphetam		Total + 1 Subst.	
Rome, prov.	23	42.6	0	–	1	1.8	1	1.8	25	46.3
Italy	227	37.6	30	4.9	18	2.9	9	1.5	284	47.0

Opiate + 2 Substances

	Opiate + Barbit. + THC		Opiate + Cocaine + THC		Opiate + Barbit. + Cocaine		Opiate + Amphet. + THC		Opiate + Amphet. + Barbit.		Opiate + Amphet. + Cocaine		Total + 2 Subst.	
Rome, prov.	3	5.6	0	–	0	–	2	3.7	0	–	0	–	5	0.2
Italy	18	3.0	11	1.8	1	0.1	31	5.1	4	0.6	2	0.3	67	11.1

Opiate + 3 Substances

	Opiate + Amphet. + Barbit. + THC		Opiate + Amphet. + Cocaine + THC		Opiate + Barbit. + Cocaine + THC		Total + 3 Substances	
Rome, prov.	0	–	0	–	0	–	0	–
Italy	2	0.3	2	0.3	1	0.2	5	0.8

The trend of multiple drug abuse among opiate users, in the Rome area, laid the foundation for the national average.

Table 5

CANNAB IS (THC) USERS (n), per age range, educational level, occupation: indications concerning tobacco-smoking and consumption of alcohol

Distribution (Prevalence rate x 1,000) in Rome and in Italy (young men (N) from 9 urban areas), 1982.

Project TO.DI.2.

AGE RANGE:	18 and under			19 – 25			Total		
	N	n	Rate	N	n	Rate	N	n	Rate
Rome, prov.	1493	127	85.1	39	5	128.2	1532	132	86.2
Italy	7853	615	78.3	261	34	130.3	8114	649	80.0

EDUCATIONAL LEVEL:	No-Schooling			PRIMARY			SECONDARY		
	N	n	Rate	N	n	Rate	N	n	Rate
Rome, prov.	4	0	–	73	14	191.8	1454	118	81.2
Italy	14	1	71.4	531	73	137.5	7558	571	75.6

OCCUPATION:	EMPLOYED			UNEMPLOYED			STUDENTS		
	N	n	Rate	N	n	Rate	N	n	Rate
Rone, prov.	410	44	107.3	109	22	201.8	1013	66	65.1
Italy	2688	269	100.1	737	127	172.3	4639	253	54.0

TOBACCO SMOKING: Cigarette/day	1 – 9			10 – 19			20 – 29			30			Non-Smokers		
	N	n	Rate	N	n	Rate	N	n	Rate	N	n	Rate	N	n	Rate
Rome, prov.	155	15	96.8	555	6.4	115.3	126	22	174.6	16	1	62.5	680	30	44.1
Italy	747	65	87.0	1778	225	126.6	976	179	183.4	204	38	186.3	4409	142	32.2

ALCOHOL.	DRINKERS			Non-Drinkers		
	N	n	Rate	N	n	Rate
Rome, prov.	603	59	97.8	835	67	80.2
Italy	2425	231	95.3	5576	412	73.9

Table 6: Morphine and Methadone (kg) in Italy

(a) for narcotic-analgesic preparations
(b) estimated for treatment of addicts

		1980	1981	1982	1983
MORPHINE	(a)	82	68	75	76
	(b)	60	46 (-23%)	53 (+15%)	54 (+2%)
METHADONE	(a)	34 (*)	65	80	76
	(b)	17 (*)	17 (+182%)	63 (+31%))	59 (-6%)
MORPHINE + METHADONE	(b)	77 (*)	94 (+22%)	116 (+23%)	113 (-3%)

(*) Until 10 October 1980 the use of methadone for narcotic-analgesic purposes was permitted only in hospital.

Table 7 Morphine inject, and methadone syrup, sold in Rome (Latium). (Al and in Italy (B)

1982 – 1983

		1982		1983		1983/1982 (%)	
		A	B	A	B	A	B
Morphine.	10 mg	43,700	785,530	22,000	629.520	50,3	80.1
	20 mg	164,000	3.586,400	74,400	2,772.925	45.4	77.3
Total (kg)		3,757	79,583	1-.708	61.753	45.9	77.6
Methadone.	5 mg	3,830	299,163	5,180	351.915	135.2	117.6
	10 mg	8,130	464,915	14,940	503,822	183.8	108.4
	20 mg	267,100	3,458,958	343.400	3,259,849	128.6	94.2
	200 mg	6,650	10,250	3,250	4.900	48.9	47.8
total (kg)		6,772	77,374	7,695	72,’975	113.6	94.3

Sources: I.S.S. from pharmaceutical firm data.

The amount of morphine injections was halved (-46%), compared with the increase of “agonistic” preparations sold in Latium (+13,6% in 1983 overall).

This was in agreement with other data (unpublished) from the services.

Table 8

REGION	SERVICES SET UP BEFORE 1980	SERVICES SET UP AFTER 1980	TOTAL
PIEMONTE	9	36	45
VALLE D'AOSTA	1	-	1
LOMBARDIA	4	20	24
TRENTINO A.A.	4	-	4
VENETO	3	25	28
FRIULI V.G.	1	3	4
LIGURIA	5	13	18
EMILIA ROMAGNA	9	-	9
TOSCANA	10	20	30
UMBRIA	3	2	5
MARCHE	1	11	12
LAZIO	5	17	22
ABRUZZI	-	6	6
MOLISE	-	1	1
CAMPANIA	-	14	14
PUGLIA	.	4	4
BASILICATA	1	-	1
CALABRIA	-	4	4
SICILIA	4	10	14
SARDEGNA	-	2	2
ITALY	60	188	

From: Di Fiandra T and Mariani F, 1984.

Table 9

Addicts under treatment (pharmacological and other) in public services and persons under treatment in therapeutic communities

September 1984

Data from Drug Abuse Monitoring Department – Ministry of the Interior

	Rome	Italy	%
Public Services (considered)	22	383	5.75
Males	902	14,739	6.12
Females	210	3,571	5.88
Total Addicts	1,112	18,310	6.07
Therapeutic Comm.	9	215	4.19
Males	193	3,466	5.57
Females	48	892	5.38
Total subjects	241	4,358	5.53

The number of addicts (all of them heroin addicts) treated as at 15 September 1984 in 22 SAT's (1,112) and in therapeutic communities (241) is in agreement with the number of users and addicts calculated on the basis of population sample cross-research (4,200 and 1,400 respectively in 1982).
Less than half of the subjects (631) are pharmacologically treated. This figure tends to decrease.

Table 9a

First Treatment Demand – Rome and Italy
1st half of 1984

	Public services	Therapeut. Communities
Rome	750 (11.1%)	290 (13.7%)
Italy	6.747	2.114

Table 9b

Subjects under treatment – Rome and Italy
1984-85

	Public services		Therap. communities	
	1984	1985	1984	1985
Rome	1.025	1.909	293	259
Italy	3.786	17.620	4.568	4.881

Table 10: Seizures and people involved in drug, trafficking in Rome (A) and in Italy (B) – 1983.

SUBSTANCE	SEIZURES						PEOPLE CHARGED					
	Kg			No.			ITALIAN			FOREIGN		
	A	B	A/B%	A	B	A/B%	A	B	A/B%	A	B	A/B%
OPIOIDS												
OPIUM	2.219	6.863	32.3	972	202,715	0,48	5	28		4	5	
MORPHINE	0.755	2.951	25.58	511	1,109	46.07	4	119		8	12	
HEROIN	65.739	313.834	20.94	1564	3,700	31.43	793	7,069		120	332	
OTHERS, NATUR.	1.620	1.653	98	-	197	-	2	2		1	1	
MORPHINE-LIKE:	2.235	9.874	22.63	260	742	35.04	4	35		0	2	
TOTAL	72.563	335.23	21.64	3307	208,463	1.55	813	7,253	11.21	133	352	3378
STIMULANTS												
COCAINE	72.899	223.392	32.63	164	281	58.36	191	678		50	109	
AMPHETAMINES	49.465	70.674	70	2	91.9	0.21	1	11		0	0	
OTHER STIMUL.	0.516	2.859	18.04	40	120	0.333	1	4		1	2	
TOTAL	122.83	296.925	41.38	206	1,320	15.6	193	693	27.85	51	111	45.95
HALLUCINOGENS												
MARIJUANA	688.694	1017.648	67.67	15	1,170	1.28	71	617		104	151	
HASHISH	196.489	4136.844	4.75	587	1,244	47.18	337	2,625		67	273	
Liq. HASHISH	4.870	23.407	20.8	-	46		5	23		3	8	
LSD	-	0.013		-	3,650		0	26		0	6	
OTHER HALLUC.	0.070	0.71	98.6		10		0	0		0	0	
TOTAL	890.123	5177.983	17.19	602	6,120	9.33	413	3,291	12,55	173	438	39.50
TOTAL AMOUNT	1085.571	5810.138	18.68	4115	215,903	1.91						

Source: processing from Narcotic Enforc. Central Service data.

Table l0a: Drug seizures, Italy, 1980-85 (kg)

	1980	1981	1982	1983	1984	1985
HEROIN	197.1	142.0	290.0	313.9	457.0	276.0
COCAINE	53.0	64.1	105.1	223.4	71.7	104.5
CANNABIS	4,907	11,204	4,899	5,179	6,056	1,449

Table 11: Seizures and people charged with drug-trafficking and passing And of drugs. Per age range (A), per sex (B), 1983

	SEIZURES		A:	–18		18-25		26-40		+40		Italian	Foreign
	Kg	No.	B:	M	F	M	F	M	F	M	F		
Rome	1,023	1,229		25	2	696	113	804	133	174	47	1,612	382
Italy	5,800	7,771		401	69	7,202	1,030	4,792	625	891	176	14,166	1,018

Source: Narcotic Enforc. Central Service – Ministry of the Interior.

Table 11a: People charged with drug trafficking

	1980	1981	1982	1983	1984	1985
ITALY	7,783	9,469	12,982	15,184	17,876	18,57
ROME	–	–	1,213	1,130	1,435	–

Source: Narcotic Enforc. Central Service – Ministry of the Interior.

Table 12: Seizures and people mentioned for “Small quantity”. 1983.

	SEIZURES		PEOPLE MENTIONED	
	Kg	No.	Italian	Foreign
LATIUM	0.254	114	185	3
ITALY	11,180	1,958	2,958	209

Source: Narcotic Enforc. Central Service – Ministry of the Interior.

Table 13: Viral hepatitis among addicts under treatment, per age range and per sex, Latium 1984, addicts assessed 778 (570 M; 208 F).

