



**Lifestyles and history of use of  
drug abusers in four EU countries:**  
exploratory analysis of survey data

editors  
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# PREFACE

Recent trends in drug use challenge monitoring methodologies presently used at the local, national and European level. New indicators are needed to evaluate the impact of policy and programmes, whilst new models are necessary to mirror the various populations involved in the use, abuse and dealing of drugs and in order to estimate their size. Innovative data collection can provide valuable data which can help to fill the information gap.

In order to acquire information about the lifestyles of “problem” drug users, their drug using career and involvement in criminal activities, a survey among residents in therapeutic communities and clients of low threshold services has been conducted in four countries: Czech Republic, Italy, Portugal and Spain in the framework of the EU project JUST/2010/DPIP/AG/1410 *New methodological tools for policy and programme evaluation*.

The data collection was conducted in the period January-July 2012 using a questionnaire developed by a research group composed of: Vera Balanchova (for the Czech survey), Maria Caterina Bramati, Antonia Domingo Salvany, Francesco Fabi, Fernanda Feijao, Marta Cristina da Silva Alves de Menezes Montenegro (for the Portuguese survey), Roberto Ricci, Carla Rossi and Alberto Zuliani.

The English version of the questionnaire appears as an appendix to this book.

Data collection, data analysis and intermediate and final reports have been provided by Easy and Faster s.r.l., that won the competition for these services.

Sampling design, data collection, data entry and analysis have been conducted by a working group coordinated by Roberto Ricci and composed of: Francesco Fabi, Umberto Iallicco, Claudia Musella and Claudia Restelli.

Marta Cristina da Silva Alves de Menezes Montenegro gave an important contribution to data collection in Portugal, Antonia Domingo Salvany coordinated the data collection in Catalonia, whilst Lida Pribisova coordinated the data collection in the Czech Republic.

Mike Watson revised the text.

The data analysis provided very valuable information on lifestyles, gateway substances, typical periods in a drug using career, the involvement of drug users in criminal activities, imprisonment, the market price of substances and many other aspects which allow for the analysis of the market from the demand and supply perspective and for the estimation of the size of the market and of the populations involved.

The first chapter draws comparisons across the studies, whilst the following four chapters contain independent country reports; in the chapter 6 a pilot survey, carried out in Albania by Julia Sallaku and analyzed in cooperation with Roberto Ricci is reported.

Excel files containing various tables are available on the project website.

Carla Rossi

# INTRODUCTION

## **1. Sampling Methodology**

The research methodology used is based on a surveying unit composed of those who personally approached the socio-sanitary structures to deal with their drug addiction. These structures comprise outpatient (LTS), and inpatient services (therapeutic communities, detoxification centers and rehabilitation centers).

These patients can be divided into three groups:

### *1. Users who enter the socio-sanitary circuit autonomously.*

These users form the majority. These individuals have usually gained an adequate consciousness of their condition. By the time they enter these health care structures, they have entered into the critical stage of addiction and the desire to escape this severe condition is strong.

### *2. The patients of LTS might in cases have only the intention of avoiding a worsening of their situation and may not be truly determined to quit substance abuse.*

These patients get in touch with these services only in order to "reduce the harm" inflicted by their addiction, to gain assistance and information and to get access to a drug substitute (such as methadone, to take one example), when the LTS is authorized to dispense such alternatives. In any case, this is the first step towards a possible way out of the vicious cycle of dependence.

### *3. Users who enter the health care structures as an alternative sentence.*

These individuals - which are in the minority - can be found in TC when they have been allowed to convert their prison sentence into a kind of

house arrest. Their numbers are not high perhaps because other alternatives to prison are available especially in the Czech Republic, Spain and Portugal.

In these cases they do not have the same motivation that brings users into the rehabilitation process (conscious choice and willingness to be relieved from the pain of the critical phase). They are certainly addicts, but the decision to look for help is motivated by the desire to get out of prison rather than the desire to start a rehabilitation process.

## **2. Data Collection**

In 2010 a large survey was carried out in Italy and has been used as a reference for this survey, which has been extended to other European Countries.

In the Italian Report many comparisons are given between the survey of 2010 and the survey conducted in 2012. The trends and the main findings of the 2010 survey have been confirmed by the more recent survey. As such, the methodology used in Italy can be considered solid enough to be applied to the surveys conducted in the other three countries.

The composition of the sample is reported below: the relative importance of the Institutions in each country is well represented.

The study of Czech services is mostly based on their general health care system as they do not make use of therapeutic communities as much as in Italy; Spanish and Portuguese services are mostly focused on Treatment Centers, which provide an intermediate step after first contact with the health care system and before a complete rehabilitation; a Treatment Center ensures the treatment of deprivation syndromes in addicts, under medical supervision through inpatient care for a short period of seven to nine days.

<i>The Collected Sample</i>					
	Italy	Czech Republic	Portugal	Spain	Total
Valid records	720	148	381	513	1762
Low Threshold Services	189	114	83	98	484
Treatment Centers			174	319	493
Therapeutic Communities	531	34	124	96	785

### 3. Main findings and Main Differences Between Countries

This book aims to present a general overview of the findings of the studies conducted in all of the four countries studied, providing a first comparison of:

- The characteristics of drug users, age at first use, motivations;
- Education, work, contact with law enforcement;
- Consumption, doses and prices of drugs in the market;
- Legal and illegal sources of revenue;
- Evaluation of services.

Other data and comparisons for the less important variables are provided in the appendixes.

### 4. The Case of Albania

Before the conclusion of this book and after the surveys of the four countries, a pilot survey of Albania has been included.

The situation in Albania is very specific. It was isolated before 1990 and is now experiencing a rapid development and regarding the drug market the findings obtained by the pilot survey show some common points with the Czech situation and the Albanian drug market in this book could be indicated as an extreme confirmation of the differences among the drug markets.





# PART 1

## Comparison Between Italy, Czech Republic, Portugal and Spain

Sampling design, data collection, data entry and analysis have been conducted by the Easy and Faster s.r.l. working group coordinated by Roberto Ricci and composed of: Francesco Fabi, Umberto Ialiccio, Claudia Musella and Claudia Restelli.





# CHAPTER 1

## Characteristics of Users

**Table 1.1. mean average of ages of patients by country**

AGE	ITALY		CZECH REPUBLIC		PORTUGAL		SPAIN	
	Male	Female	Male	Female	Male	Female	Male	Female
Mean	36.18	35.36	30.47	27.21	40.54	40.52	37.93	37.57

**Table 1.2. gender distribution**

	Italy	Czech Republic	Portugal	Spain
Female	14.8%	34.0%	19.2%	23.8%
Male	85.2%	66.0%	80.8%	76.2%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

The youngest people were encountered in the Czech Republic, the eldest in Portugal (Table 1.1.).

Taking into consideration the analysis of age at first use (Table 1.4.) and of the latency period between soft drug use and hard drug use (Table 1.5.) the age differences (see also Table 1.3.) should depend on the attitude of individual health structures (whether they are more or less friendly towards younger or older people) and, presumably, upon the prevalence of hard drug use (See Table 1.4. for 'first use' and Chapter 3 for prevalence of hard drug use).

Table 1.3. age distribution

	Italy	Czech Republic	Portugal	Spain
<b>&lt;18</b>	0.1%	0.7%	0.3%	0.4%
<b>18-24</b>	8.9%	24.1%	1.6%	6.4%
<b>25-34</b>	35.8%	56.7%	19.4%	29.3%
<b>35-44</b>	37.3%	14.9%	49.3%	41.8%
<b>45-54</b>	15.4%	2.8%	26.0%	18.9%
<b>&gt;54</b>	2.4%	0.7%	3.4%	3.1%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

Table 1.4. age at first use

	Italy	Czech Republic	Portugal	Spain
<b>&lt;11</b>	1.7%	4.9%	2.9%	3.9%
<b>11-12</b>	7.2%	5.6%	14.5%	9.4%
<b>13-14</b>	35.8%	30.1%	25.3%	35.0%
<b>15-16</b>	30.2%	30.8%	29.6%	25.2%
<b>17-18</b>	13.5%	14.7%	16.4%	12.5%
<b>19-20</b>	5.7%	5.6%	4.0%	5.5%
<b>&gt;20</b>	5.9%	8.4%	7.4%	8.6%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

**Table 1.5. first drug experimented with**

	Italy	Czech Republic	Portugal	Spain
* Pervitin	0.0%	16.4%	0.0%	0.0%
Tranquilizers/sedatives (without medical prescription)	1.4%	0.7%	4.2%	1.4%
Amphetamines	0.3%	0.7%	2.4%	2.0%
Ecstasy (MDMA. XTC. etc...)	1.0%	5.5%	2.6%	3.0%
Cannabis (marijuana. hash. ganja)	73.3%	63.7%	77.2%	76.0%
Crack	0.3%	0.0%	0.5%	0.0%
Cocaine	11.6%	0.7%	3.1%	10.2%
Heroin	7.2%	1.4%	6.3%	3.9%
Steroids	0.0%	0.0%	0.0%	0.2%
Inhalables volátiles	0.0%	0.0%	0.0%	0.4%
Psychedelic mushrooms	0.1%	0.7%	0.0%	0.0%
Ketamine	0.1%	0.0%	0.0%	0.0%
LSD	0.4%	1.4%	0.0%	0.8%
Kobret	0.1%	1.4%	0.0%	0.4%
Street methadone (without prescription)	0.0%	0.7%	0.0%	0.0%
Other	4.0%	6.8%	3.7%	1.8%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

**Table 1.6. latency period of the passage from soft drug to hard drug use**

	Italy	Czech Republic	Portugal	Spain
<b>Same year</b>	27.8%	42.7%	17.5%	20.4%
<b>1</b>	15.4%	18.3%	15.5%	13.5%
<b>2</b>	19.8%	11.5%	16.6%	20.2%
<b>3</b>	12.5%	9.9%	19.2%	13.3%
<b>4</b>	7.6%	5.3%	8.3%	10.6%
<b>5</b>	4.5%	3.1%	4.9%	6.0%
<b>6</b>	3.2%	3.8%	3.7%	4.4%
<b>7</b>	2.3%	1.5%	4.3%	3.3%
<b>8</b>	2.4%	-	1.7%	0.8%
<b>9</b>	0.6%	-	0.9%	1.7%
<b>10</b>	0.5%	-	1.4%	0.6%
<b>&gt;10</b>	3.2%	3.8%	6.0%	5.2%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

**Table 1.7. motivations for starting drug use**

	Italy	Czech Republic	Portugal	Spain
<b>For fun/entertainment</b>	57.8%	45.3%	50.9%	48.7%
<b>To be alternative</b>	38.8%	25.7%	17.1%	5.7%
<b>For self-hurt</b>	4.4%	4.1%	1.8%	0.6%
<b>My friends were doing it</b>	36.9%	30.4%	36.2%	40.9%
<b>My girlfriend/boyfriend was doing it</b>	6.5%	10.8%	10.8%	5.7%
<b>High availability at school</b>	3.1%	5.4%	6.8%	2.3%
<b>High availability at work</b>	0.8%	0.7%	1.3%	1.0%
<b>To perform better</b>	4.7%	9.5%	3.7%	3.3%
<b>To calm down. relax</b>	13.2%	15.5%	16.0%	8.0%
<b>To make new friends</b>	5.1%	4.1%	5.8%	3.3%
<b>To escape my problems. my life</b>	18.9%	31.8%	22.3%	21.8%
<b>Curiosity</b>	36.8%	45.3%	47.2%	43.5%
<b>Other</b>	6.2%	8.8%	7.1%	5.5%

No major difference among countries has been reported regarding the main motivations for drug use: as will be seen in the surveys of single countries, the main differences regard motivations for first use of drugs.

# CHAPTER 2

## Lifestyle: Education, Work and Contact with Prison

**Table 2.1. education level**

	Italy	Czech Republic	Portugal	Spain
No level	0.6%	2.7%	1.6%	4.4%
Primary school	5.8%	44.9%	10.9%	25.5%
Middle school	49.3%	29.3%	21.1%	37.7%
Secondary school	33.2%	15.6%	33.6%	19.0%
High secondary school	0.0%	0.0%	26.1%	0.0%
University	3.2%	4.1%	5.9%	6.0%
Other	7.9%	3.4%	0.8%	7.4%
Total	100.0%	100.0%	100.0%	100.0%

**Table 2.2. education level – been or never been in a therapeutic community**

	Italy		Czech Republic		Portugal		Spain	
	Yes	Never	Yes	Never	Yes	Never	Yes	Never
No level	0.6%	0.0%	0.0%	3.7%	1.2%	4.5%	6.2%	2.7%
Primary school	6.1%	3.8%	39.5%	46.8%	9.7%	20.5%	25.3%	25.8%
Middle school	48.9%	52.6%	36.8%	26.6%	21.8%	15.9%	38.6%	36.9%
Secondary school	32.9%	35.9%	13.2%	16.5%	33.8%	31.8%	17.4%	20.4%

<b>High secondary school</b>	0.0%	0.0%	0.0%	0.0%	26.6%	22.7%	0.0%	0.0%
<b>University</b>	3.0%	5.1%	2.6%	4.6%	6.0%	4.5%	6.2%	5.8%
<b>Other</b>	8.6%	2.6%	7.9%	1.8%	0.9%	0.0%	6.2%	8.5%
<b>Total</b>	100%	100%	100%	100%	100%	100%	100%	100%

Education level is an important facet of lifestyle. It must be noted that respondents from Portugal had a generally higher education level than respondents from other countries, as a percentage of education level achieved from the total surveyed national sample (Table 2.1), principally because lower percentages are reported for 'Primary School' and for 'Middle School' in Portugal. A slightly higher education level was reported in the case of those who have never been in a therapeutic community in Italy, but this issue is not confirmed by the data collected in the other countries (Table 2.2).

**Table 2.3. last employment situation**

	Italy	Czech Republic	Portugal	Spain
<b>Long term contract</b>	24.8%	11.9%	12.7%	8.5%
<b>Short term contract</b>	20.6%	4.2%	6.3%	6.5%
<b>Self-employed or professional work</b>	17.5%	8.4%	3.7%	3.7%
<b>Occasional worker</b>	28.8%	56.6%	6.1%	3.5%
<b>Never employed</b>	4.5%	14.7%	0.8%	1.2%
<b>Student</b>	1.8%	2.1%	3.4%	2.6%
<b>Student worker</b>	2.0%	2.1%	-	-
<b>Unemployed</b>	-	-	67.0%	53.7%
<b>Permanent disability</b>	-	-	-	4.7%
<b>Retired</b>	-	-	-	14.6%
<b>Work at home</b>	-	-	-	1.0%
<b>Total</b>	100%	100%	100%	100%

The "last" employment situation seems to have been misunderstood in Portugal and in Spain where the "unemployed" category was introduced in

the questionnaire. Unemployment is a condition of “without a job” and it is asked “last” employment situation because the objective of the question was to know the previous situation. The work topic can be better analyzed looking at the answer to question 38 (asked to respondents over 25 years of age) where the employment situation of the respondents is also asked for (Appendix 4 and Table 2.4 to be analyzed together with Table 2.5). The most prevalent current condition is “unemployed” also in Italy when it is answered to the question 38, but the “last” situation – in the case of the question 6 - was previous to the situation of unemployed.

Always regarding the question 6, three other categories were introduced in the Spanish questionnaire and they can be considered as specification of the pre-existing categories, used due to local conditions being different to those in other countries: Retired in the other countries is included in Long Term Contract; Work at Home is included in Self-Employed or Professional Work; moreover Permanent Disability is a condition that could be included in Never Employed or in other categories, if the working activity was interrupted by an accident. The working career of these drug addicts is never brilliant and progressively moves towards unemployment. In chapter 4 the financial consequences of addiction are analyzed with reference to other sources of income and with entrance into criminal life.

**Table 2.4. what was your employment situation when you were 25?  
(from question 38, 70 in Spain)**

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
Student			2.67%	4.76%				
Full-time steady job	35.0%	40.0%	59.00%	54.76%	53.6%	46.9%	31.0%	36.0%
Self employed or professional work	16.9%	0.0%	7.00%	2.38%	11.3%	4.7%	6.9%	4.0%
Part-time job (occasional work for Italy)	23.3%	31.1%	12.00%	23.81%	3.6%	6.3%	3.4%	8.0%
Short term contract	6.4%	4.4%	14.67%	11.90%	16.1%	17.2%	25.9%	24.0%
Unemployed	14.3%	22.2%	4.67%	2.38%	14.1%	21.9%	22.4%	24.0%
I've never been employed	4.1%	2.2%	0.00%	0.00%	1.2%	3.1%	10.3%	4.0%
Total	100.0%	100.0%	100.00%	100.00%	100.0%	100.0%	100.0%	100.0%



**Table 2.5. what is your current employment?**  
*(from question 38. see question 6 for Spain)*

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
Student								
Full-time steady job	13.8%	10.0%			15.4%	16.4%	16.1%	9.1%
Self employed or professional work	10.9%	0.0%			3.4%	3.0%	8.9%	0.0%
Part-time job (occasional work for Italy)	13.0%	22.5%			0.4%	1.5%	3.6%	13.6%
Short term contract	3.6%	0.0%			3.4%	6.0%	10.7%	18.2%
Unemployed	55.9%	65.0%			75.7%	70.1%	48.2%	59.1%
I've never been employed	2.8%	2.5%			1.9%	3.0%	12.5%	0.0%
Total	100.0%	100.0%			100.0%	100.0%	100.0%	100.0%

**Table 2.6. arrest and incarceration across the different countries (%).**

		Italy	Czech Republic	Portugal	Spain
Arrested	<b>Never</b>	38.6%	38.0%	40.9%	39.5%
	<b>For dealing</b>	17.1%	4.9%	17.2%	8.6%
	<b>For other crimes</b>	30.0%	54.2%	36.7%	47.0%
	<b>Both for dealing and other crimes</b>	14.3%	2.8%	5.3%	4.9%
	<b>Total</b>	100.0%	100.0%	100.0%	100.0%
Incarcerated	<b>Never</b>	42.9%	64.8%	57.2%	59.2%
	<b>For dealing</b>	13.8%	4.2%	14.1%	6.1%
	<b>For other crimes</b>	29.5%	30.3%	26.6%	32.3%
	<b>Both for dealing and other crimes</b>	13.8%	0.7%	2.1%	2.4%
	<b>Total</b>	100.0%	100.0%	100.0%	100.0%

To be highlighted (Table 2.6): almost the same percentage of “arrested people” are reported in every country, but a great difference can be seen in those “incarcerated” in Italy in comparison with other countries. “Dealing” is more important in Italy and in Portugal than in Spain or in the Czech Republic. In the latter, drug selling is the least significant of activities in this respect, on the other hand the Czech Republic sees the maximum percentage for “other crimes” (arrested).

The most worrying situation regards Italy, where are reported the highest percentages for “dealing and other crimes” (14.3% arrested and 13.8% incarcerated) and for “dealing” alone (17.1% arrested and 13.8% incarcerated) are reported.

**Table 2.7. percentage of patients who received an alternative sentence to avoid prison.**

*(Spanish respondents were allowed only one answer; other countries more than one)*

	Italy	Czech Republic	Portugal	Spain
<b>Never</b>	46.5%	54.1%	67.5%	77.3%
<b>In a therapeutic community</b>	33.1%	8.1%	8.1%	6.0%
<b>Under supervision by social services</b>	9.4%	20.3%	9.7%	2.3%
<b>Community work</b>	1.1%	21.6%	8.7%	7.5%
<b>House arrest</b>	22.8%	0.7%	2.6%	1.9%
<b>Other type of treatment</b>	0.0%	0.0%	5.0%	5.0%

Alternative sentences (Table 2.7) are applied in Italy mostly in the form of house arrest and attendance at a Therapeutic Community, which is in itself a form of 'house arrest'.

The greatest difference between Italy and other countries relates to the more permissive legislation applied in other countries (where larger quantities of drugs are allowed for personal use). Moreover, overcrowded prisons could have influenced the application of these alternatives in Italy, and is no indication of leniency in Italy.



# CHAPTER 3

## Consumption, Doses, Prizes.

This chapter concerns the consumption analysis in the last 30 days for LTS patients, in the case of TC patients and TrC (Portugal and Spain) it refers to the last month before entering the current therapeutic community.

Therefore it is possible to have 4 different categories: ex users, occasional users (1-5 times in the last 30 days), regular (6 – 19 times) and intensive (20 times and more).

The last month is not always a month of high consumption because the patients could already be in treatment (for detoxification) before starting a treatment period in a TC or they might be simply reducing their normal consumption whilst keeping in touch with an health care structure.

**Table 3.1. frequency of consumption**

	Italy	Czech Republic	Portugal	Spain
<b>Ex users (last month)</b>	4.6%	0.7%	0.3%	5.1%
<b>Occasional</b>	9.1%	4.9%	11.9%	8.9%
<b>Regular</b>	46.3%	46.2%	48.8%	35.6%
<b>Intensive</b>	40.1%	48.3%	39.0%	50.4%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

**Table 3.2. consumption frequency - female**

	Italy	Czech Republic	Portugal	Spain
<b>Ex users (last month)</b>	5.8%	-	-	3.3%
<b>Occasional</b>	9.7%	10.4%	11.1%	11.6%
<b>Regular</b>	36.9%	43.8%	47.2%	38.8%
<b>Intensive</b>	47.6%	45.8%	41.7%	46.3%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

**Table 3.3. consumption frequency - male**

	Italy	Czech Republic	Portugal	Spain
<b>Ex users (last month)</b>	4.3%	1.1%	.3%	5.5%
<b>Occasional</b>	9.0%	2.1%	11.8%	8.1%
<b>Regular</b>	48.0%	47.9%	49.3%	34.5%
<b>Intensive</b>	38.6%	48.9%	38.5%	52.0%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

These first three tables (Tables 3.1, 3.2, 3.3) show the different situations of the drug addicted population of the different countries surveyed prior to starting therapy. The small, but significant, percentage of ex-users reported in Italy and in Spain means some people remain under the care of the health system to avoid relapsing after the detoxification period (smaller percentage are reported in Czech Republic and Portugal).

**Table 3.4. drug consumption for last month: percentage of consumers for each drug**

	Italy	Czech Republic	Portugal	Spain
<b>*Pervitin</b>	-	86.0%	-	-
<b>Tranquilizers/sedatives</b>	26.7%	21.7%	21.2%	26.8%
<b>Amphetamines</b>	7.0%	3.5%	5.0%	7.7%
<b>Ecstasy</b>	7.8%	12.6%	5.8%	7.5%
<b>Cannabis</b>	42.0%	63.6%	43.8%	54.5%
<b>Crack</b>	18.6%	2.1%	21.2%	11.4%
<b>Cocaine</b>	63.9%	5.6%	55.2%	64.8%
<b>Heroin</b>	52.1%	7.0%	68.2%	32.7%
<b>Psychedelic mushrooms</b>	2.9%	5.6%	2.7%	1.4%
<b>Steroids</b>	0.7%	2.1%	0.3%	0.2%
<b>Ketamine</b>	8.4%	1.4%	2.1%	2.8%
<b>Assentium</b>	2.6%	-	-	-
<b>Salvia divinorum</b>	1.5%	-	-	-
<b>Smart drugs</b>	1.5%	2.1%	1.9%	-
<b>Lsa</b>	1.3%	0.7%	1.1%	0.4%
<b>Lsd</b>	6.5%	4.9%	4.2%	3.0%
<b>GHB</b>	2.2%	0.7%	0.5%	1.0%
<b>Kobret</b>	4.8%	0.7%	-	13.8%
<b>Street methadone</b>	-	16.8%	8.2%	6.5%
<b>*Inhalables volatiles</b>	-	-	-	1.4%
<b>*Kat</b>	-	-	-	0.2%
<b>Another drug</b>	15.7%	9.1%	8.8%	4.1%

**Table 3.5. poly-use. percentage of the sample**

	Italy	Czech Republic	Portugal	Spain
<b>No drugs</b>	4.6%	0.7%	1.1%	5.1%
<b>Cannabis</b>	3.1%	5.6%	4.8%	9.3%
<b>Cocaine</b>	13.2%	0.0%	10.3%	13.4%
<b>Heroin</b>	9.3%	1.4%	14.9%	4.7%
<b>Other drugs *</b>	8.7%	32.2%	4.5%	4.3%
<b>Cannabis and cocaine</b>	4.8%	0.0%	1.6%	10.6%
<b>Cannabis and heroin</b>	2.3%	0.0%	5.3%	4.1%
<b>Cannabis and other drugs *</b>	2.3%	50.3%	4.8%	3.3%
<b>Cocaine and heroin</b>	9.3%	0.0%	16.4%	3.5%
<b>Cocaine and other drugs</b>	4.7%	0.7%	2.1%	7.7%
<b>Heroin and other drugs *</b>	2.5%	1.4%	3.7%	2.0%
<b>Cannabis. cocaine and heroin</b>	4.3%	0.0%	8.0%	2.8%
<b>Cannabis. cocaine and other drugs *</b>	6.5%	3.5%	2.7%	13.6%
<b>Cocaine. heroin and other drugs</b>	5.9%	0.0%	3.2%	4.7%
<b>Cannabis. heroin and other drugs *</b>	3.4%	2.8%	5.8%	2.4%
<b>All together *</b>	15.3%	1.4%	10.9%	8.5%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

\*Pervitin included.

Consumers of one drug alone are in the minority in all countries and it is necessary to consider that this is the situation for drug use in the last month, when a slight reduction in use is possible because respondents had at that point already made a decision to reduce drug consumption.



Table 3.6. Prices of Drugs

	Italy		Czech Republic		Portugal		Spain	
	Mean	Median	Mean	Median	Mean	Median	Mean	Median
<b>Ecstasy (MDMA)</b>	9€	15.0€	8.2€	8.1€	11.4€	8.5€	9.4€	6.0€
<b>Ecstasy powder/crystals</b>	-	-	10.0€	10.2€	30.6€	30.0€	42.8€	50.0€
<b>Amphetamine</b>	13.5€	10.0€	8.3€	8.1€	16.2€	10.0€	8.9€	5.0€
<b>Ketamine</b>	22.6€	20.0€	7.8€	8.1€	23.2€	20.0€	33.9€	30.0€
<b>Marijuana</b>	9.6€	10.0€	8.3€	8.1€	9.5€	5.0€	4.9€	5.0€
<b>Hashish</b>	9.1€	10.0€	11.6€	10.2€	6.6€	5.0€	4.3€	4.0€
<b>Crack</b>	61.2€	60.0€	38.3€	32.5€	37.1€	40.0€	49.8€	50.0€
<b>Cocaine top-quality</b>	82.9€	80.0€	97.4€	101.6€	45.2€	50.0€	59.1€	60.0€
<b>Cocaine poor quality</b>	59.0€	60.0€	70.4€	65.1€	34.8€	35.0€	49.0€	50.0€
<b>Heroin top-quality</b>	51.0€	50.0€	92.3€	74.2€	40.8€	40.0€	56.7€	50.0€
<b>Heroin poor quality</b>	35.2€	30.0€	50.8€	40.7€	31.9€	30.0€	44.7€	50.0€
<b>Kobret</b>	30.6€	25.0€	36.0€	40.7€	-	-	-	-
<b>Pervitin</b>	-	-	45.3€	40.7€	-	-	-	-
<b>Espid</b>	-	-	-	-	-	-	20.8€	20.0€
<b>Setas alucinógen</b>	-	-	-	-	-	-	56.8€	60.0€
<b>LSD</b>	-	-	-	-	-	-	9.7€	10.0€
<b>GHB</b>	-	-	-	-	-	-	16.0€	15.0€
<b>Methadone</b>	-	-	-	-	-	-	5.0€	5.0€
<b>Liquid Methadone</b>	-	-	-	-	-	-	5.9€	5.0€

The drug market is summarized in Table 3.6.