Age (y.)	15-19		20-24		25-29		30-39		40-44		Unre-corded		TOT. 100%
	N	%	N	%	N	%	N	%	N	%	N	%	
MALES													
Non-Hepatopatients	58	14.8	125	32.0	120	30.7	37	9.5	4	1.0	47	12.0	391
Hepatopatients													
A – HeP.			5	55.6	3	33.3	1	11.1	-			-	9
B – Hep.	7	6.1	55	47.8	43	37.4	9	11.1	-		1	0.9	115
NA – NB	1	14.3	1	14.3	2	28.6	3	7.8	-			-	7
undetermined	6	12.5	18	37.5	16	33.3	8	42.8	-			-	48
Total	14	7.8	79	44.1	64	35.8	21	16.7	-		1	0.6	179
FEMALES													
Non-Hepatopatients	17	11.8	76	52.8	34	23.6	15	10.4	2		1.4	-	114
Hepatopatients													
A – Hep.	1	100.0	–	–	–	–	–	–	–		–	–	1
B – Hep.	8	19.5	22	53.7	10	24.4	1	2.4	–		–	–	41
NA – NB	1	20.0	–	–	3	75.0	–	–	–		–	–	4
undetermined			5	27.8	8	44.4	–	–	–		5	27.8	18
Total	10	15.6	27	42.2	21	32.8	1	1.6	–		5	7.8	64

Source: I.S.S – Abusive Drugs Sect. – Clinical Biochem. Depart.

Table 14: Trend in hepatatis (Acute B-H, Chronic-H, nB-H) and addicts involved, treated in the main specialist hospital in the district of Rome. and total number of cases in Rome, 1973-80

Year	Hepatopatients		Addicts		Hepatitis in Rome Total
	ACUTE B Hep. + CHRONIC	nB - Hep.	No.	(%)	
1973	238	599	17	(2)	2308
1974	467	275	47	(6.3)	1413
1975	519	255	49	(6.3)	1337
1976	520	388	42	(4.6)	1847
1977	484	265	85	(11.3)	1497
1978	474	348	88	(12.1)	1445
1979	535	254	172	(21.8)	1401
1980	595	288	148	(16.8)	--

Source: G Visco – L Spallanzani Hospital – April 1980

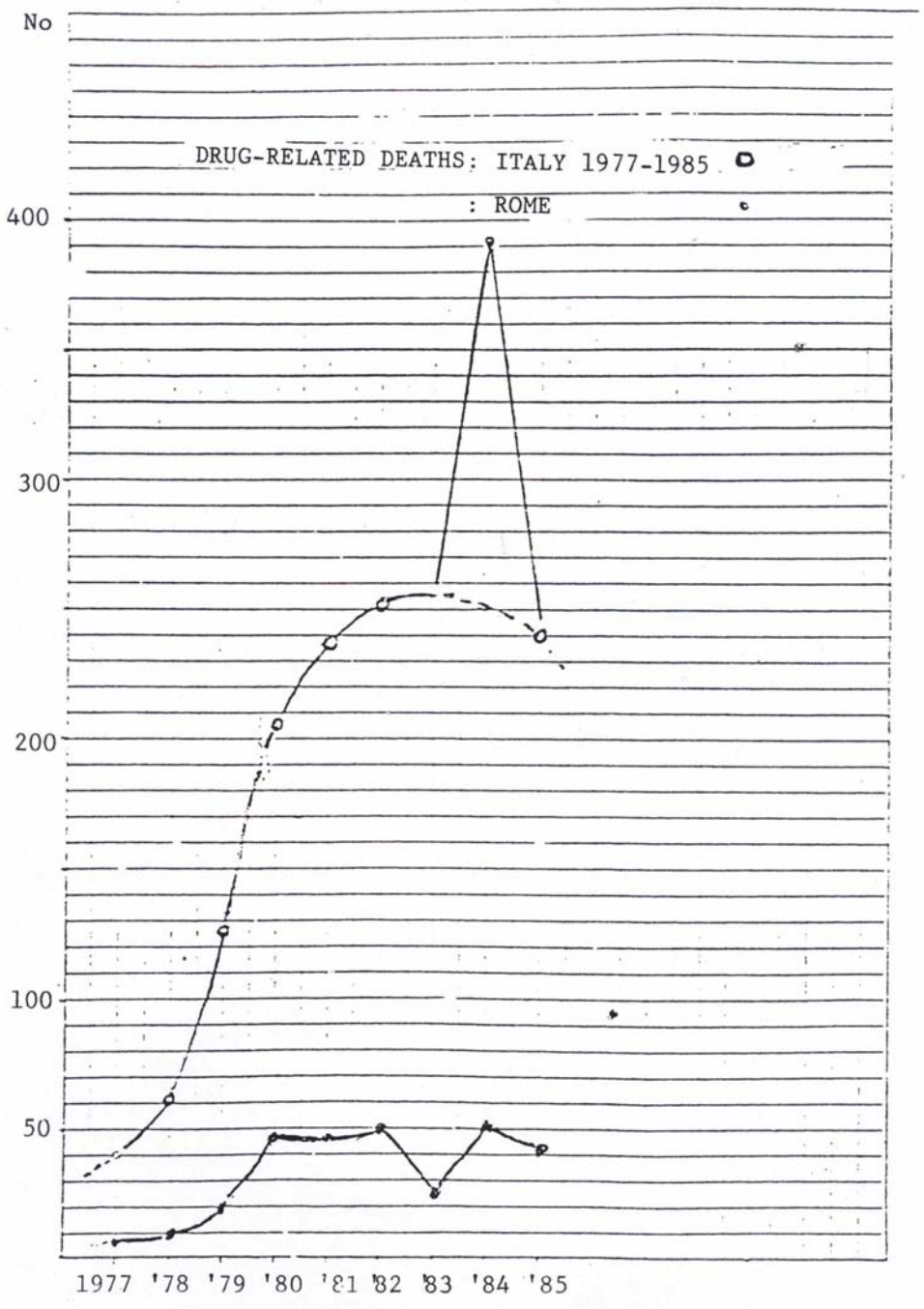
L Spallanzani Hospital is a structure specialising in both the treatment of addicts and the treatment of infectious diseases. Approximately 50% of hepatopatients in Rome are cared for in the L Spallanzani Hospital.

Table 15 Persons reported by the police (charged for drug offence), imprisonments and other reports, Rome, 1982-85

Year	For trafficking		For small quantity (personal use) and other drug users
	reported	imprisonment	
1982	1,745	1,565 (90%)	569
1983	2,164	1,925 (89%)	510 <r
1984	2,373	2,184 (92%)	492
1985	2,416	2,128 (88%)	652

Source: Drug Enforcement Central Service – Ministry of the Interior.

Figure 1


No
DRUG-RELATED DEATHS: ITALY 1977-1985
: ROME
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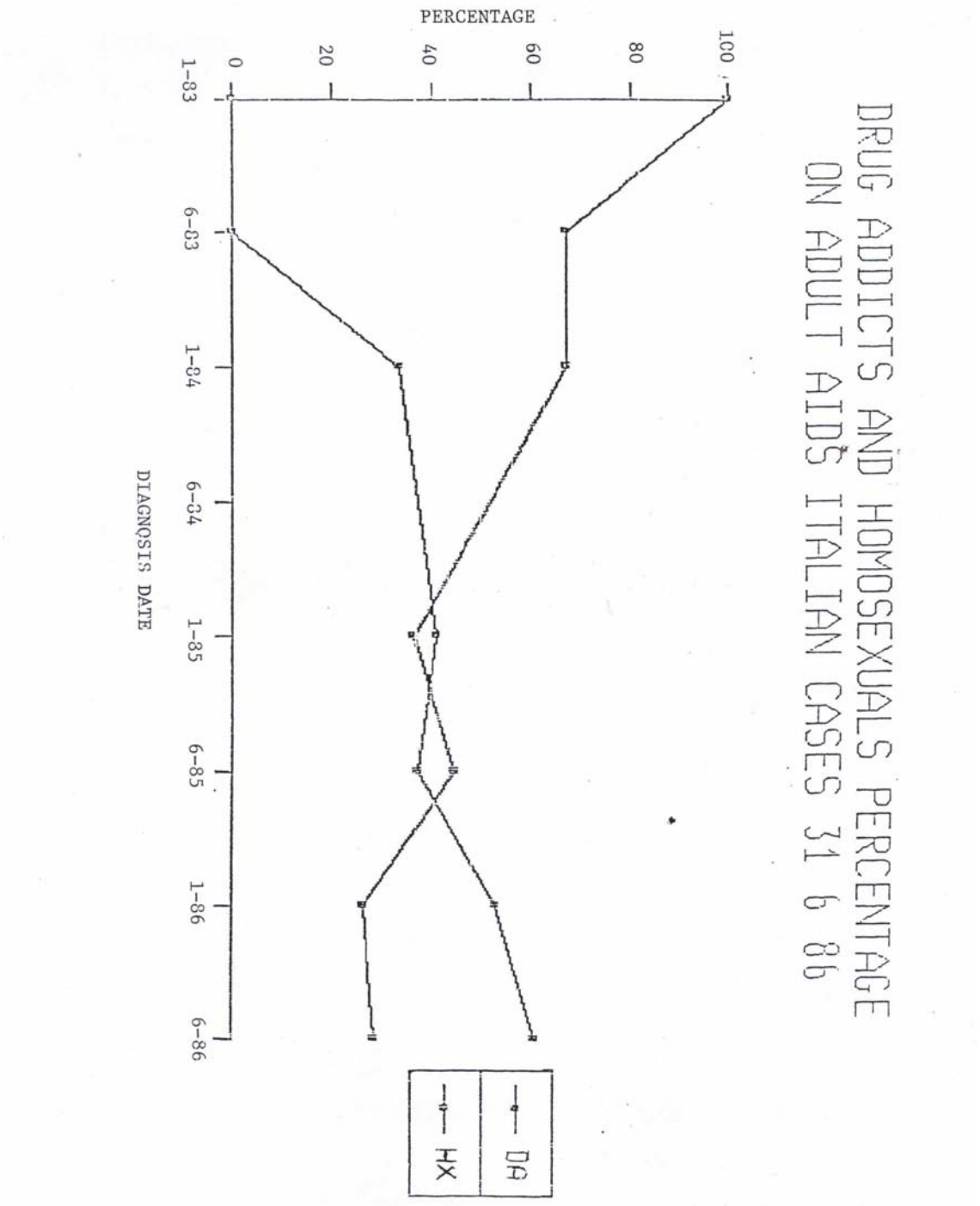
300
200
100
50
1977 '78 '79 '80 '81 '82 '83 '84 '85

Figure 2


DRUG ADDICTS AND HOMOSEXUALS PERCENTAGE
ON ADULT AIDS ITALIAN CASES 31 6 86
PERCENTAGE
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APPENDIX III

DEFINITIONS AND CONCEPTS

AIMED TO IMPLEMENT COMPARABILITY -OF INDICATORS AND RELIABILITY OF ESTIMATIONS AS WELL AS OF ASSESSMENTS OF.DRUG ABUSE (Proposal for discussion)

DRUG USER – A PERSON WHOSE BODY FLUID DISPLAYS THE PRESENCE OF A DRUG AND/OR ITS METABOLITES WITHIN THE THRESHOLD VALUE OF THE ADOPTED METHOD.

If .we use methods with a threshold value of 10 ng/ml of MORPHINE equivalent, the DRUG USER, as defined above, corresponds to a "DAILY and REGULAR (WEEKLY) USER".

Opiate users aged 17-29 years numbered 108,000 according to a survey carried out in Italy (1982) on over 36,000 young men from the general population. This research was carried out by means of chemical clinical methods, as above (Project TO.DI.2). The figures so obtained (by carrying out research on the general population) supply the only feasible objective estimation of the extent of the submerged portion of users/addicts.