The great variability in prices among the different countries increases, if the variability within a single country is taken into consideration. In Table 3.6 mean and median are reported to allow a better evaluation of the distribution of prices that were reported by respondents.



## CHAPTER 4

# Legal and illegal sources of revenue for drug addicts

Around three out of four drug addicts in Italy and in the Czech Republic earn their living through illegal activities. This percentage decreases in Portugal and in Spain (with three out of five people sustaining themselves through criminality - Table 4.2). One out of five respondents in Italy sustain themselves through illegal activities alone (Table 4.1).

Family is another main source of income for drug addicts (Table 4.1).

“Other” stands for “Social contribution” and “Debts”, but nobody can live by borrowing alone. As reported below (Table 4.7) social contributions are not as important for Italian drug addicts as they are in other countries such as the Czech Republic and Spain.

**Table 4.1. sources of money for drug consumers**

	Italy	Czech Republic	Portugal	Spain
<b>Other</b>	1.3%	4.3%	3.1%	2.8%
<b>Family</b>	2.2%	2.9%	5.3%	3.9%
<b>Work</b>	13.4%	7.2%	22.2%	16.7%
<b>Illegal sources</b>	21.5%	14.4%	14.2%	8.5%
<b>Family and work</b>	9.1%	12.9%	11.9%	13.6%
<b>Family and illegal sources</b>	6.2%	17.3%	5.6%	6.5%
<b>Illegal sources and work</b>	16.5%	5.8%	16.4%	15.6%
<b>Family, illegal sources and work</b>	29.8%	35.3%	21.4%	32.5%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

**Table 4.2. illegal sources of money**

	<b>Italy</b>	<b>Czech Republic</b>	<b>Portugal</b>	<b>Spain</b>
<b>No illegal activities</b>	26.0%	27.3%	42.8%	37.0%
<b>Dealing</b>	21.2%	9.4%	16.7%	15.2%
<b>Prostitution</b>	0.9%	2.2%	2.8%	2.0%
<b>Theft/robbery</b>	18.9%	26.6%	13.6%	17.3%
<b>Dealing and prostitution</b>	1.0%	1.4%	0.6%	0.6%
<b>Dealing. theft and robbery</b>	23.6%	26.6%	15.3%	22.4%
<b>Prostitution. theft and robbery</b>	0.7%	0.7%	1.4%	2.0%
<b>Dealing. prostitution. theft and robbery</b>	2.3%	3.6%	3.1%	0.8%
<b>Other illegal activity</b>	5.3%	2.2%	3.9%	2.8%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

Dealing alone (21.2% in Italy, Table 4.2) and together with other illegal activities is the most important illegal source of revenue in Italy and in Portugal. Looking at Table 2.2, concerning arrests and incarcerations, dealing is less important than other crimes, which can be against property (robbery and theft) or against persons (violence and vandalism).

This statistical evidence drives us to the following principles:

- 1) Law enforcement officers can't deal with all of the street dealers (because there are too many), so only a minority of them are arrested;
- 2) Robbery and theft and perhaps also violence and vandalism are so frequent as crimes committed by drug addicts, that they are often incarcerated for these crimes, which are less frequently committed by other people.

Table 4.3. illegal sources of money – female

	Italy	Czech Republic	Portugal	Spain
<b>No illegal activities</b>	20.6%	33.3%	43.3%	47.1%
<b>Dealing</b>	25.5%	11.1%	14.9%	9.1%
<b>Prostitution</b>	4.9%	2.2%	13.4%	8.3%
<b>Theft/robbery</b>	9.8%	17.8%	11.9%	11.6%
<b>Dealing and prostitution</b>	4.9%	2.2%	1.5%	2.5%
<b>Dealing, theft and robbery</b>	12.7%	24.4%	4.5%	9.9%
<b>Prostitution, theft and robbery</b>	4.9%	-	3.0%	7.4%
<b>Dealing, prostitution, theft and robbery</b>	8.8%	6.7%	6.0%	2.5%
<b>Other illegal activity</b>	7.8%	2.2%	1.5%	1.7%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

Table 4.4. illegal sources of money – male

	Italy	Czech Republic	Portugal	Spain
<b>No illegal activities</b>	26.9%	24.5%	42.7%	33.9%
<b>Dealing</b>	20.5%	8.5%	17.1%	17.1%
<b>Prostitution</b>	0.2%	2.1%	0.3%	-
<b>Theft/robbery</b>	20.5%	30.9%	14.0%	19.1%
<b>Dealing and prostitution</b>	0.3%	1.1%	0.3%	-
<b>Dealing, theft and robbery</b>	25.4%	27.7%	17.7%	26.4%
<b>Prostitution, theft and robbery</b>	-	1.1%	1.0%	0.3%
<b>Dealing, Prostitution, theft and robbery</b>	1.2%	2.1%	2.4%	0.3%
<b>Other illegal activity</b>	4.9%	2.1%	4.4%	3.1%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

**Table 4.5. distribution of respondents who contracted a debt in order to buy drugs, versus those who didn't - male**

	Italy	Czech Republic	Portugal	Spain
<b>No debt</b>	61.3%	38.1%	57.5%	33.7%
<b>Borrowing</b>	6.4%	19.4%	18.1%	3.5%
<b>Borrowing from dealer</b>	10.5%	12.2%	5.8%	25.2%
<b>Borrowing from dealer and other</b>	21.8%	30.2%	18.6%	37.6%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

**Table 4.6. distribution of respondents who contracted a debt in order to buy drugs, versus those who didn't - female**

	Italy	Czech Republic	Portugal	Spain
<b>No debt</b>	57.8%	42.2%	59.7%	38.0%
<b>Borrowing</b>	5.9%	13.3%	20.9%	5.0%
<b>Borrowing from dealer</b>	14.7%	20.0%	4.5%	22.3%
<b>Borrowing from dealer and other</b>	21.6%	24.4%	14.9%	34.7%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

A final observation concerns the welfare assistance policy of the Czech Republic and Spain that seems to provide for a large number of drug addicts. The results are measurable in a minor incidence of street drug selling among the respondents.

**Table 4.7. distribution of respondents who got contributions from social assistance**

	Italy	Czech Republic	Portugal	Spain
<b>social assistance alone</b>	0.3%	1.4%	0.6%	1.2%
<b>social assistance and other sources</b>	3.9%	45.0%	10.8%	35.9%
<b>no contribution from social assistance</b>	95.8%	53.6%	88.6%	63.0%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

# CHAPTER 5

## Evaluation of Services

Evaluations of services [1= lowest rating - 5 = highest rating] are at approximately the same levels in all the countries included in this survey. An exception is “legal access to drug substitutes” which is evaluated by respondents as positive (3.70) only in Portugal (Table 5.1). The lowest evaluations are always reported in Czech Republic.

**Table 5.1. average rate of patient satisfaction for health care services**

	Italy	Czech Republic	Portugal	Spain
<b>Psychological assistance</b>	3.95	3.18	4.05	3.97
<b>Medical assistance</b>	3.35	2.98	3.86	3.93
<b>Sharing my experiences with others in a therapeutic community</b>	3.65	3.10	3.56	3.39
<b>Getting back to living according to rules in a community</b>	3.67	3.56	4.13	4.24
<b>Legal access to drug substitutes</b>	2.57	2.45	3.70	2.96
<b>Retraining. Assistance to find work</b>	3.87	3.48	4.37	3.71

Table 5.2 shows the evaluations of institutions. In the Czech Republic the possible answers for this question include the complete chain of possible services rather than possible Institutions<sup>1</sup>.

**Table 5.2. average rate of patient satisfaction for institutions**

	Italy	Czech Republic	Portugal	Spain
<b>Public socio-therapeutic services (Ser.T. in Italy. drug substitution in Czech R.)</b>	3.80	3.13	3.99	4.32
*Detoxification units-		3.02		
Middle period residential care-		3.20		
*Diagnostical institutions -		2.00		
<b>Low threshold services</b>	3.46		3.67	4.19
*Street programs/territory programs-		4.31		
Contact centers/low threshold services -		4.32		
Ambulant medical care for depended people*		3.23		
Homeless shelters; meal centres	3.43	3.08	3.23	3.34
Drop-in centre	-	2.40	2.98	4.18
Therapeutic community	4.17	3.62	4.03	3.92
Outpatient Follow -up care -		3.31		
Sheltered accomodation and protected work -		2.96		
Hospital psychiatric/mental health services	2.76	2.59	2.84	3.46
Public psychological/counseling services	3.08		3.54	3.64
Private psychological/counselling services	2.78	2.74	3.41	3.17
Family doctor	3.06	2.75	3.14	3.71
Private detoxification centres	2.79	2.55	3.68	3.34

<sup>1</sup> Quite interesting is the organization of these services. For an examination see: Mravčík, V., Grohmannová, K., Chomynová, P., Nečas, V., Grolmusová, L., Kiššová, L., Nechanská, B., Fidesová, H., Kalina, K., Vopravil, J., Kostelecká, L. & Jurystová, L. 2012. Výroční zpráva o stavu ve věcech drog v České republice v roce 2011 [The Czech Republic - Drug Situation 2011], Praha, Úřad vlády ČR [Office of the Czech Government].



## APPENDIX 1 – Other variables related to Lifestyle.

**Question 6 Employment status per gender**

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
Student	2.6%	9.9%	3.1%	12.3%	3.9%	1.4%	0.0%	11.8%
Stable work	25.0%	23.4%	8.5%	15.4%	12.4%	13.7%	11.7%	13.7%
Temporary contract	20.9%	20.7%	6.4%	12.3%	6.9%	4.1%	3.2%	7.8%
Self employment	19.3%	6.3%	4.6%	1.5%	3.3%	5.5%	10.6%	3.9%
Occasional job	27.9%	34.2%	3.4%	7.7%	5.6%	8.2%	58.5%	51.0%
I've never worked	4.2%	5.4%	1.5%	0.0%	0.7%	1.4%	16.0%	11.8%
Unemployed	0.0%	0.0%	52.8%	10.8%	67.3%	65.8%	0.0%	0.0%
Disabled	0.0%	0.0%	4.9%	7.7%	0.0%	0.0%	0.0%	0.0%
Retired	0.0%	0.0%	14.7%	24.6%	0.0%	0.0%	0.0%	0.0%
Work at home	0.0%	0.0%	0.0%	7.7%	0.0%	0.0%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**Question 9 First experiences (average age)**

	ITALY		SPAIN		PORTUGAL		CZECK REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
When did you try the first drug	14.76	14.27	14.02	15	14.55	14.32	14.88	14.58
When did you try a hard drug	17.44	16.76	16.74	17.79	18.02	18.16	17.29	16.79
When did you start to sell drugs?	17.78	18.97	19.46	20.19	20.51	22.32	18.94	19.16

**Question 12 Where did you try first drugs?**

	ITALY		SPAIN		PORTUGAL		CZECK REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
At home	9.5%	19.2%	9.5%	22.5%	18.7%	32.9%	12.4%	14.3%
On the street	45.3%	35.6%	46.3%	33.3%	55.5%	28.6%	30.9%	12.2%
Social center/squat	0.7%	0.0%	0.5%	2.5%	1.3%	2.9%	3.1%	0.0%
Prison	0.2%	1.0%	0.5%	0.0%	0%	0%	2.1%	0.0%
Club disco bar	6.8%	10.6%	14.7%	19.2%	4.7%	2.9%	17.5%	26.5%
Rave	0.2%	1.0%	1.1%	0.0%	0.7%	1.4%	2.1%	2.0%
School	7.5%	6.7%	4.7%	3.3%	8.0%	12.9%	4.1%	6.1%
Work	2.3%	0.0%	0.5%	0.8%	0.7%	1.4%	1.0%	2.0%
Friend's house	13.3%	12.5%	7.6%	11.7%	8.4%	12.9%	9.3%	24.5%
Gym	0.2%	0.0%	0.5%	0.0%			1.0%	2.0%
Park	6.6%	6.7%	6.6%	3.3%	1.7%	2.9%	12.4%	6.1%
Parish	0.3%	0.0%	0%	0%	0.0%	1.4%	0.0%	2.0%
Stadium	0.8%	0.0%	0.3%	0.0%	0%	0%	0%	0%
Other	6.3%	6.7%	7.1%	3.3%	0.3%	0%	4.1%	2.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**Question 13 When did you first try drugs?**