ADDICT – DRUG USER WHO NEEDS THE HELP OF SOCIAL AND HEALTH SERVICES. REGARDLESS OF THE KIND OF TREATMENT HE OR SHE WILL RECEIVE (PHARMACOLOGICAL, PSYCHOLOGICAL, FAMILY OR COMMUNITY REHABILITATION TREATMENT, etc) OR WHO COMES INTO TOUCH WITH PUBLIC INSTITUTIONS FOR OTHER REASONS (ILLICIT ACTIVITIES, ARRESTS, CONVICTIONS, etc).

APPENDIX IV

REQUIREMENTS QF INDICATORS OF USE IN PLANNING TECHNICAL OR POLITICAL MEASURES TO COMBAT OR REDUCE DRUG ABUSE

AVAILABILITY	immediate to arrange
RELIABILITY	directly related to the problem multi-stage depending on the whole
COMPARABILITY	nationwide Internationally among trends
FEASIBILITY	at once depending on changes in laws or in regulations
OBJECTIVITY	the operator should be ideology-free and prejudice-free
BENEFIT/COST	can be obtained by comparing the “quality” and the “meaning” of the result with those of the other,?

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REPORT ON DRUG MISUSE IN STOCKHOLM

by

MM B Olsson and L Lenke

INTRODUCTION

This report contains a relatively extensive description of the drug situation in the greater Stockholm area. It constitutes a part of the “multi-city” study conducted by the Pompidou Group within the Council of Europe. The long-term goal of this study is to reach an understanding of the drug abuse situation in respective participating cities (countries) by relating such aspects as the development of abuse problems, present drug abuse patterns, control and treatment methods, etc. This understanding could be developed into an active communication process (framework of communication) based upon the descriptions of the drug abuse situation in the respective cities.

For approximately 20 years now drug abuse has been recognised as a serious problem in Sweden. Over that time a number of research efforts have attempted to clarify the extent of the problem. Statistics have been made available by various authorities in contact with narcotics problems. To a large extent, these statistics can be used as indicators of the character and extent of the abuse situation. Certain research projects have been conducted over a number of years and can therefore be used to investigate the development of the abuse problem.

This report attempts to describe and judge the current situation, as well as to note trends in the development of the drug problem during the period for which data are available.

The quality of available data varies greatly, as does the suitability of generalising from research subjects to larger groups. Therefore, the reliability of the data presented is also discussed. A demographic overview of the greater Stockholm area is presented as background to the study.

A. DESCRIPTION OF THE CITY

The greater Stockholm area is in principle the geographic region to be considered by the study. There is, however, no formal designation for this region; the term is used to describe a large urbanised area. The formal designation which most nearly covers the area under consideration is Stockholm County. Stockholm City is another region with formal boundaries which will be used in this study. In the historical description of the development of drug abuse problems, Stockholm City is most often used as the study area as abuse was noted as a problem there at an earlier stage. The study of the present situation refers most often to Stockholm County since the problem has now spread to suburban areas. In certain cases data is available for only the County or only the City, and in these cases there is some deviation from the above principle. Clarification as to which area is being considered is given in the course of the study.

A.1 History of drug misuse

In this section we will try to give a short description of how the use and abuse of certain drugs have developed. The general description refers to the country as a whole, but is valid for Stockholm City and County as well.

The period before 1965

Opiates (opium, morphine, heroin etc) were abused to a limited extent. This misuse was mainly a phenomemon among physicians and persons in medical care who became dependent. The physicians often prescribed drugs generously to persons dependent on them. Early assessments claim that Sweden had approximately 200 persons addicted to opiates, most of them known and in contact with physicians. In the early sixties this picture began to change; the abuse started to spread among groups who previously had not used opiates.

Cannabis is another drug not so commonly used in Sweden before 1965. Before 1965 cannabis had been smoked in small groups of jazz musicians and other artists, but at this time it became a popular drug among the youth.

Misuse of other medical substances originally started with barbiturates, but over the years a variety of psycho-active drugs have been produced. Many of them have caused dependence. This type of misuse started in the beginning of the 20th century and has been growing ever since. No continuous control of prescriptions of drugs has existed. Later on psycho-active drugs other than barbiturates arrived on the market, eg Heminevrin in 1959, Librium in 1960 and Valium in 1962. Fairly widespread abuse of these substances developed, often in combination with other narcotic drugs and alcohol.

Typical for the Swedish drug scene is the high consumption of central nervous system stimulants (CNS). These drugs were originally introduced for a variety of medical purposes, but soon became popular for misuse. Amphetamines were the first synthetic CNS. They came into medical use in 1935 and were introduced on the Swedish market in 1938 as Phenedrin and Benzedrin. At the beginning they were

sold without a prescription and were openly recommended in newspapers and professional journals. The consumption increased rapidly. During the first six months of 1938, 140,000 tablets were sold; this figure increased to 260,000 tablets during the last six months. In 1939 new rules were introduced and it became impossible to buy amphetamines without a prescription. After a temporary decrease in consumption it soon started to increase again. In 1942, 6 million tablets were sold and in 1942/43 the total number of users was assessed at 200,000 persons, which corresponded to *3%* of the adult population. Most of them were occasional users, but many used amphetamines often and in high doses. It was calculated that 3,000 persons had a consumption of 5 to 10 tablets per day, while 200 were heavy abusers with a consumption of up to 100 tablets per day. This oral abuse of amphetamines was already widely spread a couple of years after the introduction on the market. During 1943 the authorities succeeded in reducing the legal consumption by approximately *50%* through new instructions to physicians. As from 1944 amphetamines were treated in parity with other narcotic drugs.

The early CNS abuse was individual in its character, but soon it became a social and collective abuse when it started to spread among new groups, eg musicians and other artists. The first groups of this type were established in Stockholm during the mid-forties. Small-scale misuse of amphetamines probably took place in certain asocial groups already at this time. The situation became more severe when the injection technique was taught in about 1950. The CNS used originated from doctors' prescriptions. Phenmetralin and Preludin were introduced in 1955 as substances used in slimming programmes. The situation rapidly became problematic. Voices were raised in favour of legally classifying these substances as narcotic drugs. This was done in 1959. That year the legal selling of CNS was as high as 33 million tablets. In 1961 the number of CNS abusers was estimated at 2,000 persons, a number that was continuously increasing. When the legal availability of CNS was limited, the illegal import increased. In 1965 the legal selling had decreased to five million tablets. Despite this fact the number of abusers was increasing as well as the illegal import and selling. As from 1968 CNS could be prescribed only by obtaining special authorisation from the National Board of Health and Social Welfare in each individual case.

<u>1965-1969</u> – During this period more and more attention was paid to drug abuse and from that time on it was generally considered a serious social and medical problem. The abuse became concentrated in groups of young people, the differences between the sexes decreased and the abuse continued to grow. This growth was almost entirely ascribed to cannabis abuse, while the abuse of CNS stagnated at the end of this period. The limited LSD abuse decreased. The surveys at this time do not give any information about opiate abuse. At the hospitals the total number of drug abusers increased from 556 in 1966 to 697 in 1968. Between these years the proportion of CNS abusers in hospitals was doubled. Within the psychiatric hospitals and clinics the number of persons with the diagnosis narcomania (primary and secondary diagnosis) rapidly grew from 1,614 persons in 1965 to 5,233 in 1967. Also in this group the abusers became younger and younger.

To sum up: during this period the authorities dealing with drug problems came into contact with a rapidly growing number of drug abusers. The abuse spread to new groups, both under 20 and over 30 years old. In the total population there was a substantial increase in the number of persons who tried drugs, mainly cannabis smoking. The abuse of CNS levelled off. In a case-finding study in Stockholm and its suburbs the total number of heavy drug abusers was estimated at 3,000 persons in this area and 3,000 in the rest of Sweden.

1970-1982 – During the seventies and up to the present day several surveys of different groups of young people have been carried out in Sweden. The most important surveys – among school-children and conscripts – indicate no increase in the use of drugs. Among pupils in class 9 the number who had tried drugs decreased from *15%* in 1971 to *Q%* in 1982. Among 18 year old conscripts the number who had tried drugs remained almost unchanged during this period. In both 1971 and 1982 the figure was *1Q%*. The number of persons abusing drugs at present is much lower; *2%* of the pupils in class 9 and 3.7% of the conscripts reported that they had tried drugs during the last month. In 1980 the total number of persons under 25 years who had tried drugs was estimated at 200,000 persons of whom 30,000 had used drugs during the last month.

Changes in heavy drug abuse during this period are more uncertain. No continuous surveys have been done. Existing indicators are often linked to drug offences and they probably say more about changes in legislation and police resources than about drug abuse. As mentioned above, the total number of heavy drug abusers in Sweden in the late sixties was estimated at 6,000 persons, mainly abusers injecting CNS. During 1979 a nation-wide case-finding study on heavy drug abuse was undertaken, ie persons mainly injecting drugs or with some other kind of daily abuse. For the whole of Sweden, the scale of heavy drug abuse is assessed at 10,000-14,000 persons. Of these, 7,500-10,000 are injection-abusers, of whom 1,500-2,000 inject daily or almost daily. *60%* of the estimated total heavy drug abuse was reported from the metropolitan areas.

Over 80% of the injection abusers used CNS, *30%* used opiates (mainly heroin), while few of the persons reported using cocaine. Cannabis use is quite marked in all the sub-categories included in heavy drug abuse. The findings of the study indicated that multiple drug abuse is extremely common. Few abusers seem to stick to a single drug. It is also extremely common at the same time to misuse alcohol as well.

A.2 General policy; legislation

Swedish drug policy can be categorised as restrictive and the parliament has declared the goal to be a drug-free society. The drug policy can be divided into four main categories: information, prevention, control and treatment.

Information will increase the knowledge of drugs and their effects on man and society as well as influencing attitudes towards drugs. Information is given both by public and private organisations, eg client organisations and other interest groups. The public responsibility for drug information rests mainly with the National Board of Health and Social Welfare, the National School Board and CAN (the Swedish Council for Information on Alcohol and Other Drugs). Documentation concerning drug research is also centralised by CAN, whose task is also to follow changes in the drug situation.

Prevention includes both what is usually called primary and secondary prevention. Primary prevention is considered to mean general political activities to increase the standards of living, ie measures to combat unemployment, to improve education and housing, etc. Secondary prevention involves activities directed towards risk-groups, aiming at limiting their drug use. The responsibility for secondary prevention – such as leisure-time activities, counselling etc – rests mainly with the local communities according to .the social services legislation.

The control system is based on legislation which regulates the use of substances which, either through international convention or through Swedish legislation, are classified as narcotics. The most important laws in this regard are known as: "Narcotic Ordinance" (narkotika Forordning), "Penal Law on Narcotics" (narkotika strafflag), and "Law on the Penalties for Smuggling of Goods" (lagen om varusmuggling). The Penal Law on Narcotics contains paragraphs which were drawn in 1968 from an earlier narcotics "ordinance" and which increased the maximum penalty for drug offences from one to four years in prison. Later stiffening of this law has increased the penalty to 10 years (12 years if the narcotics offence is committed in conjunction with another offence).

In general, one may say that recent, tougher Swedish legislation on drugs has given the police greater authority to intervene in personal affairs. For example, one particular law gives the police the possibility, with a court order, to tap telephones of persons suspected of serious drug crimes (including cannabis trafficking on a large scale).