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
An ordinary day	78.2%	81.1%	75.1%	70.8%	77.5%	80.2%	59.8%	51.0%
Private party	7.1%	6.6%	8.1%	10.0%	11.3%	11.2%	18.6%	10.2%
During vacations	5.3%	6.6%	4.7%	7.5%	5.6%	4.3%	8.2%	12.2%
Public events (concerts. dimostrations. Public party)	5.5%	4.7%	4.9%	5.0%	5.6%	4.3%	8.2%	24.5%
Other	4.0%	.9%	7.3%	6.7%	0%	0%	5.2%	2.0%
Total	100.0%	100.0%	100.0%	100.0%	100%	100%	100.0%	100.0%

























### Question 32.3 How long have you been in a Therapeutic Community?

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
More than two years	30.6%	31.9%	2.9%	3.5%	15.3%	12.3%	1.8%	0.0%
Between one and two years	27.0%	25.3%	3.2%	3.5%	20.5%	22.8%	5.3%	0.0%
Less than one year	30.8%	28.6%	11.5%	12.4%	38.2%	24.6%	43.9%	23.5%
Never	11.6%	14.3%	82.5%	80.5%	26.1%	40.4%	49.1%	76.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

### Question 34 Why did you choose to enter into a therapeutic community? (more than one answer allowed)

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
It was my decision	54.50%	47.17%	37.57%	24.35%	59.81%	61.90%	33.33%	41.46%
It was the only way to stay away from drugs and from bad companies	17.35%	13.21%	18.78%	13.91%	24.88%	26.19%	11.11%	21.95%
I was convinced by the medical services I was using	9.00%	10.38%	14.92%	6.96%	5.26%	9.52%	22.22%	9.76%
I was convinced by my relatives/ my friends	11.29%	21.70%	17.68%	12.17%	16.27%	19.05%	11.11%	4.88%
I was forced but not convinced	6.06%	8.49%	3.87%	2.61%	9.57%	2.38%	11.11%	0.00%
I thought it was better for me to stay in a community rather than in prison	18.33%	7.55%	10.22%	3.48%	2.39%	0.00%	11.11%	17.07%
Other	4.58%	12.26%	1.66%	1.74%	2.87%	9.52%	0.00%	4.88%









### With whom did you live when you were 25?

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
Alone	26.4%	26.0%	16.03%	13.00%	14.06%	13.88%	19.05%	25.58%
My parents	46.0%	34.0%	36.54%	25.00%	26.56%	46.53%	23.81%	11.63%
My partner	23.0%	36.0%	42.31%	53.00%	53.13%	35.51%	47.62%	32.56%
Friends	4.6%	4.0%	5.13%	9.00%	6.25%	4.08%	9.52%	30.23%
Total	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

### With whom did you live when you were 35?

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
Alone	30.3%	20.0%	22.17%	31.94%	30.91%	18.23%	0.00%	15.79%
My parents	27.1%	26.7%	27.15%	25.00%	21.82%	31.03%	0.00%	10.53%
My partner	37.2%	46.7%	45.25%	38.89%	47.27%	42.36%	100.00%	57.89%
Friends	5.3%	6.7%	5.43%	4.17%	0.00%	8.37%	0.00%	15.79%
Total	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

### With whom do you live now?

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
Alone	33.8%	34.4%	22.27%	22.22%	32.08%	26.55%	33.33%	14.29%
My parents	36.9%	21.9%	46.88%	40.40%	28.30%	46.33%	8.33%	14.29%
My partner	21.2%	31.3%	25.00%	29.29%	37.74%	22.03%	58.33%	28.57%
Friends	8.1%	12.5%	5.86%	8.08%	1.89%	5.08%	0.00%	42.86%
Total	100.0%	100.0%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

### What was your employment situation when you started using drugs?

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
Student (only for SPAIN)	0%	0%	47.2%	38.3%	0%	0%	0%	0%
Full-time steady job	29.0%	29.3%	23.9%	27.5%	40.9%	39.0%	28.2%	26.7%
Self employed or professional work	12.4%	4.0%	2.6%	3.3%	5.5%	.0%	1.4%	6.7%

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
Part-time job (occasional work for Italy and Spain)	23.3%	21.3%	6.6%	12.5%	3.5%	6.8%	1.4%	3.3%
Short term contract	5.9%	8.0%	7.3%	2.5%	6.3%	6.8%	11.3%	16.7%
Unemployed	22.0%	28.0%	3.9%	4.2%	22.4%	22.0%	32.4%	30.0%
I've never been employed	7.4%	9.3%	4.7%	5.0%	21.3%	25.4%	25.4%	16.7%
Permanent disability	0%	0%	0.00%	0.00%	0%	0%	0%	0%
Retired	0%	0%	0.3%	0.8%	0%	0%	0%	0%
Work at home	0%	0%	0.0%	3.3%	0%	0%	0%	0%
Other	0%	0%	3.4%	2.5%	0%	0%	0%	0%
Total	100%	100%	100.0%	100.0%	100%	100%	100%	100%

### What was your employment situation when you were 25?

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
Student (only for SPAIN)	0%	0%	2.3%	3.8%	0%	0%	0%	0%
Full-time steady job	35.0%	40.0%	50.4%	43.4%	53.6%	46.9%	31.0%	36.0%
Self employed or professional work	16.9%	0.0%	6.0%	1.9%	11.3%	4.7%	6.9%	4.0%
Part-time job (occasional work for Italy and Spain)	23.3%	31.1%	10.3%	18.9%	3.6%	6.3%	3.4%	8.0%
Short term contract	6.4%	4.4%	12.5%	9.4%	16.1%	17.2%	25.9%	24.0%
Unemployed	14.3%	22.2%	8.5%	10.4%	14.1%	21.9%	22.4%	24.0%
I've never been employed	4.1%	2.2%	4.0%	1.9%	1.2%	3.1%	10.3%	4.0%

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
Permanent disability	0%	0%	0.3%	1.9%	0%	0%	0%	0%
Retired	0%	0%	0.9%	0.9%	0%	0%	0%	0%
Work at home	0%	0%	0.0%	3.8%	0%	0%	0%	0%
Other	0%	0%	4.8%	3.8%	0%	0%	0%	0%
Total	100%	100%	100.0%	100.0%	100%	100%	100%	100%

### What was your employment situation when you were 35?

	ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
	Male	Female	Male	Female	Male	Female	Male	Female
Student (only for SPAIN)	0%	0%	1.4%	0.0%	0%	0%	0%	0%
Full-time steady job	30.3%	20.6%	28.3%	32.6%	38.1%	38.3%	17.2%	25.0%
Self employed or professional work	17.9%	5.9%	7.1%	1.1%	7.0%	3.3%	10.3%	0.0%
Part-time job (occasional work for Italy and Spain)	19.4%	32.4%	4.6%	7.9%	5.6%	6.7%		
Short term contract	7.5%	8.8%	8.5%	6.7%	14.0%	16.7%	17.2%	25.0%
Unemployed	22.4%	32.4%	31.4%	29.2%	34.4%	33.3%	44.8%	50.0%
I've never been employed	2.5%	0.0%	2.8%	2.2%	0.9%	1.7%	10.3%	0.0%
Permanent disability	0%	0%	2.8%	4.5%	0%	0%	0%	0%
Retired	0%	0%	8.5%	10.1%	0%	0%	0%	0%
Work at home	0%	0%	0.4%	4.5%	0%	0%	0%	0%
Other	0%	0%	4.2%	1.1%	0%	0%	0%	0%
Total	100%	100%	100.0%	100.0%	100%	100%	100%	100%





## APPENDIX 5 – Question 8: doses used along three periods.

During the first year of use - After three years of use - Last time

### Question 8.4 Cannabis joints per day.

		ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
		Male	Female	Male	Female	Male	Female	Male	Female
First year	Mean	7.41	6.24	5.57	4.01	6.40	4.68	2.68	2.13
	Median	5	6	4	2	5	3	2	2
	St.dev	6.71	4.77	5.81	5.01	5.35	5.67	3.37	1.43
After three years	Mean	10.76	9.82	8.65	6.86	10.09	6.77	4.35	2.79
	Median	10	10	7	5	9	5	3	2
	St.dev	8.13	6.81	6.70	4.95	5.89	10.43	3.92	2.10
Last time	Mean	7.85	5.97	6	4.82	6.34	7.23	4.32	2.12
	Median	5	5	4	2	3	3.5	3	2
	St.dev	8.18	4.79	5.95	5.35	7.66	10.9	4.94	1.64

### Question 8.6. Cocaine. lines per day.

		ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
		Male	Female	Male	Female	Male	Female	Male	Female
First year	Mean	5.69	5.38	6.69	8.21	5.07	3.77	1.57	4.50
	Median	4	3	4	6	2	2	1	3.50
	St.dev	5.40	6.90	9.46	9.43	6.07	5.20	1.13	3.87
After three years	Mean	10.47	13.29	12.55	15.98	8.61	4.23	2	5.50
	Median	7	10	9	10	4	3	2	3
	St.dev	10.46	11.50	12.96	18.44	11.03	2.92	0.82	6.40
Last time	Mean	11.50	12.14	13.05	13.69	6.61	5.85	2	6.25
	Median	7	10	8	8	3	3	2	2
	St.dev	12.15	13.24	13.87	16.85	8.24	10.43	1	9.22

### Question 8.7 Heroin doses per day.

		ITALY		SPAIN		PORTUGAL		CZECH REPUBLIC	
		Male	Female	Male	Female	Male	Female	Male	Female
First year	Mean	3.69	3.67	4.42	3.39	2.76	2.56	1.57	2
	Median	2	3	2.5	2	2	1	1	2
	St.dev	4.67	3.38	6.89	3.19	5.58	3.72	1.23	1.41
After three years	Mean	6.15	6.83	8.39	5.52	5.34	4.81	1.94	2
	Median	4.5	5	4.5	4.5	3.5	3	1	2
	St.dev	5.99	4.43	12.35	3.74	10.98	6.11	1.58	1
Last time	Mean	6.54	6.17	6.90	3.37	4.28	6.13	3.57	2.5
	Median	5	4.5	3	2	3	2.50	3	2.5
	St.dev	6.69	5.13	12.46	3.78	4.61	9.36	2.99	0.71







## PART 2

# Italian Survey

Francesco Fabi, Umberto Iallicco, Claudia Musella,  
Claudia Restelli and Roberto Ricci

Sampling design, data collection, data entry and analysis have been conducted by the Easy and Faster s.r.l. working group coordinated by Roberto Ricci and composed of: Francesco Fabi, Umberto Iallicco, Claudia Musella and Claudia Restelli.



# INTRODUCTION

## 1. Sampling Methodology

The research methodology used in this study is based on a sample composed of those who approached socio-sanitary structures to deal with their drug addiction. These structures include Low Threshold Services (LTS) and Therapeutic Communities (TC). Public services (Ser.T. in Italy) are not involved in this survey.

## 2. Typology of Services

The two kinds of structures are well integrated with the Ser.T. in Italy. The LTS - Low Threshold Services - are important for a first contact and to provide support for the drug addict who doesn't want to be registered on a public programme. They are structures for people who don't want to enter into a residential therapeutic center and you can meet both young and old users there. Most patients are still using substances.

LTS are services aimed at reaching more addicts and remaining in contact with them, without requesting abstinence.

If the LTS seem to be specialized in the first phase of treatment, the Therapeutic Community is more focused on the final phase, but as we have already underlined it is so frequent to fall again into use that sometimes, also in the case of a residential patient of a TC, the final stage of rehab is never completely reached.

TCs are drug-free environments distinguished by a residential long-term approach, where drug addicts live in an organized and structured way, in order to get ready for a drug-free life. TCs provide psychotherapeutic support to the addicts under psychiatric supervision, namely, the creation of the conditions for their social reintegration.

In both cases - with regard to residential or non-residential services - it's important to specify that these services cannot grant a different and specifically designed path of treatment for each and every case of problematic consumption.

For example, most users who are poly-drug users generally can't be oriented towards a specific and adequate treatment plan because of a lack of knowledge about the many possible damages to the nervous system inflicted by drugs (that can cause mental disorders and complex dependences). Currently there is neither a formal protocol on methodologies and length of treatment nor a specific treatment methodology for these patients.

Some patients, either poly-drug users or basic consumers, often leave before the end of treatment because they don't find their program to be effective and consistent with their specific addiction.

### **3. Care phases**

The treatment plan offered by the two types of services can be articulated into four main steps:

1. First contact
2. Detoxification
3. Psychological treatment
4. Social reintegration

These steps can be undergone in residential and non-residential programs. The latter 3 services can be provided both by non-residential structures and by therapeutic communities. 'First contact' is more usual in LTS and Ser.T (the Italian public service for drug addicts).

In fact in Italy the fees for a therapeutic cycle in a TC are paid by the Ser.T. A Ser.T defines therapeutic programs for the single user and can address a user to a therapeutic community. In these structures the treatment programs could be implemented at any stage of the process. Usually the first step consists of drug treatment (detoxification), which is often considered to be the best start to a path of treatment.

It is not so rare, especially for people who don't want to be registered as drug addicts, that someone pays a therapeutic community directly and first contact happens without the authorization of the Ser.t. This often happens on demand by users who prefer entering into a community while keeping anonymity.

During detoxification, substitutive drugs dispensation is applied, with a consequent diminution in discomfort. Detoxification is a difficult process for poly-drug users to go through, since this type of subject is more prone to relapse. Even those who find a way to detoxify by using methadone find it really hard to successfully reach their goal. There's a deficiency in specific knowledge that should be applied in this field in order to find new methods of detoxification, especially when it comes to poly-users.

Psychological treatment aims to give solid instruments to avoid using drugs again.

The last step consists of social reintegration, which can be provided by therapeutic communities or by other specific structures. Here patients are supported in work and social rehabilitation.