On the other hand, according to Swedish law the actual use of drugs is not criminalised. In practice, however, users in possession of drugs are breaking the law. Prosecutors have the option of not pursuing cases involving small quantities of drugs "intended for personal use". However, these lavs have been strengthened considerably since 1980, and this is reflected in criminal statistics. A more detailed description of Swedish legislation on narcotics is given in Appendix IV.

The Swedish drug rehabilitation system attempts to build a complete chain of treatment, including identification activities, open and closed wards, and follow-up care. This treatment chain is established within the framework of existing social and medical services. According to law, the responsibility for medical care rests with local government at the level of the county (Lan), while responsibility for social services lies at the level of the city or township (primarkommun). This means that most official Swedish drug treatment consists of detoxification and limited therapy within the medical care system, and institutional rehabilitation centres under the social service system. Places for drug abusers also exist under the auspices of criminal and family care authorities, and some treatment is administered by foundations and volunteer organisations. Young abusers may also be cared for by schools, treatment homes, and psychiatric clinics especially for children and young people.

The bulk of Swedish drug treatment is voluntary, that is to say that the abuser seeks care himself. However, social authorities are empowered by two 1982 laws to assign drug abusers to care against their will. According to LVU (Law on the Care of Youth), treatment can be provided without consent to those under the age of 18 if there is sufficient evidence that inadequate home care or the subject's own behaviour puts his or her health or development at risk. Those who are assigned care under LVU because of their behaviour may be held until they reach the age of 20. Most young abusers who are committed in the Stockholm area are treated under this law. Through a second law, LVM (Law on the Care of Abusers), older alcoholics and drug abusers who are in need of emergency care can, under certain circumstances, be provided treatment regardless of consent. In order for LVM to be exercised, it must be decided that care through other laws would be inadequate and that the abuser is placing his own and/or someone else's well-being in serious danger. Extremely few drug abusers are cared for under LVM. Within the medical care system, treatment of abusers is allowed without consent under some circumstances through LSPV (Law on Enforced Psychiatric Care).

A.3 Demographic information

In 1983, Stockholm County had 1,544,454 residents living in 2r4 municipalities. The largest of these is the City of Stockholm with 649,686 residents. Two municipalities have populations of between 75,000 and 100,000; five have from 50,000 to 75,000 residents; nine have from 25,000 to 50,000 and seven have fewer than 25,000 residents. Apart from a few areas it can be said that the whole region is a single urban entity.

Table 1 (Appendix I) gives age and sex breakdown for Stockholm County and City.

During the past 20 years, the population of Stockholm County has grown by approximately 240,000 while the population of the City of Stockholm has decreased by over 150,000. These changes are of course largely due to movement to suburban communities.

The areas covered by Stockholm City and Stockholm County are 185 km2 and 6,500 km2 respectively.

The 1983 unemployment rate among young people under 25 is 1.3% in Stockholm and 3.7% in Stockholm County (Stockholm County 1985 = 3.2%). The figures refer to unemployed persons who have at least once during the past two months applied for a position of employment.

A.4 Surveys on drug misuse

Drug use patterns among youth

The drug abuse situation in regard to youth is studied primarily through surveys of students and military conscripts.

Drug use among the youngest students (grade six, twelve years old) is, according to surveys, at a relatively low level. Only a small percentage reply that they have ever tried drugs. Among 15 year old students in grade nine (Stockholm County 1980) the percentage grows to 13% of the boys and 15% of the girls. This research also shows that 3% of the boys and 2% of the girls had used drugs in the last four weeks before the survey.

In Stockholm City in 1981, 22% of the boys and 23% of the girls had at some time used drugs. This is a dramatic decrease from a 1971 study, i" which comparable figures were 35% for boys and 30% for girls, *For* the most recent years, research is lacking for both Stockholm County and City, but figures from the entire country indicate a continuing decrease in drug use among youth during the years 1981-83. This trend probably applies as veil to the Stockholm region.

Among 18 year old military conscripts from the Stockholm area, the percentage of those who at some time had used drugs grew from 31% in 1977 to 38% in 1980. After this, the figure has fallen every year to 23% for 1983. 19% for 1984 and 14% for 1985. The number of persons who had used drugs in the last month has decreased from 8.9% in 1980 to 1.4% in 1985.

According to research, cannabis is far and away the most commonly used drug. This holds true for those who have experimented only a few times as well as among those who are regular drug users. The research also shows that those who use drugs are more likely than non-users to abuse alcohol, prescription drugs, paint thinner, etc. Cannabis smoking can best be seen as a complement to other abuse, primarily alcohol abuse. Drug abuse appears still to be concentrated in the larger cities although the dominance of the cities has decreased somewhat. Cannabis smoking occurs at some levels over virtually the entire country.

The extent of heavy drug abuse

From the end of 1978 until the summer of 1979 a case-finding study was performed by UNO (the Swedish Committee on the Extent of Drug Abuse) with the intention of calculating the extent of heavy drug abuse. (See also section A.I).

After correcting the data with consideration for incomplete and incorrectly classified information, UNO judged the total number of heavy drug abusers (1) in Stockholm County in 1979 to-be 3,000-4,500 persons, or two to three abusers per 1,000 residents. Of these, 2,700-3,700 were taking drugs intravenously, and 650-900 injected on a daily or near-daily basis. According to this study, Stockholm County accounted for approximately 30% of the total heavy drug use in Sweden. Of the heaviest abuse, that is daily or virtually daily injection of narcotics, Stockholm County accounted for 45% of the nation's total.

Drug abuse began to spread widely during the mid-to-late sixties, primarily in Stockholm, and by 1967 a case-finding study had already been performed to determine the extent of the problem. From this study, one can estimate that the number of intravenous abusers was approximately 3,000, compared with 2,700-3,700 in a 1979 study. This Indicates that there has not been a great change during these 12 years. During the earlier years, central nervous system stimulants were almost alone as injected drugs, but by the end of the seventies heroin had entered the picture and "mixed-abuse" had increased.

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(1) Heavy drug abuse is defined as all abuse in which injection is the primary method of intake as well as all other daily or near-daily abuse.

According to a recent case-finding study undertaken in 1984, the number of heavy drug abusers was estimated to be approximately 3,000 persons ie the same level as in 1967 and 1979. One change is that cannabis and amphetamines became more common in 1984 than in 1979. Instead, heroin use seems to have decreased.

From the limited sources available to assess the current situation with regard to heavy drug abuse, statistics on drug-related deaths show a picture largely unchanged since 1979. Law enforcement estimates based on institutional records indicate that there has been no readily obvious change in the number of abusers who come into contact with the criminal justice system. There has, however, been a notable increase in the quantity of narcotics confiscated by police and customs officials as well as an increase in reported offences against drug laws. These increases can be interpreted as improved efforts by customs, police, and prosecutors rather than an increase in drug use. Declarations on the drug situation are made by various authorities in Sweden to a narcotics group within the national crime prevention authority. These reports are based primarily on current contacts with regional and local bodies within the respective authorities' field of responsibility. The latest reports to this narcotics group indicate that local authorities are reporting no change in the extent of heavy drug use.

Most heavy drug users are between 20 and 30 years old. The number of men is considerably higher than the number of women, and most heavy abusers have had, in some way, a difficult growing-up process. They have often been raised in broken homes, and a large proportion have had problems in school and left with inadequate skills. Many began early to use alcohol or other dependence producing substances, and most have been called to the attention of social authorities from an early age.

Heavy drug use is dominated by central nervous system stimulants, and increased access to stimulants has been reported for some time. Abuse of opiates – almost exclusively heroin – constitutes a permanent and extensive trend within the abuse picture. However, heroin abuse seems to have decreased somewhat over the last few years. Cannabis is abused to a greater or lesser extent by virtually all heavy abusers. Similarly, prescription drugs and alcohol play a significant role in the total picture of many heavy abusers. Few serious drug abusers restrict themselves to a single substance; "mixed-abuse" appears to be more the rule than the exception among heavy users.

If available data are correct, heroin abuse increased during the late seventies at the same time that amphetamine use decreased. This development seems to have reversed during recent years. An explanation for this could be that most heavy abusers have a long history of amphetamine use behind them, but that limited availability of stimulants during the last half of the seventies caused part of the group to use heroin periodically. One simply used the substance that was available, and as amphetamines became more readily available again former patterns of abuse returned. Addicts seem to go from one substance to another largely on the basis of availability and price.

The present situation

The nearer one comes to the present time, the more difficult it becomes to give an accurate overview of the narcotics situation. This is of course largely due to the fact that statistical information is not yet available for the most recent periods. In order to describe today's picture, one must rely on qualitative observations received from the field. However, when statistics become available, it should be possible to quickly obtain information in certain areas.

There presently exists nothing in these observations that points clearly towards change in any particular direction; carefully stated, there is little evidence that any dramatic changes are underway. Developments in recent years, however, indicate that a large part of today's youth is taking a strong stand against all dependence-producing substances; there is a growing consciousness of the ill-effects of drug abuse, and more and more young people are actively opposed to drugs and alcohol.

At the same time, there are reports that cause concern. Several treatment units are noting that they receive younger and younger heavily-dependent abusers, with serious, daily cannabis use often dominating the picture. Many units experience difficulty in treating this group. One unit that has observed this problem is the Maria Youth Unit in Stockholm, where statistics show the composition of the client group to have changed so that cannabis use now completely dominates. On the other hand, there are indications that heroin use has decreased appreciably in the client group. However, it is presently uncertain whether these figures represent the larger situation.

Another troubling development is that the police have lately made confiscations (seizures) of cocaine at the street level. In spite of the fact that cocaine seizures are not increasing as a whole, the presence of cocaine on the streets can indicate that the narcotic is gaining a foothold among traditional circles of abusers. Availability of amphetamines as estimated by the number of confiscations (seizures) appears to remain quite widespread. Also, information is being received that amphetamines are now commonly sniffed. The trend is disturbing as this method of ingestion can readily lead to a situation where cocaine sniffing becomes a practice.

This information appears quite contradictory. On the one hand, many young people are actively opposed to drug use, while on the other, younger abusers are coming into contact with drug treatment units. However, both sets of information can be true. It would appear that a polarisation of sorts has taken place in recent years with regard to substance abuse in general. This polarisation is most apparent with alcohol abuse, but is clearly true as well with drugs – especially "hash". Greater numbers are saying no to any contact at all with drugs while those who are occasional users seem to be increasingly moderate in their consumption. The opposite pole is represented by the group of very heavy abusers, a group which makes up a minority and apparently has not grown larger in recent years, but which now has younger and more deeply addicted members. Today's heavy abusers consume more drugs than ever before, with the result that many are quickly debilitated – medically, psychologically, or socially – and come into earlier contact with social and/or law enforcement authorities.

A.5 Treatment and social care systems/facilities

Social service

According to social service law, it rests upon social authorities to ensure that those in need of help receive the assistance they require. This means that, among other things, the regular social service manages outreach programmes and out-patient therapy for abusers. In 1982 there were 12 out-patient units for drug abusers in the form of “advice bureaux”. In addition, some communities have assembled narcotic teams which perform field work such as prevention education and recruiting of clients to other forms of treatment.

There are over 350 beds in Stockholm County for drug abusers in therapeutic communities, collectivities and similar institutions. About one third of these are reserved for people under the age of 18. An eight-bed treatment centre for pregnant women was set up in 1984, and a 20-bed unit for compulsory treatment in 1985.

Medical care

Care for somatic illnesses and other complications is administered by medical units. Detoxification, motivation therapy, and psychiatric care are administered through psychiatric units. There are 78 of these beds directly reserved for drug abusers, but the number cared for in psychiatric units is significantly higher. In 1979, approximately 500-600 persons were treated by the county’s psychiatric units with drug addiction as the primary diagnosis. An estimated 100 of these were court-ordered care cases under the law requiring closed-ward psychiatric care (LSPV).

A limited methadone maintenance programme is run within the medical care system. Approximately 50 of the 70 clients in Sweden’s only methadone prescription programme come from Stockholm County, while another 18 persons receive methadone treatment from individual doctors under the direction of the National Board of Health and Social Welfare.

Care within prison

Many drug abusers, due to offences against narcotic laws or other types of offences, find themselves in prison or local jails. In order to provide care for convicted drug abusers, certain treatment facilities have been created in recent years within the framework of the criminal care system. There are at present 60 treatment places for drug abusers at Osteraoker prison, which receives offenders from throughout the country. In addition, a team has been created in association with Stockholm remand prison specifically to deal with drug abuse problems. Apart from general information and discussion contacts, this team also provides therapy and psycho-social work. During a one-year period in 1982-83, the team had contacts with 199 abusers.

A.6 Control systems and resources (law enforcement)

The apparatus for the control of narcotics has been the object of dramatic growth since the middle of the sixties. Swedish customs now run their own intelligence-gathering agency against drug smuggling, and special units have been established in Stockholm, Gothenberg, and Malmo. The fight against narcotics has the highest priority among all of the approximately 2,300 customs offices in the country.

Beyond customs officials, it is primarily police agencies which have responsibility for control of narcotics. Responsibility for the collective management of police agencies has since 1965 rested with the National Police Administration, a state organ which oversees the Swedish police. At the local level special narcotic squads have been created in every county. These squads are connected with police resources of some 300-500 persons, in addition to approximately 200 local policemen. A squad of about 80 operates in Stockholm for pursuit of serious narcotic crimes, as well as approximately 50 persons in different districts with activities aimed at street transaction.

In 1984 the total number of policemen in full-time work on drugs and drug-related criminality was estimated at 123 in Stockholm City and 48 others in Stockholm County.

A.7 Monitoring systems

No monitoring system has been set up in Stockholm (or elsewhere in Sweden). Instead, different types of routine information are provided by authorities working with the drug situation. This generates a variety of statistics and survey data, presented separately and with little co-ordination. Since 1985, CAN (the Swedish Council for Information on Alcohol and Other Drugs) has the public responsibility for collecting and analysing drug data and for regularly reporting changes in the drug situation. Among other things, CAN is developing a “regional reporting system” (early warning system), where “key-persons” regularly report what is happening in the drug field. Stockholm City and parts of Stockholm County are included in the system. The information from this system will be co-ordinated and analysed together with other statistics and survey data to give a better picture of the Swedish drug situation. The work within CAN also covers alcohol and abuse of medical substances.

B. INDICATORS

B.1 First treatment demand

No routine data on treatment demand is available and in general it is difficult to acquire very precise information on the total number of drug abusers who receive care through the various treatment centres described above. This is especially true with regard to those treated in open wards. We therefore do not attempt to estimate here how many persons yearly come into contact with one or more of the treatment units named above.

Instead, the above information on numbers of beds, etc, should be taken as a point of departure for an approximation of respective size of the various treatment units.

It follows that we are not able to provide a precise figure on the total treatment population. A certain amount of research has however been carried out on various treatment units. A few studies are presented as examples of how these populations may be viewed.

Within the "BAK" project (Behandlingsforskning Avseende Klienter inom narkomanvfeorden) a study has been made, among others, of which types of clients come to the various treatment units. Preliminary results now exist from interviews with 1,227 clients admitted to 31 treatment units in 1983. The greatest share of the clients were from Stockholm City and County. Of the 31 units, 17 were therapeutic communities and collectivities, nine were for youth, four were special drug treatment units within the medical care system, and one was a special treatment unit within a prison. 69% of the interviewees were men and 31% women; the average age was 26. Breakdown according to age and type of treatment unit is given in Table 3 (Appendix I).

The "growing-up situation" for these individuals was characterised to a very large degree by broken homes or families with serious friction. 61% of the subjects had grown up in homes that split up before they reached the age of 16 or had been born out of wedlock. 55% reported serious tensions in their families. Many had incomplete schooling – 21% had not completed grammar school – and a majority (67%) were unemployed during the most recent period before being admitted to treatment.

Narcotic abuse during this year was dominated by central nervous system stimulants. 45% reported amphetamines as their main form of abuse, 31% cannabis, 19% opiates, and 5% other substances. 75% reported daily or virtually daily abuse. While one substance could dominate, mixed abuse was common, with alcohol, tranquillizers, sleeping pills, or glue-sniffing often a part of the picture. 55% reported that they had abused alcohol as well as drugs during the past year, and more than one third had abused tranquillizers.

74% had been admitted to some institutional framework during the year before admission to the current treatment unit, primarily because of drug and alcohol problems.

The data presented above agree fairly well with other studies of the treatment population. It is therefore possible to conclude that this information gives a reasonably good picture of the group of abusers in treatment centres, collectivities, and similar facilities.

Five adult units are run in Stockholm City or Stockholm County. The main difference between the findings for these and for former studies was that 43% of the former group were opiate (=heroin) abusers compared with 19% in the latter group.

B.2 Hospital admissions

Information on hospital admissions is not available on a routine basis. On the other hand the National Board of Health and Social Welfare is producing statistics concerning the number of discharges from psychiatric hospitals. The statistics also include drug addiction (ICD 9 classification). As the system operates today, only total figures are presented and with a time-lag of about five years. Without more rapid data collection and presentation, the statistics for hospital discharges are of less importance as an indicator of drug addiction in the greater Stockholm area.

Data can, however, be obtained from the internal statistics produced by each hospital. Some of these data are presented below to give a brief picture of the drug addicts treated at hospital units.

The Maria Youth Unit cares for those under the age of 20 who suffer from abuse problems. This is a joint effort between the social service and medical care systems. The unit includes extensive open-ward activities, a detoxification unit with 12 spaces, and an emergency reception service. The unit functions as a care base for further placement in treatment collectivities or in family care. Since Maria functions as a reception centre for the entire county, information received from there as regards substance abuse should give a good picture of the situation in the county as a whole.

During the period from 1978 to 1982, the total number of clients at the Maria Youth Unit grew by 69%. Between 1981 and 1982, cannabis abuse continued to increase considerably, while amphetamine abuse decreased somewhat. Heroin shows a continued decrease. The average age of the clients has decreased from 17.9 in 1981 to 17.3 in 1982. The majority of the clients are judged to be mixed abusers.

Between 1982 and 1985, the total number of clients diminished by 18% and the relation between the drugs used stabilised – cannabis at a lower level than in 1982. 65% of the clients in 1984 had their first contact with the unit this year.

Table 4 (Appendix I) presents the primary abuse substance among adult clients treated during 1982 at two of the special drug abuse treatment units within the medical care system (Danderyd and Huddinge hospitals). The third unit of this type in the county Sabbatsberg hospital – only gives the average number of admissions per month. In 1984 there were 29 admissions per month and in 1985 there were 37. The average time in treatment was 6.1 days in 1984 and 4.5 days in 1985.

Among the most important roles that the medical care system plays in the context of drug abuse is treatment of overdose cases and other complications. Therefore, substances that are easier to over-ingest and that cause more serious withdrawal symptoms are over-represented in relation to the total abuse picture. Accordingly, we find in these hospital units a relatively high (in the Swedish context) percentage of heroin abusers. Mixed-abuse is also high, while amphetamines show a lower share here than in other studies.

In 1982 the average age for Danderyd patients was 27 and for Huddinge 28. Women represented approximately one-third of the total in both units. Danderyd also reports the proportion of patients treated for the first time at the unit. In 1984 this proportion was 54% and in 1985 44%.

B.3 Viral hepatitis

According to the Swedish law on contagious diseases, each case of hepatitis must be reported to SBL (the National Bacteriological Laboratory). They present annual statistics on the number of cases of hepatitis B (and hepatitis Non A-Non B).

Like cirrhosis of the liver as an indicator of alcoholism, the reliability of using hepatitis as an indicator of drug abuse is limited by those cases which occur from other causes. However, taken as a whole, statistics from Stockholm have shown this indicator to have a strong correlation with other indicators. For Stockholm City and Stockholm County trends are given in Figure 2 (Appendix I).

B.4 Drug-related deaths

Sweden does not have an automatic system for reporting deaths caused by drug abuse. Statistics reported in official cause of death statements declare “drug addiction” when that is given as the primary or contributory diagnosis for the cause of death (ICD 9). However, the praxis between individual coroners in their use of this diagnosis varies. This is assumed to give rise to an unknown “dark figure” limiting the use of drug-related deaths as an indicator. The national trend is given below. Statistics for the greater Stockholm area are not available in the official statistics.

In the greater Stockholm area and the counties of Gotland and Sodermanland, a special investigation of drug-related deaths during 1975-1981 has been undertaken. In relation to the investigation, a special “dark figure study” was done. The results are presented in Table 5 (Appendix I). As can be seen, about one third of the cases of deaths were found in the “dark figure study”.

Clearly these statistics can, in their present form, only be taken as a coarse indicator of the extent of heavy drug abuse. Frequencies and their interpretation are affected by, among other things, the “dark figure”, the danger presented by various drug types, and the difficulty in determining an individual’s “membership” of the “drug addict population”.

B.5 Police arrests

Information on the number of drug addicts arrested by the police is not available (except for the “needle-mark study” presented in section B.10). Instead, other forms of statistics concerning drug-related police and court activities may serve as valuable indicators.

As regards the number of reported offences and persons who have been suspected of narcotic offences in Stockholm, the figures are given in Tables 6 and 7 (Appendix I).

Table 8 (Appendix I) gives the number of persons convicted for narcotic offences including summary fines by the prosecutor in Stockholm City and County, and the share that this represents of the total convictions in the entire country in 1980-1984.

B.6 Imprisonment

Imprisonment as an indicator of drug addiction can either be seen as the number of persons sentenced to imprisonment for offences against the drug laws – information possible to obtain but not regularly processed for the greater Stockholm area – or as the number of drug addicts in the total prison population. Information of the latter type is given by the National Board of Prison and Probation. Since the late sixties, annual estimations are made on one specific day each year. Some data for the greater Stockholm area are given in Table 9 (Appendix I).

A problem posed when dealing with such statistics is that they only estimate the point-prevalence and leave the incidence rate unknown. This is the reason why a classification system of new inmates with sentences of over two months has now been introduced. They are classified as non-addicted drug users or drug addicts. Among those imprisoned during 1983 in the Stockholm region, 19% were classified as drug addicts and 21% as drug users.

During the years 1976-80 an investigation was made of drug abuse among persons on remand in Stockholm. The object was to gain an idea of the proportion of alcoholics and drug addicts among them. There was also a wish to throw light upon the pattern of abuse and changes in it up to the probation, social and criminological background factors and their relation to the abuse and criminality. The investigation was made by means of interviews with a sample of all the persons on remand. Some results from the investigation – which has now ceased – are presented below. This investigation related chiefly to “heavy” drug abuse. In 1984 another study was undertaken in the same remand prison. The results are included in Table 10 and Figure 4 (Appendix I).