#### 4. Sample structure

The targeted number of actual interviews was 720. Users were contacted through the private-social organizations that provide services for drug addicts, throughout the country. 47 structures were contacted . Some of the centers contacted offer both services.

**Sample size in each kind of structure**

<b>LTS</b>	<b>TC</b>	<b>Total</b>
<b>189</b>	<b>531</b>	<b>720</b>

As seen in the following Table 1.1., this survey sample has a low presence of women, which confirms the results obtained from administrative data and from our 2010 survey.

Nevertheless given that there are more women under 24 years of age than men, several considerations can be inferred: (a) In general adult women can find support coming sources other than care communities; (b) they seem to be more responsible than men with regard to drug use, perhaps because they have the possibility of becoming pregnant and therefore accept a therapeutic program earlier than men, so as to not jeopardize the possibility of bearing children.

## 5. Short Recap of the Italian Survey conducted in 2010

In 2010 a large survey was carried out in Italy and it has been used as a reference point for this survey, which is now extended to other European Countries. In the text many comparisons were made ; 1440 valid questionnaires were collected in 2010, with the following sample structure. The age range was 14 – 65 with the mean age for LTS users being 36 and for 34 for TC .

	LTS	TC	Total
Sample size	299	1141	1440
Female	17,5%	16,4%	100.0%
Male	82,5%	83,6%	100.0%
Total	100,0%	100,0%	

The trends and the main findings of the 2010 survey are confirmed by the present survey.

# CHAPTER 1

## Characteristics of Users

### 1.3 Age, gender and first use

Table 1.1. shows the proportion of male and female users from the sample. Males are in the majority (85.2%). Almost the same proportion can be seen both in LTS and TC services : females represent 15.3% of those in the LTSs and 14.6% of those in the TCs. This finding confirms the results obtained in 2010.

**Table 1.1. gender distribution (LTS and TC) 717 respondents**

	low threshold	Therapeutic Communities	Total
Female	15.3%	14.6%	14.8%
Male	84.7%	85.4%	85.2%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

**Figure 1.1. age distribution (LTS and TC) 706 respondents.**

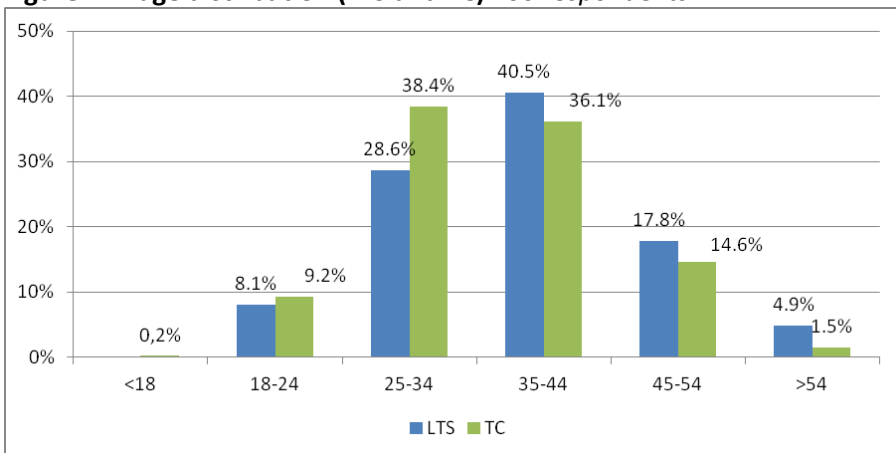
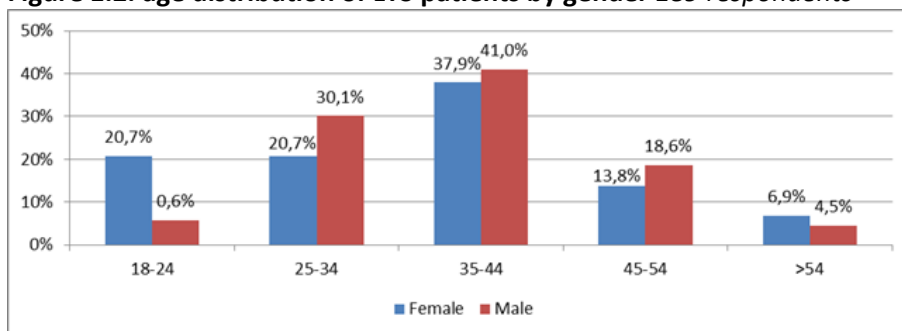


Figure 1.1 shows the distribution of the respondents by age in each service. 73% of respondents were in the age groups 25-34 and 35-44. The rest of the population (27 %) is distributed in the other four age groups from 15 to 24 years old and from 45 to the last age group > 54.

The respondents aged 35 - 44 are the main users of low threshold services, this class comprises 40.5% out of the whole population of low threshold service users. The majority of those who are in therapeutic communities are in the age group 25 - 34 (38.4%), just 2.3 % higher than the following age group.

The patients of therapeutic community services are a little younger than patients of the low threshold services, their average age is respectively 35.5 and 38.1 years old .

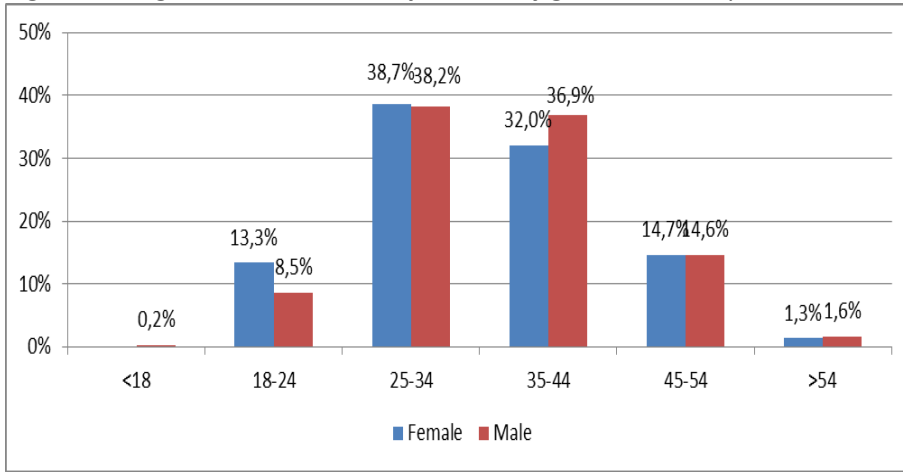
**Figure 1.2. age distribution of LTS patients by gender 189 respondents**



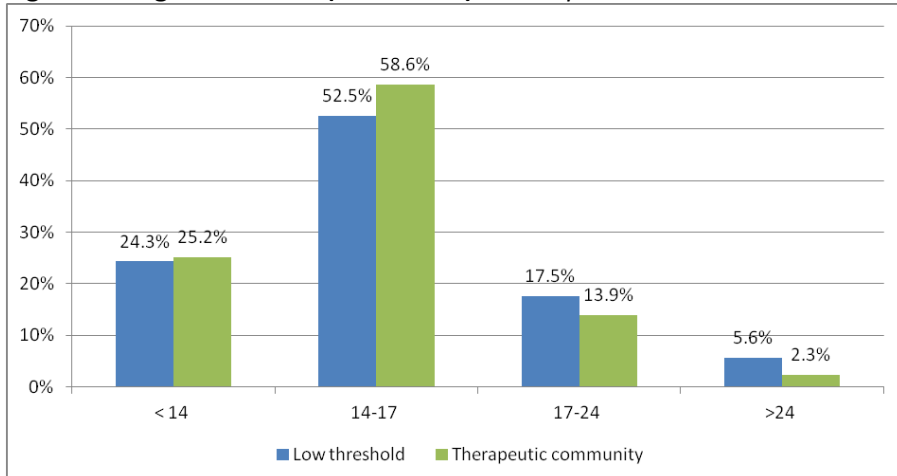
Most men (Figure 1.2) approaching LTSs are between 35 and 44 years old (41.0%). This class is followed by the age class 25 – 34 (30.1 %).

The age distribution of women displays another scenario. The modal value is always in the age cohort between 35 and 44 (37.9%), followed by 41.4% for younger subjects equally spread (20.7) among the age classes 18-24 and 25-34.



**Figure 1.3. age distribution of TC patients by gender 528 respondents**

Regarding the distribution of people using a therapeutic communities, in figure 1.3, the modal value is the age group 25-34 years old for both genders and the two distributions don't differ greatly, though women younger than 25 years old (13.3%) are much more highly represented than the corresponding male sample (8.7%).

**Figure 1.4. age at first use (LTS and TC) 665 respondents**

First use (Figure 1.4) is widespread among those in the age group 14 to 17, both for LTS (52.5 %) and TC users (58.6 %).

The second biggest age group concerns users less than 14 years old, TC and LTS are almost at the same level (25.2 % and 24.3 %).

The older the respondents get, the more the percentage of those who approach drugs the first time decreases, moreover (Figure 1.4) the older beginners seem to prefer LST; probably because LTSs are the prevalent services in the phase of "first contact", before a TC treatment period, or because the "older beginners" are of working age and they don't want to stop working and to start a therapeutic period in TC.

**Table 1.2. first drug experimented with (LTS and TC) 692 respondents.**

	Therapeutic Communities	Low Threshold	Total
Tranquilizers/sedatives (without medical prescription)	1.4%	1.7%	1.4%
Amphetamines	0.4%	-	0.3%
Ecstasy (MDMA. XTC. etc...)	1.4%	-	1.0%
Cannabis	75.6%	66.5%	73.3%
Crack	0.4%	-	0.3%
Cocaine	10.7%	14.0%	11.6%
Heroin	5.1%	13.4%	7.2%
Psychedelic mushrooms	0.2%	-	0.1%
Ketamine	-	0.6%	0.1%
LSD	0.2%	1.1%	0.4%
Kobret	0.2%	-	0.1%
Another drug	4.5%	2.8%	4.0%
Total	100.0%	100.0%	100.0%

For both groups of users (Table 1.2.) cannabis was the most usual choice for first contact with illicit drugs. Almost 7 out of 10 users (73.3%) started with this type of illicit drug (66.5% in LTS and 75.6% in TC) .

The second most popular drug for first use is cocaine (11.6% average between LTS and TC patients). Heroin use was reported by 13.4% of LTS patients and only by 5.1% of patients in TC.

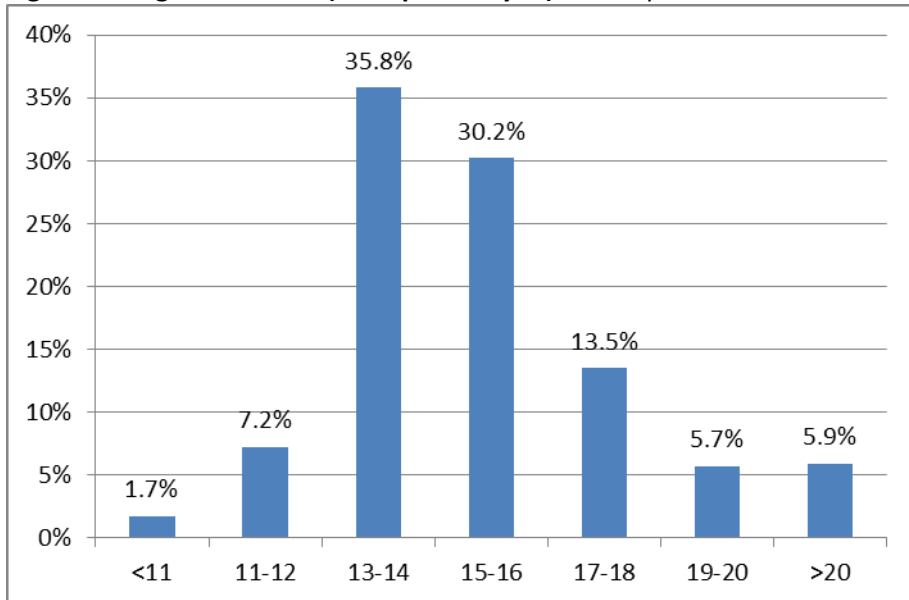
Tranquillizer use is noteworthy, specifically when taken without prescription. 1.7% of LTS users and 1.4% of TC residents used this type of substance the first time they experimented with substances. Other drugs are negligible.

## 1.2. First Contact with Drugs

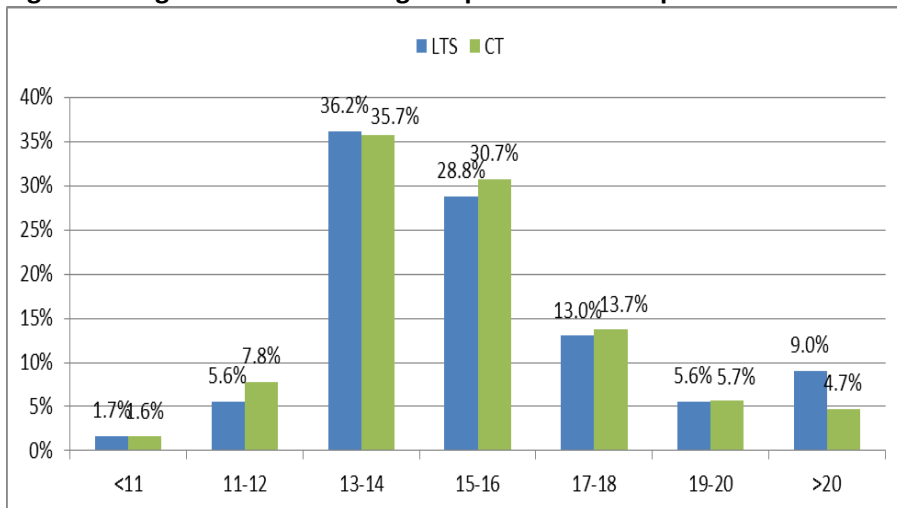
This section will attempt to provide some further information on the age of drug use initiation, and it starts with a more detailed distribution of age (Figure 1.5, 1.6, 1.7).