B.7 Seizures of illicit drugs

The efforts of customs and the police are aimed at, among other things, the seizures of narcotics. A description of the respective seizures of customs and the police at national level, divided by substance, is given in Figures 5-8 (Appendix I). Table 11 gives the number of seizures made by the police in Stockholm City and Stockholm County for the years 1983-1985.

B.8 Price/purity of illicit drugs

No systematic information is collected about price and purity of illicit drugs. However, this information will be included in the regional reporting system developed by CAN. In the future, therefore, it will be possible to have some information about price and purity of illicit drugs.

B.9 Survey data

Annual surveys are carried out among 15 year old students and 18 year old military conscripts. Both surveys are nationwide. The military survey always presents data for the greater Stockholm area, the school survey does not. Through a special design, data from Stockholm County is available for 1980, otherwise not. The local school authorities have carried out four school surveys covering Stockholm City. For the future, no regular local school surveys are planned. Some data from these surveys have been presented in section A.4.

B.10 Other indicators; comments on AIDS

An indicator which is used in Stockholm, and to which some value is attached in the Swedish drug control system, is the presence of needle marks on arrested persons. Investigation of arrestees has been practised since 1965 and shows how injection abuse has varied over time within the criminal sub-culture. This development is presented in Table 12 (Appendix I).

The advantage of using this indicator is that it is easy to administer, but it is limited by the fact that it shows only injection abuse and that it is connected to a certain population. The indicator functions best if one studies not just the number of drug abusers detected but also the number of arrestees, since the concentration of police activities can vary over time. It is naturally possible to use this method on other populations than arrestees.

Epidemiological research on drug related cases of AIDS is being planned but has not yet been carried out. Data will therefore be available in the future.

C. ASSESSMENT OF THE USE AND VALUE OF INDICATORS

Systems for control and treatment of drug problems have been discussed. This section deals with the indicators which are used to measure and describe developments in the field. Most of the data which can be used as drug indicators are produced and presented at national level. Nevertheless, many of them can be used to describe the drug situation at city or county levels.

C.1 Use of indicators in the city

Indicators at national level also available for Stockholm City and county:

1. Survey research concerning military conscripts and school-aged youth.
2. Criminal statistics: offences, persons charged, persons convicted.
3. Treatment statistics: number of admissions.
4 Treatment within prison: number of drug abusers treated.
5. Seizure statistics: police and customs.
6. Statistics on drug-related deaths.
7. Statistics on “addict hepatitis”

Indicators for Stockholm City and County:

Apart from these, the following indicators are also available:

8. Statistics concerning needle-marks on arrestees.
9. Statistics from hospitals and other treatment units.
10. Case-finding studies (1967, 1979 and 1984).

C.2 Relationship between indicators

With the help of these indicators, one can obtain a fairly good overview of drug abuse in the Stockholm area. Since the indicators are taken from a variety of sources, they should be weighed together against the background of the sources’ general organisational and legislative origins.

It should be noted in regard to this collection of data that Stockholm has a very limited legal research programme and that a comprehensive register of the “abuser population” is therefore missing. (In some research, the so-called “needle-mark population” has been used as a register where persons are identified.) Because of the high level of agreement between the various indicators as regards changes over time, such a register has been seen as unnecessary and is regarded as unsuitable from an ethical viewpoint.

When looking at the suitability of these indicators, two important considerations are quality and time aspects. By quality we mean here how well an indicator reflects actual changes in abuse, and by time how quickly an indicator shows trends and is available for analysis. A constant problem is the conflict that lies in the fact that the more fundamental the statistical declaration, the longer it takes to get a result. This problem is not great from the analytical point of view, where one attempts to follow and judge developments, but from the decision-making point of view it can be more troubling.

Among Stockholm's indicators, there are four which meet reasonable quality demands and which also could potentially be declared within a short timespan. These are listed as indicators 6-9 above. The judgement that they meet reasonable quality requirements is based on how they have functioned in relation to other data collection from indicators during the 20 years they have been used.

The required time lag of the indicators is dependent upon the character of the indicator and the functions of the administrative systems which produce the statistics. Investigation of the incidence of needle-marks on arrested persons can take place without testing or other analysis. The same principle applies to contacts with youth clinics, for example. Death cases require analysis while hepatitis cases require analysis and are further complicated by a two to five month incubation period.

That these timespans have been described here as "potentially" short is due to the fact that no one has yet attempted to produce immediate findings from the indicators. This should not be particularly difficult or expensive to accomplish, however, if one established an efficient reporting system within the respective authorities' fields. An important assignment for the expert group should therefore be to discuss the usefulness of indicators in relation to two categories – the quick and the slow – and to suggest how these can be administered and reported.

D. CONCLUSIONS

The examination of different indicators and surveys on drug abuse in the greater Stockholm area shows that it is possible to obtain a good picture of the extent of drug abuse as well as of its changes over time. However, to obtain this total picture it has been necessary to undertake extensive and time-consuming data collection and analysis. Many authorities and organisations are involved in the fight against drug abuse. Many – but not all of them – produce statistics concerning their activities which it is possible to use as indicators of the drug situation. The sets of statistics produced are not always homogeneous, different definitions are used, time and age intervals vary and often the final results are not presented together. These differences are primarily due to the original purpose of the statistics, namely as a basis for activities and not as indicators of drug abuse.

To avoid time-consuming and repetitive investigations in the future, it is thus necessary to improve the statistics (and surveys) used as indicators of drug abuse. One way of achieving this would be to give one organisation the responsibility for following changes in the drug situation. Then statistics and other forms of data could be collected and analysed where competence and knowledge are built up; it would probably also be easier to promote desirable changes in the statistics used. In Sweden an organisation with these tasks is at present being set up within the Swedish Council for Information on Alcohol and Other Drugs (CAN).

This leads to another important question, namely, will future European co-operation in epidemiology of drug problems refer to city-level – as in the multi-city study – or will it be extended to national level. In Sweden, CAN is working primarily at national level; the statistics are most often produced at this level. It is easier to argue and get resources for international collaboration when countries can be compared. Of course, big cities cannot be ignored even if nations are the units studied. Comparison between cities and other parts of the country is an interesting epidemiological question when fairly new behaviours are in focus.

Finally, to investigate and compare the extent of drug abuse in different countries has of course an interest of its own. But it will be even more interesting, both practically and theoretically, if these pure descriptions could be linked to the societal and individual consequences of drug abuse and to what effects different forms of drug policies may induce. Future European collaboration on the epidemiology of drug abuse should also tackle these aspects of the drug problem.

APPENDIX I

DATA

Table 1: Age and sex breakdown as of December 31 1982

	Stockholm County			Stockholm City		
age	Men	Women	Total	Men	Women	Total
-14	142,425	136,007	278,432	42,440	40,428	82,868
15-19	53,876	52,476	106,352	15,856	16,030	31,886
20-29	115,786	117,121	232.907	52,333	54,574	106,907
30-39	134,412	131,390	265,802	53,237	48,764	102,001
40-49	93,467	89,484	182,951	32,044	31,520	63,564
50-	207,656	270,354	478,010	106,544	155,916	262,460
Total	747,622	796,832	1,544,454	302,454	347,232	649,686

Table 2: Numbers of persons involved in heavy drug abuse

	Total number of heavy abusers	Of whom: Injection abusers	Of whom: daily injection abusers
All Sweden	10,000- 14,000	7,500- 10,000	1.500- 2,000
Greater Stockholm	3,000- 4,500	2,700- 3,700	650- 900
Greater Malmo-Lund	1,400- 2,000	1,100- 1,600	350- 450
Greater Gothenburg	1,400- 2,000	1,000- 1,400	200- 300

Table 3: Age breakdown and type of treatment unit in percentage preliminary results from the "BAK project" (a research project evaluating 31 Swedish treatment units)

Age	Adult units n=700	Youth Units n=149	Medical Units n=271	Prison units n=107	Total n=l,227
15-19	5%	88%	5%	4%	15%
20-24	27%	12%	32%	24%	26%
25-29	37%	–	34%	38%	32%
30-34	18%	–	16%	25%	16%
35-39	10%	–	8%	6%	8%
40-	3%	–	5%	3%	3%
100%	100%	–	100%	100%	100%

Table 4: Primary abuse substance among clients treated at Danderyd and Huddinge hospitals' drug abuse treatment units (in percentages)

	Heroin	Amphet-Amines	Canna-bis	Alco-hol	Tran-quil	Total (n)	Of which mixed abuse
Danderyd 1982	43%	39%	13%	5%	1%	100(192)	46%
Danderyd 1984	32%	53%	8%	7%	0.5%	100(236)	65%
Danderyd 1985	38%	49%	6%	7%	–	100(156)	55%
Huddinge 1982	36%	37%	11%	11%	4%	100(166)	21%

Table 5: Number of drug-related deaths in the Greater Stockholm area and the counties of Gotland and Sodermanland

	Group I	Total In Groups I-III	Total according to the dark figure study
1975	11	25	
1976	18	46	
1977	22	49	
1978	38	60	
1979	36	66	95 (66+29)
1980	26	55	83 (55+28)
1981	98	--	(Group I not declared)

Group I = overdoses
Group II = drug addiction's secondary diseases
Group III = death related to narcotic environment

Table 6: Reported narcotics offences, number of suspected persons, and number of narcotics offences per person in Stockholm police district 1979 – 82

Year	Number of reported offences against PLN (1)	Number of suspected persons	Narcotics offences per person
1979	1,871	983	1.9
1980	3,456	1,694	2.0
1981	3,784	1,869	2.0
1982	3,131	1,679	1.9

(1) Penal Law on Narcotics

Table 7: Number of persons suspected of possession, other narcotics offences and arrested for narcotics offences in Stockholm City and Stockholm County 1983-85

Year	Suspected of possession	Suspected of other narcotics offences	Arrested persons
1983	2,940	1,573	1,076
1984	2,118	973	916
1985	1,671	484	521

Table 8: Convictions for drug offences Including summary fines by the prosecutor in Stockholm City and County, and percentage of national total

	1980		1981		1982		1983		1984
Stockholm City	1,031	20%	1,468	22%	1,231	18%	1,063	18%	882
Stockholm County	337	7%	571	8%	754	11%	730	12%	602
Remaining Sweden	3,851	73%	4,799	70%	4,941	71%	4,198	70%	3,857
Total Sweden	5,219	100%	6,838	100%	6,926	100%	5,991	100%	5,341

Table 9: The number and proportion of drug addicts in prisons in the Stockholm region (point-prevalence on 1 April each year)

Year	Number of drug addicts	Proportion of the total Prison population (%)
1980	74	30
1983	110	40
1985	184	48

Table 10: Total proportion of drug addicts and drug users in the Stockholm Remand Prison 1976-80 and 1984

	1976	1977	1978	1979	1980	1984
Drug addicts (%)	36	53	48	49	52	28
Drug users (%)	21	10	19	18	16	22
Total	57	63	67	67	68	50

Table 11: Number of seizures made by the police in Stockholm City and Stockholm County 1983-1985

	Stockholm City and County		
	1983	1984	1985
Cannabis	1,243	834	735
Amphetamines	1,087	1,166	912
Heroin	155	98	103
Cocaine	16	17	12
Other (1)	448	420	387
Total	2,949	2,535	2,149

(1) Including medical substances classified as narcotic drugs according to Swedish law.

Table 12: Signs of intravenous abuse among Swedish citizens brought to the Stockholm Remand Prison in the second quarter of the years 1965-77

Year	Number of vein punctures	Percent of persons examined
1965	958	20
1966	1,127	25
1967	1,614	40
1968	1,537	42
1969	1,642	41
1970	1,715	39
1971	1,992	50
1972	1,776	56
1973	1,285	45
1974	1,239	40
1975	1,200	48
1976	1,394	63
1977	1,227	59

Figure 1: Breakdown of primary abuse substance among young persons at Maria Youth Unit 1978-85

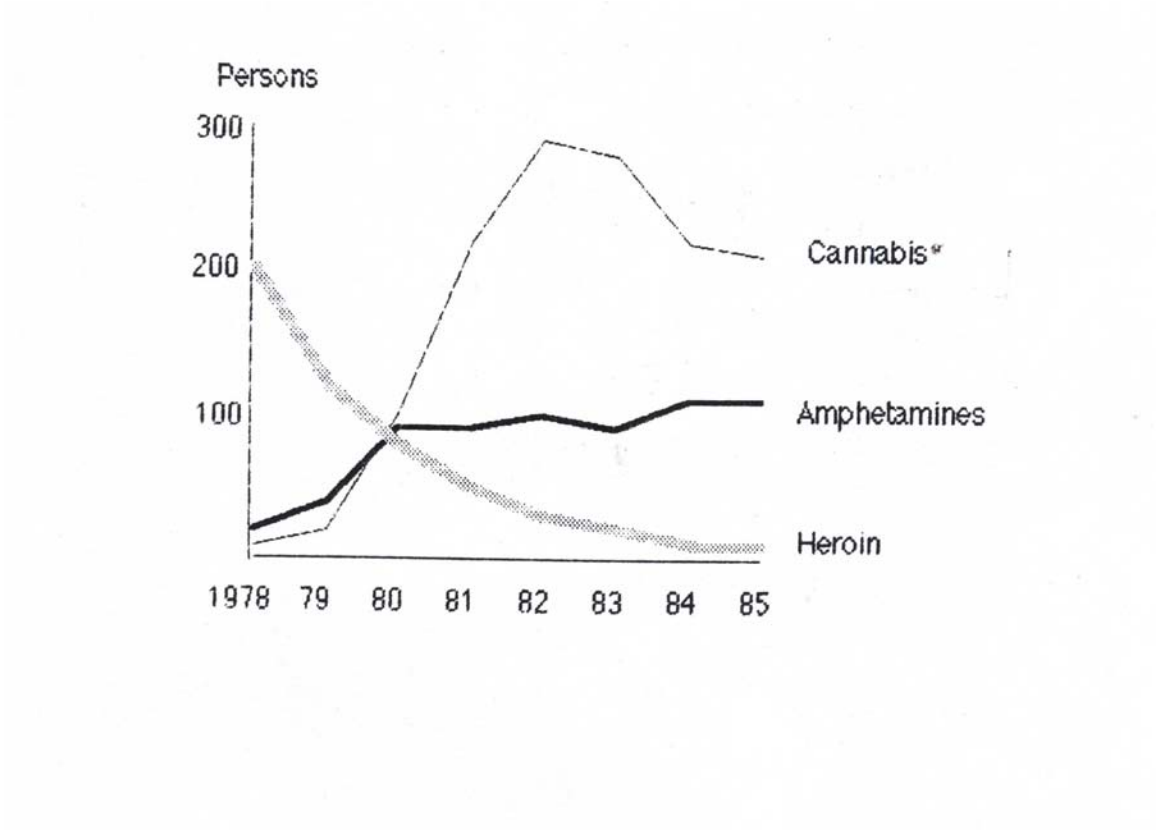


Figure 2: Number of hepatitis B cases (including Non A-Non B), Stockholm City and Stockholm County 1977-83

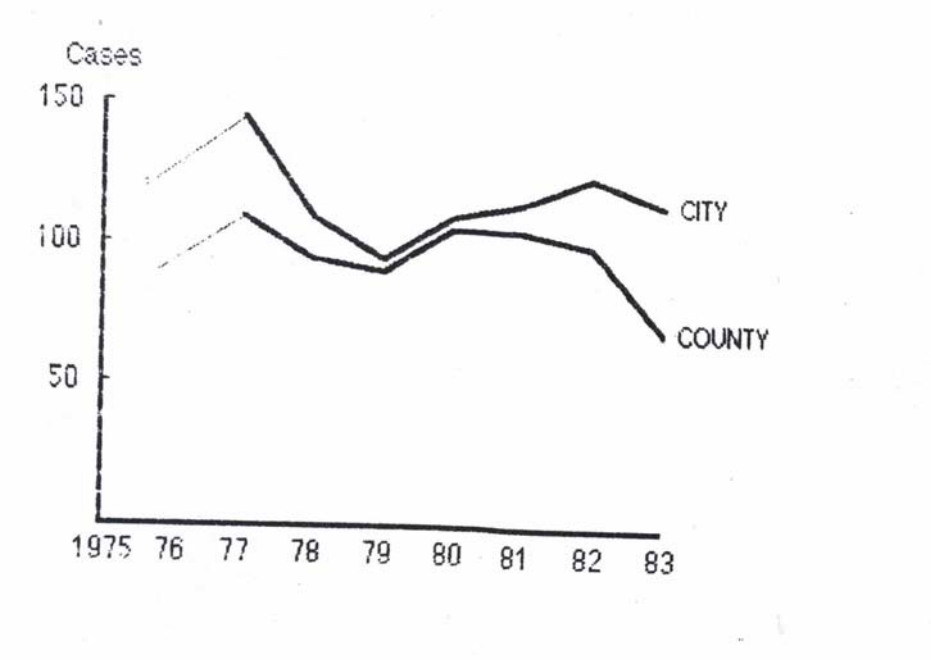


Figure 3: Official cause of death statistics - drug-related deaths in Sweden 1970-83, Primary diagnosis

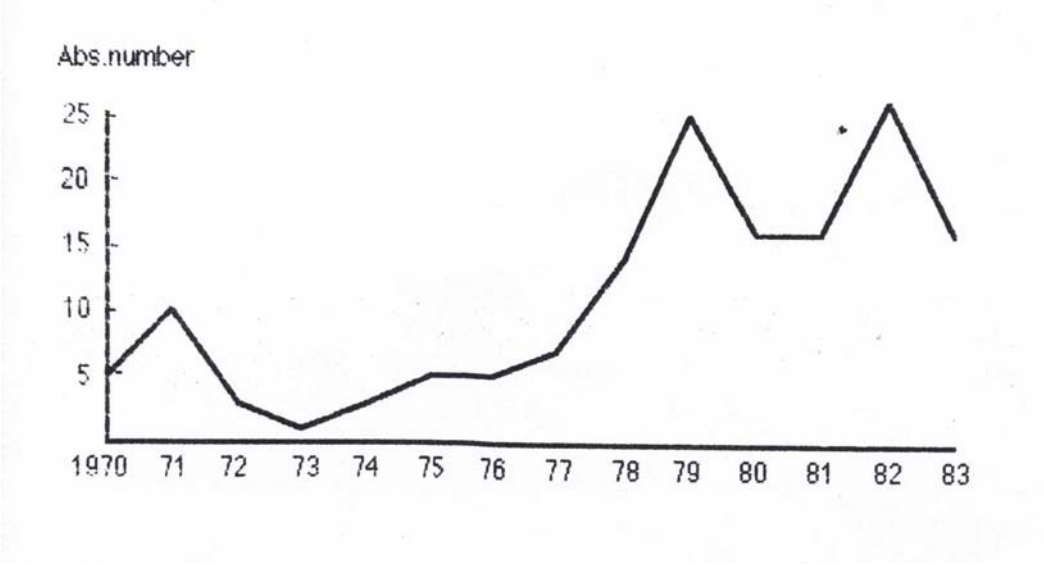


Figure 4: Main substances used by persons on remand in Stockholm 1976-80 and 1984