Females are prevalent over males among those who started use late (Figure 1.7, last age group) and those who started drug use early.

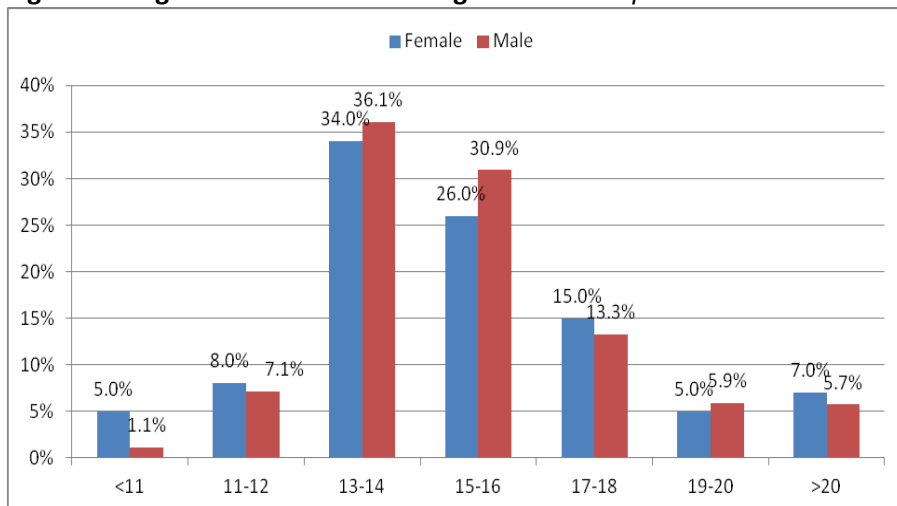
**Figure 1.5. age at first use (a deeper analysis) 665 respondents**



**Figure 1.6. age at first use among LTS patients and TC patients**



**Figure 1.7. age at first use related to gender 663 respondents**



**Figure 1.8. age at first use related to current age 655 respondents**

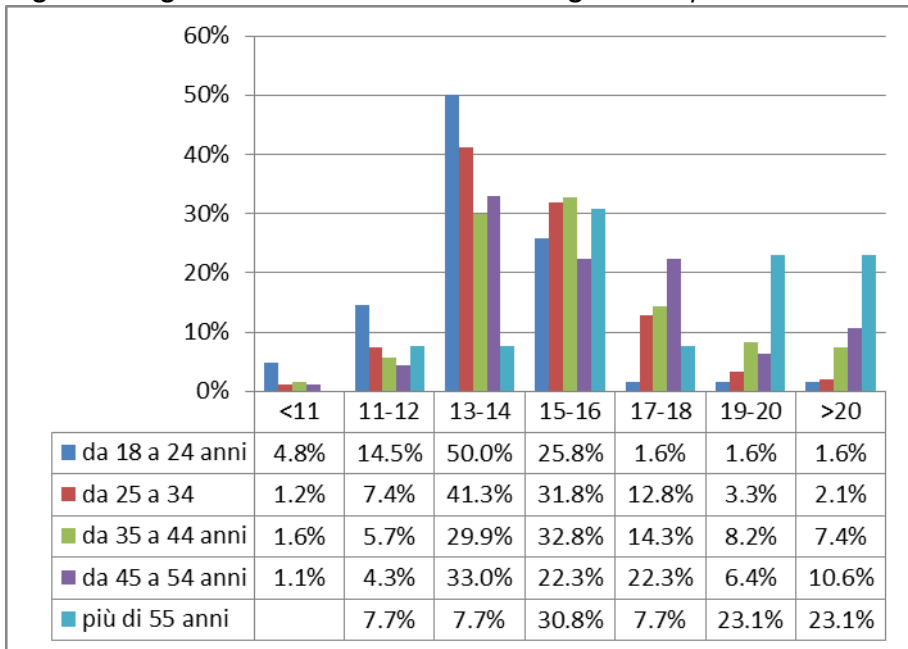
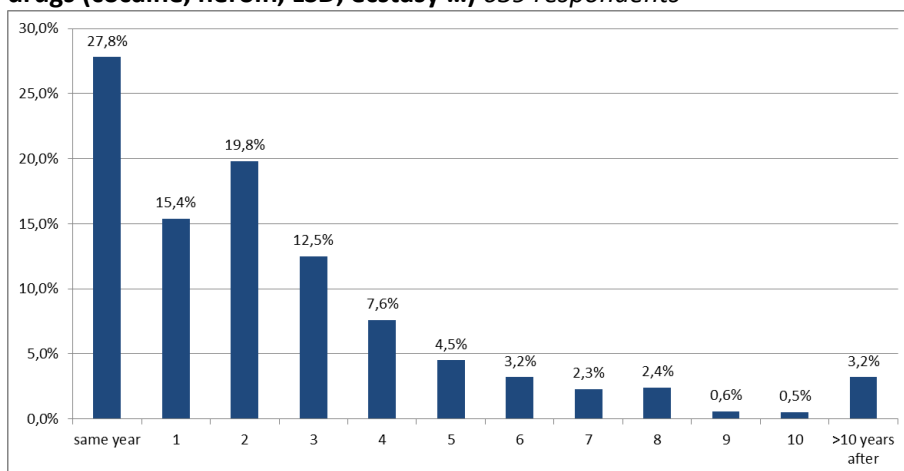


Figure 1.8 confirms that no particular differences can be found among patients, but an increasing percentage of early first users is evident in the distribution of the age group 18 – 24 years old in comparison with the distributions of the other groups. Around 50% in the age group 18 – 24 started at the age of 13 – 14 years old, a bit less than 15% in the period of 11 – 12 years old and around 5 % before 11 years old.

Figure 1.9 shows the latent period elapsed between the first use of soft drugs and the first use of hard drugs. Most patients have tried hard drugs in the same year of first use: the modal value corresponds to “same year” with 27.8 % of respondents. After 2 years around 63 % of respondents have switched to hard drugs.

**Figure 1.9. latency period of the changeover from soft drug to heavy drugs (cocaine, heroin, LSD, ecstasy ...) 639 respondents**



The latency of the switchover to hard drugs is influenced by the age at which users have experimented with drugs. Most patients who tried drugs older (19-25) changed to hard drugs in the same year that they first tried drugs (Table 1.3.). For the 80% of users who tried drugs at the age 21-25 years old and the 45.5% who tried them when they were 19-20 years old, changeover to hard drugs happened during the same year of the first consumption. Again from Table 1.3. those who first take drugs at about 11-14 years old, pass to hard drugs after 1 to 4 years.

When the age of first use increases, the latency rates decrease. The only one nonconforming case is with those starting with drugs around 17-18 years old. In fact we see a considerable percentage of these users change over to hard drugs 8 years after first use.

Notably, in Table 1.3., the small number of users starting drug use before 10 years old amounts to 1.4% of the whole sample so the analysis of these respondents has no relevant weight.

**Table 1.3. age at initiation of drug use related to latency period of the changeover to hard drugs (joint distribution) 585 respondents.**

		Age of the first drug consumption							Total
		<10	11-12	13-14	15-16	17-18	19-20	21-25	
Latency	same year	0.3%	0.5%	6.0%	7.4%	3.9%	1.7%	4.1%	23.9%
	after 1 year		0.9%	6.3%	5.8%	2.4%	0.5%	0.3%	16.2%
	after 2 years	0.2%	1.7%	9.9%	5.8%	2.4%	0.7%	0.2%	20.9%
	after 3 years		1.5%	6.2%	3.4%	1.4%	0.3%	0.3%	13.2%
	after 4 years	0.2%	1.0%	4.3%	2.1%	0.5%			8.0%
	after 5 years	0.2%	0.3%	1.9%	1.7%	0.3%	0.3%		4.8%
	after 6 years		0.5%	1.2%	1.2%	0.5%			3.4%
	after 7 years	0.2%	0.5%	0.7%	0.5%	0.3%		0.2%	2.4%
	after 8 years		0.2%	0.5%	0.7%	1.2%			2.6%
	after 9 years			0.2%	0.5%				0.7%
	over 10 years	0.3%	0.5%	1.2%	1.4%	0.3%	0.2%		3.9%
Total		1.4%	7.7%	38.3%	30.4%	13.3%	3.8%	5.1%	100.0%

A better analysis of the relationship between age, first use and latency is reported in Table 1.3.bis with conditioned percentages per column; in Appendix 4 the main parameters of these variables are also reported.

**Table 1.3.bis age at onset of drug use related to latency period of the changeover to hard drugs (conditional distributions)**

		Age of the first drug consumption							Total
		<10	11-12	13-14	15-16	17-18	19-20	21-25	
Latency	same year	25.0%	6.7%	15.6%	24.2%	29.5%	45.5%	80.0%	23.9%
	after 1 year		11.1%	16.5%	19.1%	17.9%	13.6%	6.7%	16.2%
	after 2 years	12.5%	22.2%	25.9%	19.1%	17.9%	18.2%	3.3%	20.9%
	after 3 years		20.0%	16.1%	11.2%	10.3%	9.1%	6.7%	13.2%
	after 4 years	12.5%	13.3%	11.2%	6.7%	3.8%			8.0%
	after 5 years	12.5%	4.4%	4.9%	5.6%	2.6%	9.1%		4.8%
	after 6 years		6.7%	3.1%	3.9%	3.8%			3.4%
	after 7 years	12.5%	6.7%	1.8%	1.7%	2.6%		3.3%	2.4%
	after 8 years		2.2%	1.3%	2.2%	9.0%			2.6%
	after 9 years			0.4%	1.7%				0.7%
	over 10 years	25.0%	6.7%	3.1%	4.5%	2.6%	4.5%		3.9%
Total		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

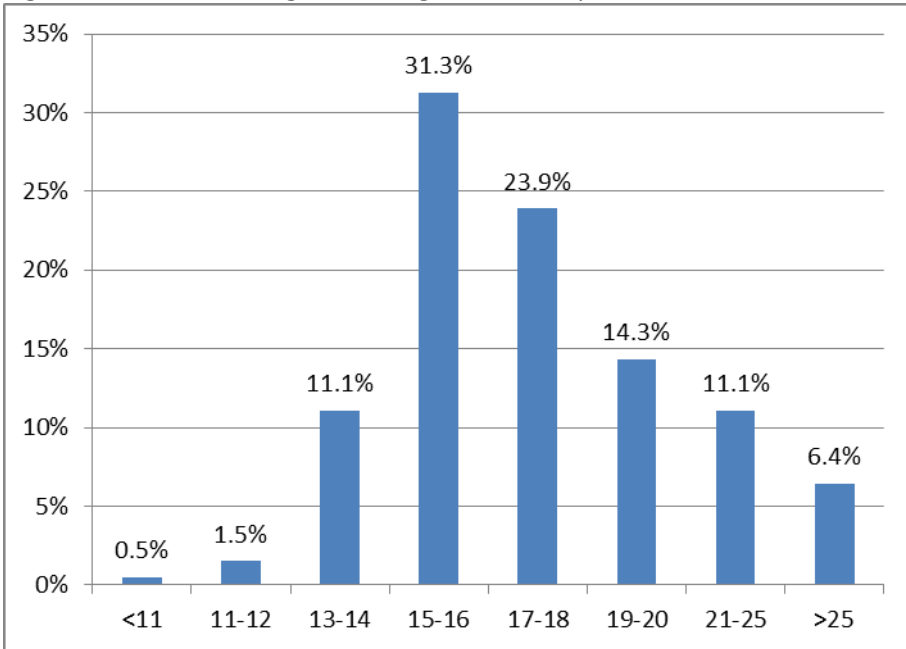
### 1.3. Age of First Drug Sale

The age of the first illegal drug sale is another important characteristic (Figure 1.10), the modal value is the age 15-16 (31.3%) followed by the age 17-18.

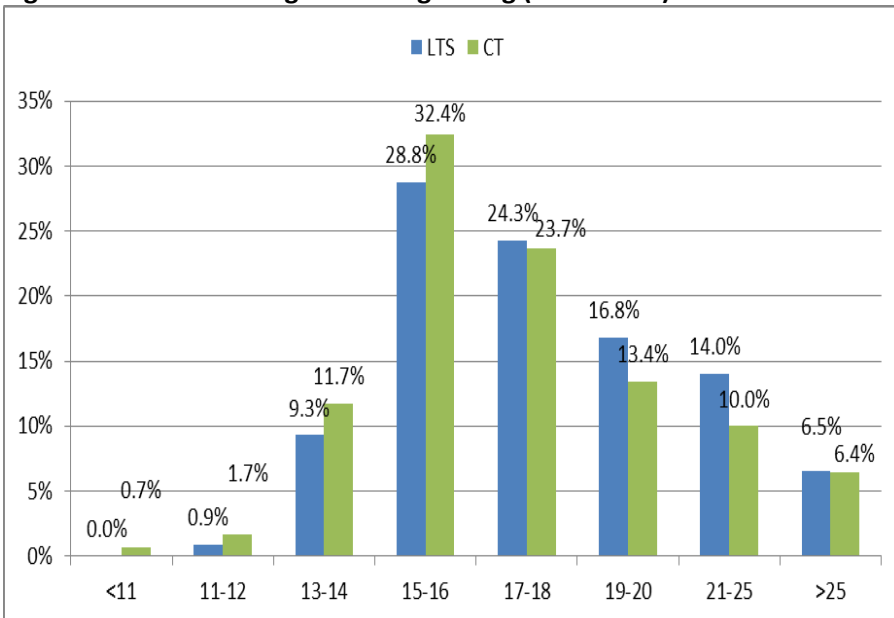
31.8% of respondents started selling drugs after the age of 19 and 13.1% before they had reached 14 years of age. Most users sell drugs for the first time during their secondary school years.



**Figure 1.10. initiation age into drug sale 406 respondents**



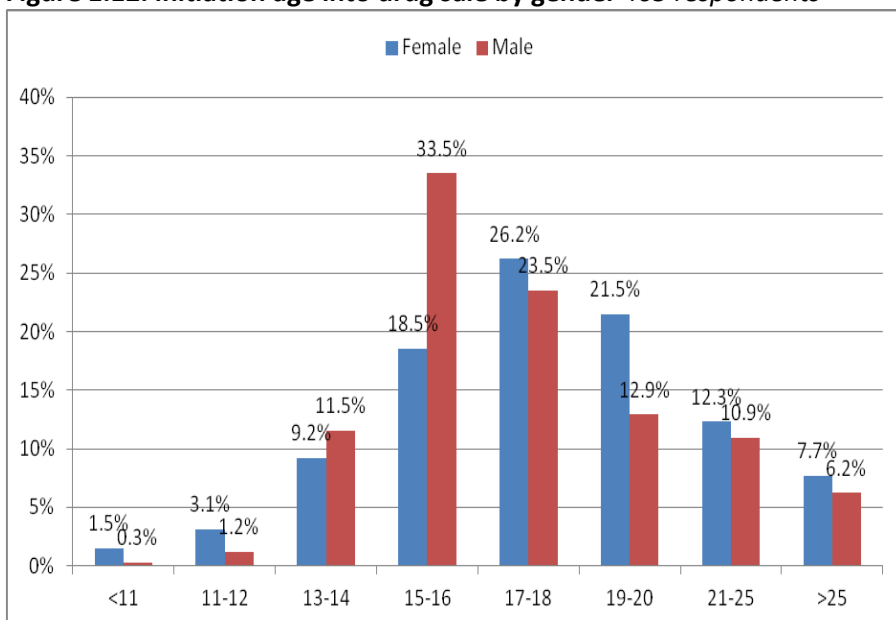
**Figure 1.11. initiation age into drug selling (LTS and TC)**



Patients of therapeutic communities started selling drugs at a younger age than patients of low threshold services. The higher rate is in the age group of 15 – 16 years old for both services .

Regarding gender the modal value is in the class of 15 – 16 years old for males and in the following one for females. Although, in the class of younger than 12 years old, women are the majority.

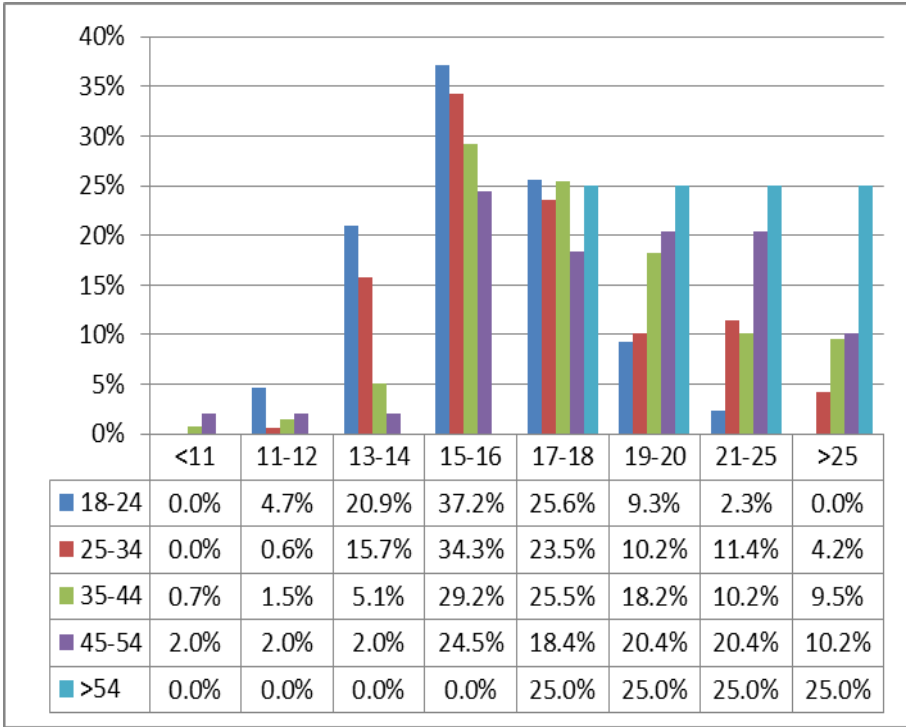
**Figure 1.12. initiation age into drug sale by gender 405 respondents**



Young patients (18-24) of TCs and LTSs generally started selling drugs at a younger age (Figure 1.13).

On the contrary all the patients over 54 started dealing after 17 years old. To make a first drug sale after 15 years old is most common for users aged between 35-44 and 45-54.

**Figure 1.13. initiation age into drug sale related to current age 400 respondents**



**Table 1.4. initiation age into drug sales related to latency period of the changeover to hard drugs (joint distribution)**

*394 respondents.*

		Age of first drug sale								Total
		< 10	11-12	13-14	15-16	17-18	19-20	21-25	> 25	
Latency	same year	0.3%	0.3%	3.0%	5.3%	6.3%	3.0%	2.3%	1.0%	21.6%
	after 1 year	0.3%		2.8%	6.6%	4.3%	2.5%	1.3%	0.5%	18.3%
	after 2 years		0.8%	2.0%	9.6%	6.3%	1.3%	2.5%	0.8%	23.4%
	after 3 years			1.0%	5.6%	3.3%	1.5%	2.3%	0.3%	14.0%
	after 4 years			1.0%	1.8%	1.0%	2.3%	1.0%	0.3%	7.4%
	after 5 years		0.5%		1.0%	1.0%	1.0%	0.8%	1.0%	5.3%
	after 6 years			0.8%	0.5%	0.3%	0.8%	0.3%	0.3%	2.8%
	after 7 years			0.3%	0.8%		0.5%			1.5%
	after 8 years					0.5%		0.5%	0.3%	1.3%
	after 9 years				0.3%		0.3%		0.3%	0.8%
	over 10 years			0.3%	0.3%	0.8%	0.8%	0.3%	1.5%	3.8%
Total		0.5%	1.5%	11.2%	31.7%	23.9%	14.0%	11.2%	6.1%	100.0%

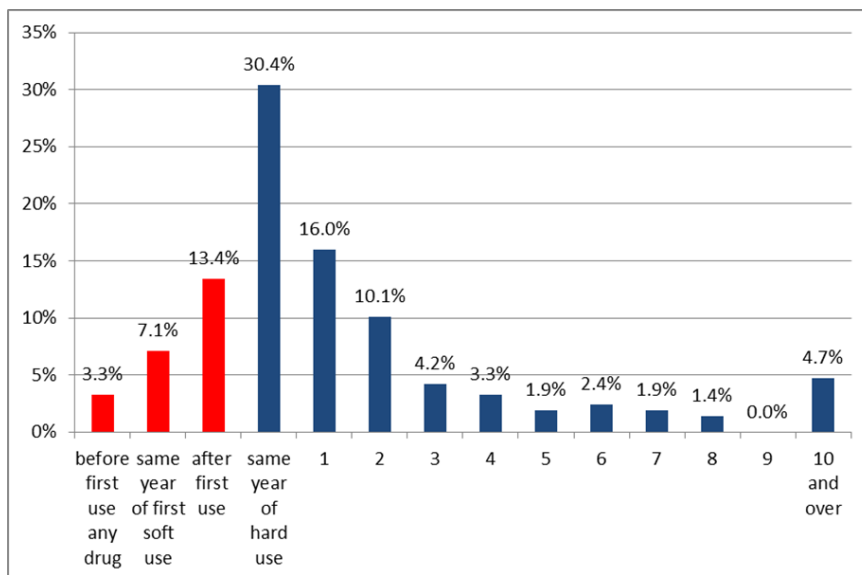
An inverse correlation can be observed between the age of first drug sale and the latency of hard drug use (Table 1.4. and Table 1.4.bis).

**Table 1.4.bis. initiation age into drug sale related to latency period of the changeover to hard drugs (conditional distributions)**

		Age of the first drug sale								Total
		< 10	11-12	13-14	15-16	17-18	19-20	21-25	> 25	
Latency	same year	50.0%	16.7%	27.3%	16.8%	26.6%	21.8%	20.5%	16.7%	21.6%
	after 1 year	50.0%		25.0%	20.8%	18.1%	18.2%	11.4%	8.3%	18.3%
	after 2 years		50.0%	18.2%	30.4%	26.6%	9.1%	22.7%	12.5%	23.4%
	after 3 years			9.1%	17.6%	13.8%	10.9%	20.5%	4.2%	14.0%
	after 4 years			9.1%	5.6%	4.3%	16.4%	9.1%	4.2%	7.4%
	after 5 years		33.3%		3.2%	4.3%	7.3%	6.8%	16.7%	5.3%
	after 6 years			6.8%	1.6%	1.1%	5.5%	2.3%	4.2%	2.8%
	after 7 years			2.3%	2.4%		3.6%			1.5%
	after 8 years					2.1%		4.5%	4.2%	1.3%
	after 9 years				0.8%		1.8%		4.2%	0.8%
	over 10 years			2.3%	0.8%	3.2%	5.5%	2.3%	25.0%	3.8%
Total		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The following figure (1.15) shows evidence of the role of hard drugs in the income generation of drug users: 30.4% respondents begin to sell drugs in the same year of their first use of hard drugs and just 23.8 % have done it before first use of hard drugs and only 3.3 % have sold drugs before using any drug.

**Figure 1.15. age of the first sale compared with age of first soft use and age of first hard use 406 respondents**



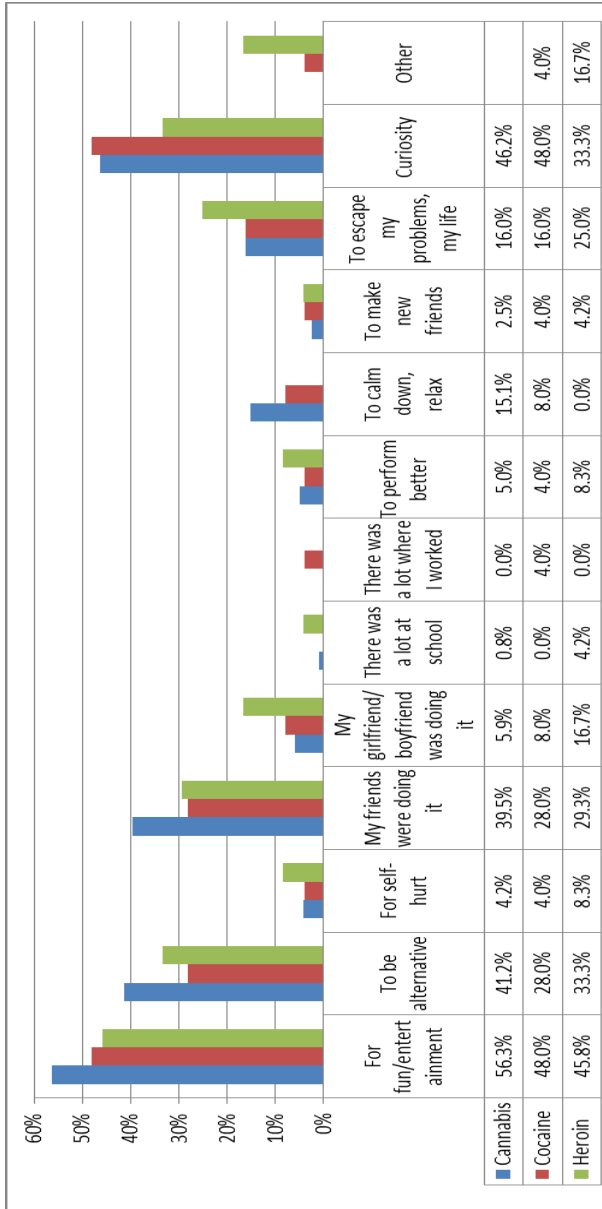
### 1.4 Motivation for First Drug Use

Respondents to this survey have been asked to choose 3 among 13 proposed motivations for the first drug experimented with for the first time (Figure 1.16 and 1.17) considering only cannabis, cocaine and heroin. Everybody has cited “positive” or recreational motivations: fun, curiosity and so on. But some differences emerge in the case of cocaine and heroin use.