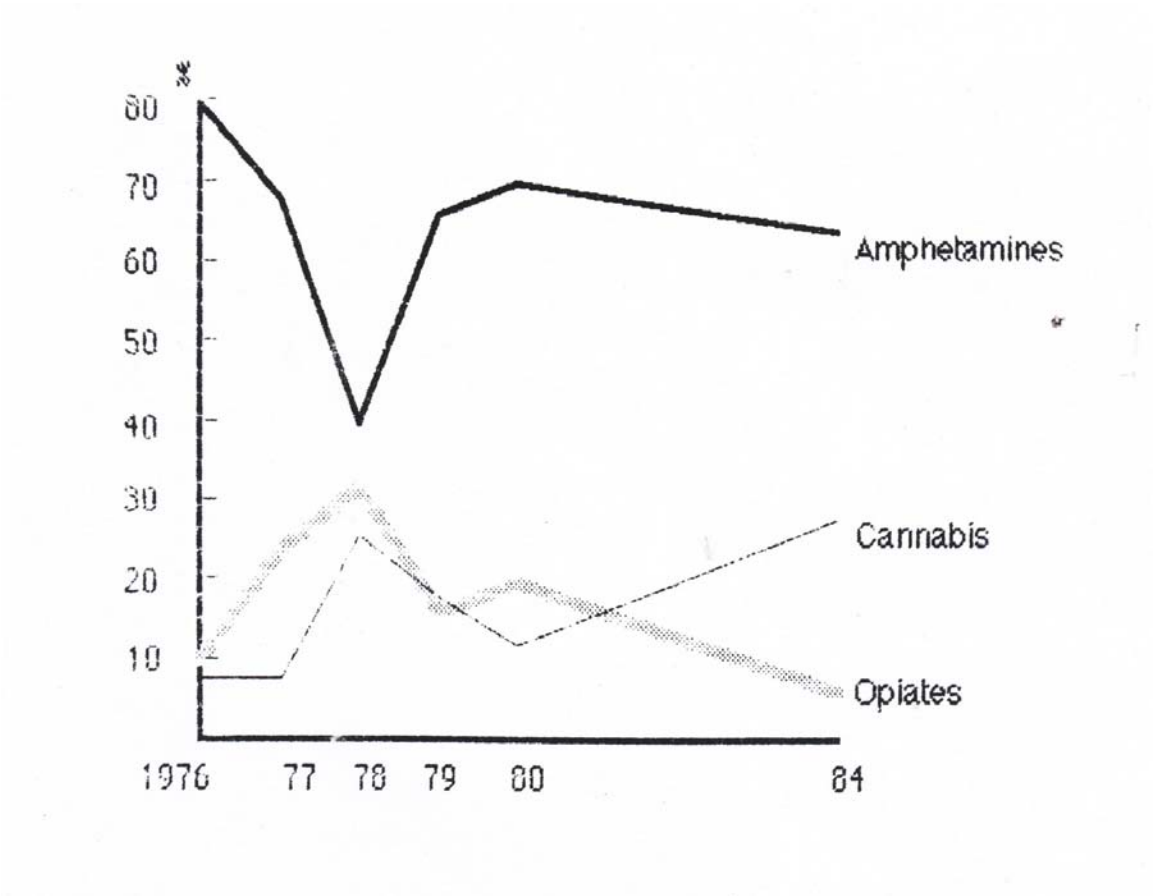


Figure 5: Quantity of confiscated cannabis 1975-82 in kg

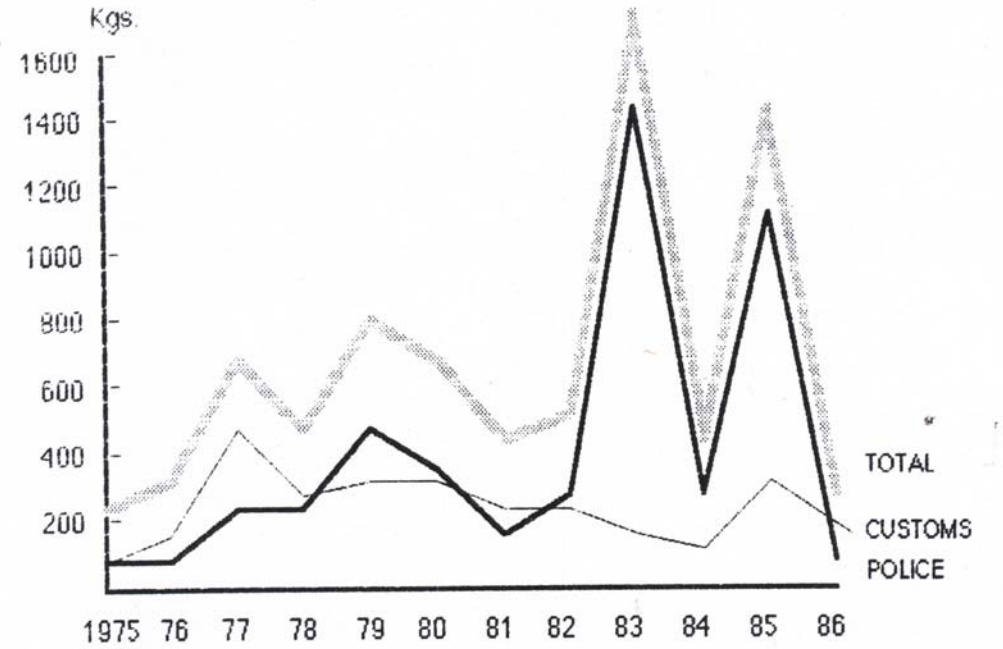
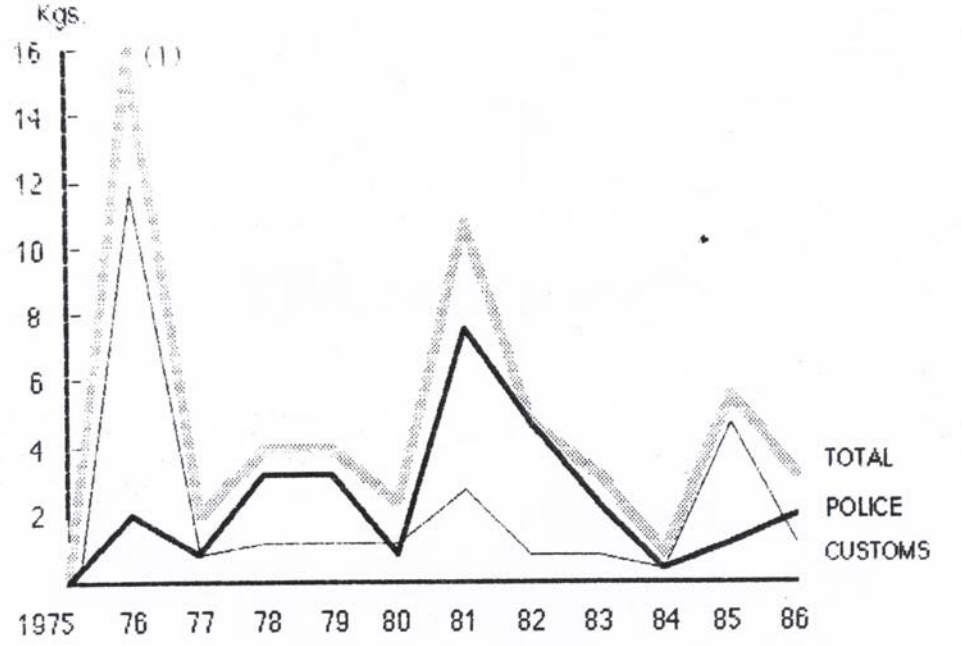


Figure 6: Quantity of confiscated heroin 1975-82 in kg



(1) One seizure of drugs destined for another country.

Figure 7: Quantity of confiscated amphetamine 1975-82 in kg

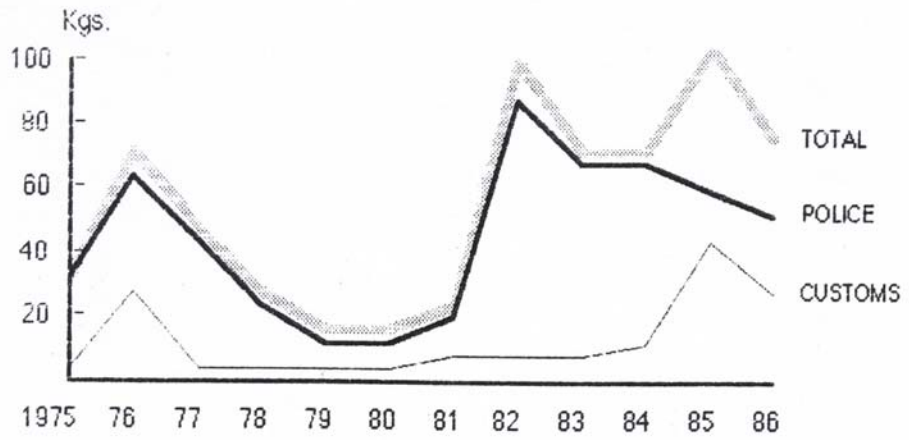
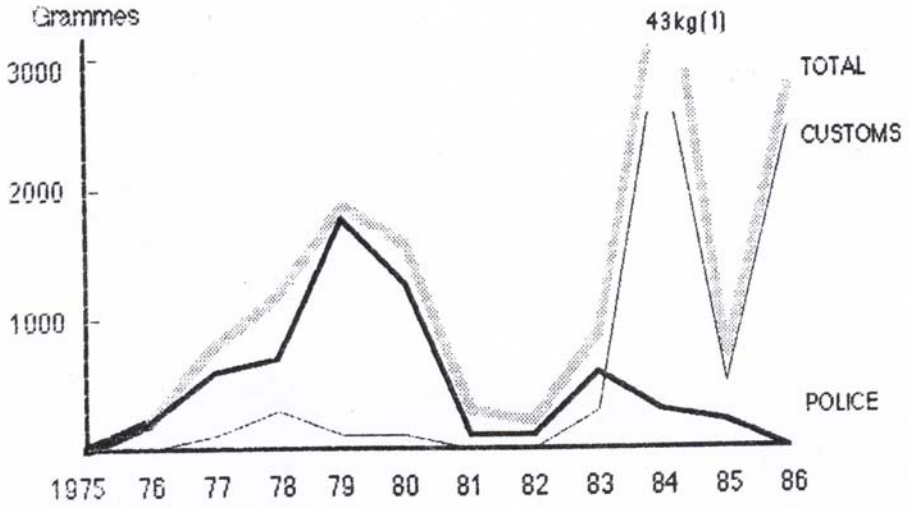


Figure 8: Quantity of confiscated cocaine 1975-82 in grammes



(1) One seizure of drugs destined for the USA.

APPENDIX II

GLOSSARY OF TERMS AND DEFINITIONS

Drug abuse

All non-medical use of substances classified as narcotics according to Swedish laws.

Heavy drug abuse

Daily or almost daily use of narcotics, and any use – regardless of frequency – where the drugs are administered mainly by injection.

APPENDIX III

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APPENDIX IV

SWEDISH LEGISLATION ON NARCOTICS AND PSYCHOTROPIC SUBSTANCES – SHORT SUMMARY

The chief statutes governing narcotics and psychotropic substances are the Narcotic Ordinance (Swedish Code of Statutes 1962:704), the Penal Law on Narcotics (Swedish Code of Statutes 1968:4) and the Law on Penalties for the Smuggling of Goods (Swedish Code of Statutes 1960:418).

The Narcotic Ordinance contains a definition of narcotics (paragraph 1) and the fundamental rules for the import, export and manufacture of, trade in and possession of narcotics, together with certain penal provisions relating to violation of the stipulations contained in the ordinance.

The Swedish Board of Health and Welfare keeps a catalogue covering all substances classified as narcotics. According to paragraph 1 the legal definition of narcotics comprises two categories:

1. substances that are subject to international control according to conventions acceded to by Sweden;

2. substances that the government has proclaimed shall be designated narcotics.

With these principles the Swedish definition of narcotic drugs has become more comprehensive than in many other countries.

The regulations in the Penal Law on Narcotics were removed from the Narcotic Ordinance when the maximum penalty for narcotic offences was raised in 1968 from one to four years of imprisonment. According to the law it is forbidden for non-authorised persons to manufacture, offer for sale, transfer or possess narcotics.

In the Penal Law on Narcotics, drug crimes are divided into drug offences, drug crimes and serious drug crimes. The penalty for a drug offence is a fine, for a drug crime a fine or imprisonment for at most three years, and for a serious drug crime imprisonment for at least two and at most ten years.

The Law on Penalties for Smuggling of Goods is the third of the laws of greatest significance for the prevention of illicit trafficking in drugs. The law stipulates a general prohibition against import of drugs into or export from the realm for anyone not possessing a special licence. For serious smuggling of drugs the penalty is imprisonment for at least two and at most ten years.

Waiving of prosecution

When interpreting the statistics of drug criminality it is important to be aware of how the provisions relating to waiving of prosecution have been applied. For, according to the Penal Code, a prosecutor may decide not to prosecute if it may be assumed that merely a fine would be imposed and that there is no reason for prosecution “from the point of view of the public interest”. Since the Penal Law on Narcotics entered into force in 1968, the application of the provisions relating to waiving of prosecution has been changed by directives from the Chief Public Prosecutor. In 1968 prosecution could be waived in the case of possession of a small quantity of drugs for personal use to provide, among other purposes, for the person’s need for treatment. Through the directives of 1970 and 1972 the application of the procedure of waiving prosecution became increasingly generous. Prosecution could now be waived also for possession of larger quantities of drugs for personal use or for transfer in conjunction with consumption. The directives issued in 1980 entailed a more stringent application of the provisions, chiefly owing to the difficulty of coping with the street traffic in drugs. Under the provisions in force today prosecution for possession of cannabis and central nervous system stimulants may be waived only if the quantities for personal use are so small that they cannot be divided further and sold. For opiates and cocaine, prosecution may be waived only if it is a matter of negligible quantities. In addition, it can be mentioned that the Swedish drug policy is very restrictive and the explicit goal expressed in parliament is a society free from narcotic drugs. In accordance with this, demands for other restrictive measures are considered, eg a criminalisation of the abuse in itself.