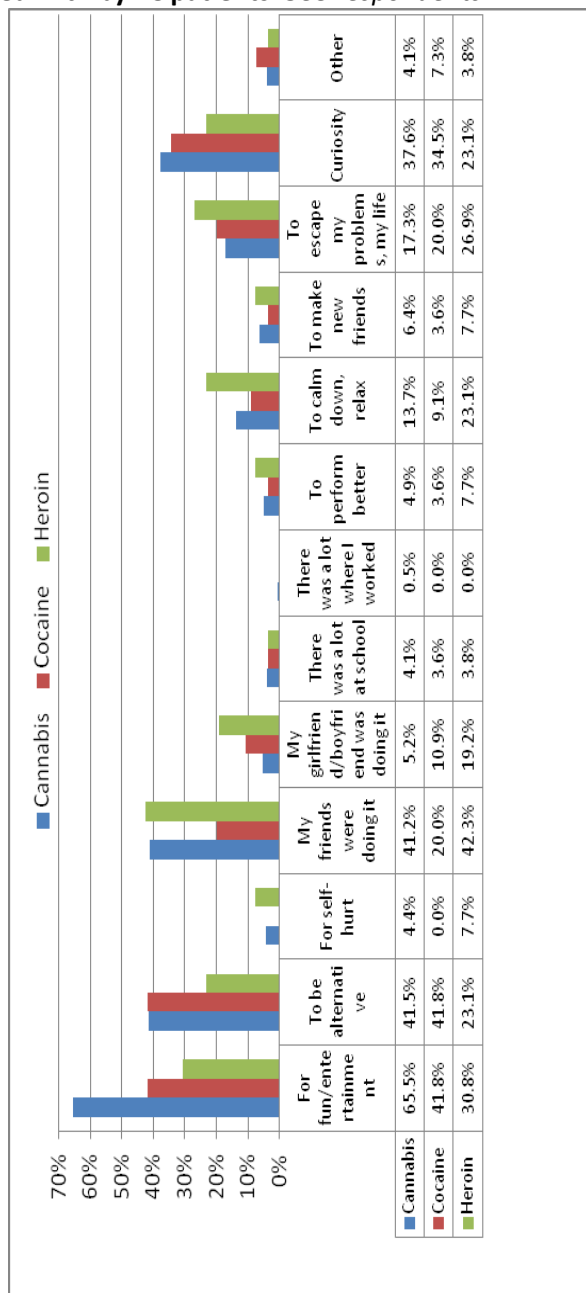
Consumers who started with cocaine have reported different motivations. LTS patients considered curiosity and entertainment as main motivations (48%, 48%); TC patients considered entertainment and the desire to be alternative ( 41.8% for each of these motivations).

Escaping life’s problem as a reason for first use of cocaine was reported by 20% of TC and 16% of LTS users. The intent of emulating a partner is also very noteworthy. 10.9% of TC residents and 8% of LTS users admitted this was a crucial influence.

**Figure 1.16. Motivations of starting drug use related to drug experimented with by LTS patients. 119 respondents**



**Figure 1.17. Motivations for starting drug use related to the kind of drug experimented with by TC patients. 388 respondents**





The distribution of heroin users diverges from LTS to TC users. The majority of LTS respondents (45.8%) assign relevance to recreational use; 42.3% of TC users said they started using heroin drug because their friends were already doing it.

26.9% of heroin users in TC tried drugs to escape life's problems while 29.3% of LTS heroine consumers took it to emulate friends. Providing a better performance, the “self-hurt boost” and the “desire to establish new friendships” are also notable motivations for users of the two services.



# CHAPTER 2

## Lifestyle:

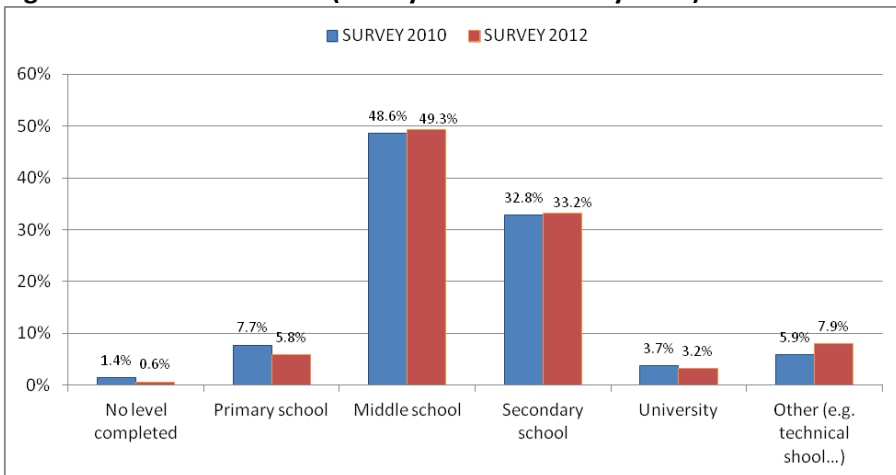
### Education, Work and Contacts with Prison

#### 2.1. Education Level

**Table 2.1. educational level 720 respondents**

<i>Education level</i>						Total
No level	Primary school	Middle school	Secondary school	University	other (technical school...)	
0.6%	5.8%	49.3%	33.2%	3.2%	7.9%	100.0%

**Figure 2.1. education level (survey 2010 and survey 2012)**

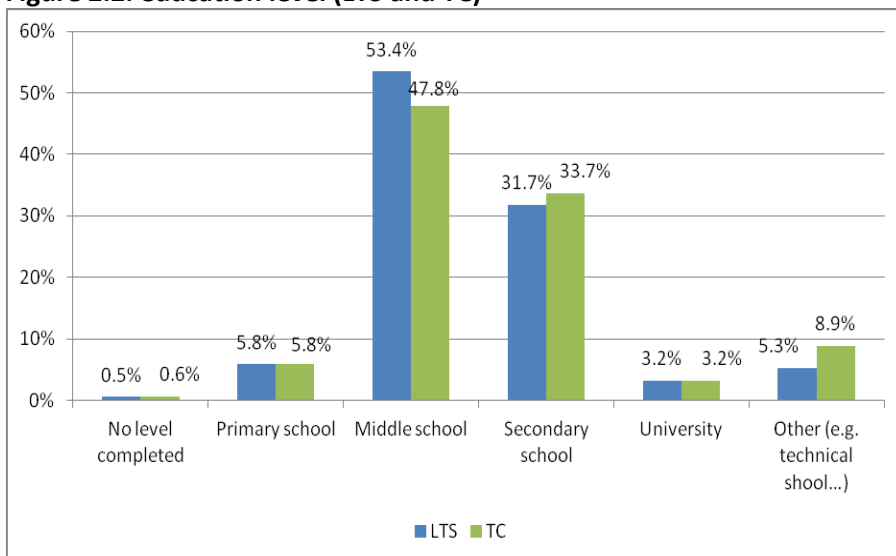


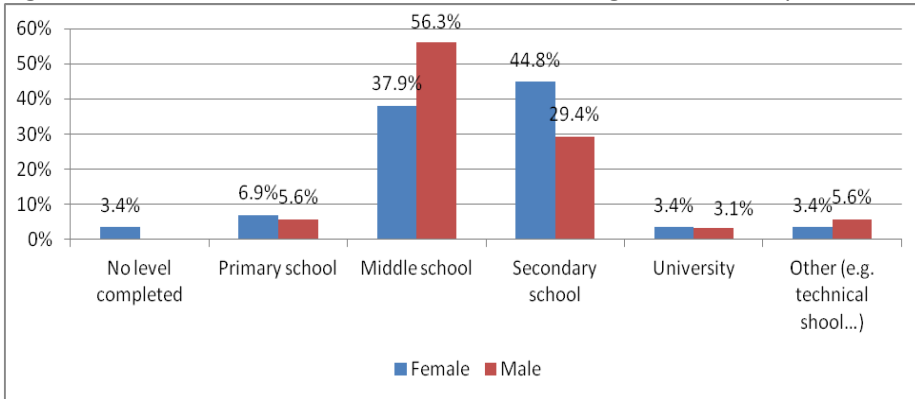
When comparing data collected in 2010 and in 2012 regarding the educational qualification of users we found that we could not find significant differences over the two samples (Figure 2.1).

Middle and secondary school graduates remained almost unchanged between 2010 and 2012.

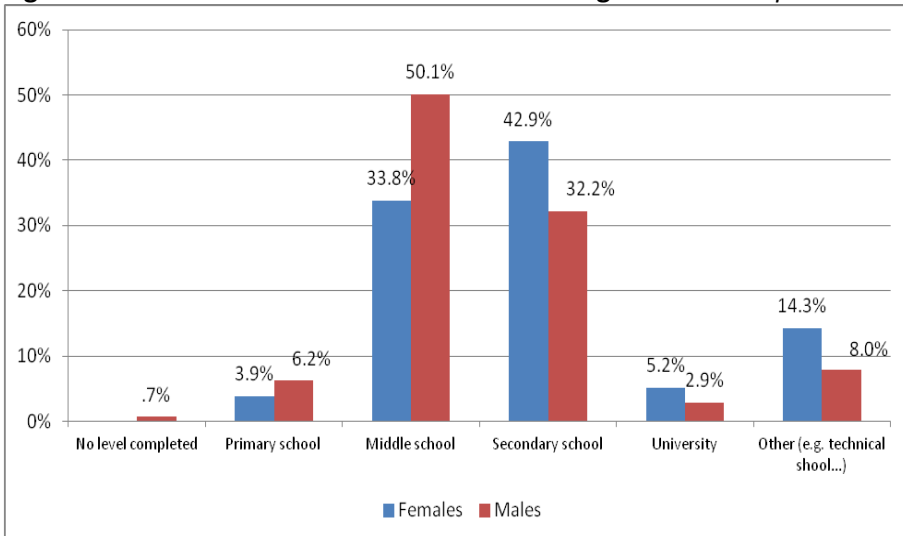
Regarding the survey 2012 (figure 2.2), higher proportions of middle school graduates were reported from low threshold services (53.4% vs 47.8% of TC patients), while higher rates of secondary school certificates were reported by therapeutic communities patients (33.7% vs 31.7% of LTS patients).

**Figure 2.2. education level (LTS and TC)**



**Figure 2.3. education level of LTS users related to gender 189 respondents**

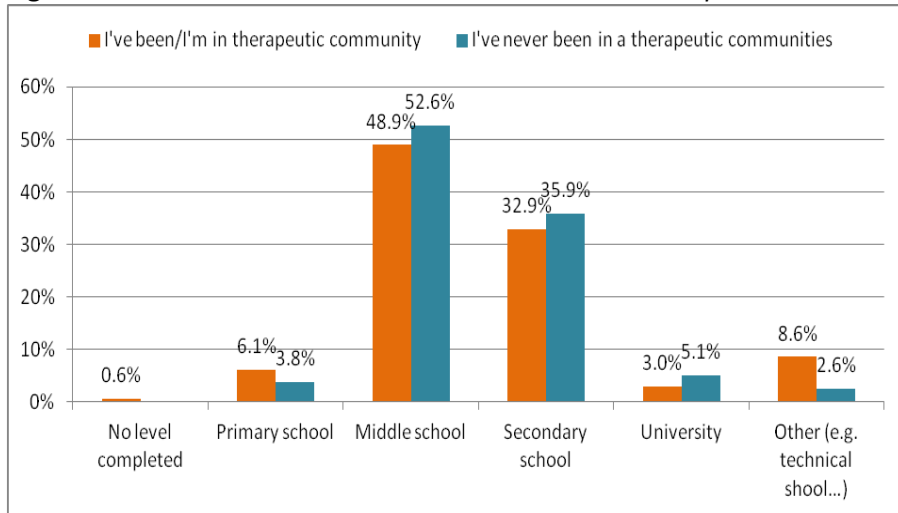
Among LTS patients, 56.3% of men vs 37.9% of women had just got a middle school diploma. Secondary school diploma was reported mostly by women (44.8%) and less by men (29.4%). A slightly smaller percentage of women attended technical schools, 3.4% versus the male rate of 5.6%. It is interesting to notice how among those who don't have any educational qualification men are not represented at all, whereas women number 3.4%.

**Figure 2.4. education level of TC users related to gender 528 respondents**

As in LTS, women in therapeutic communities (Figure 2.4) mostly reported a secondary school diploma (42.9%); the same qualification was obtained by 32.2% of men. Middle school level, on the other hand, was reported mostly by men (50.1% vs 33.8% of women).

In conclusion women, in TC and LTS, seem more qualified than men.

**Figure 2.5. education level of TC and non-TC users 561 respondents**



Generally those who have never been in a TC have higher qualifications than TC patients (Figure 2.5): 52.6% reached middle school level, 35.9% obtained a secondary school diploma and 5.1% had graduated.

Moreover the high percentage who have other qualifications like technical school degrees (8.6%) could be explained as a proof of a certain success of TC's in reintegrating their patients into work.

**Figure 2.6. education level of Ser.T and non-Ser.T users 720 respondents.**

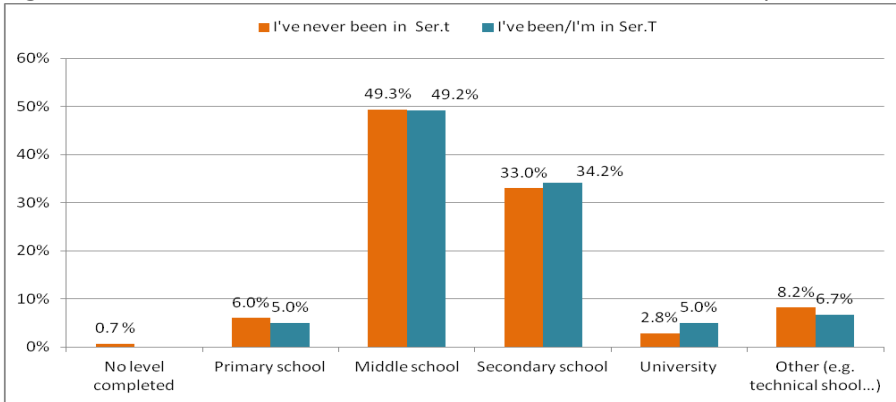
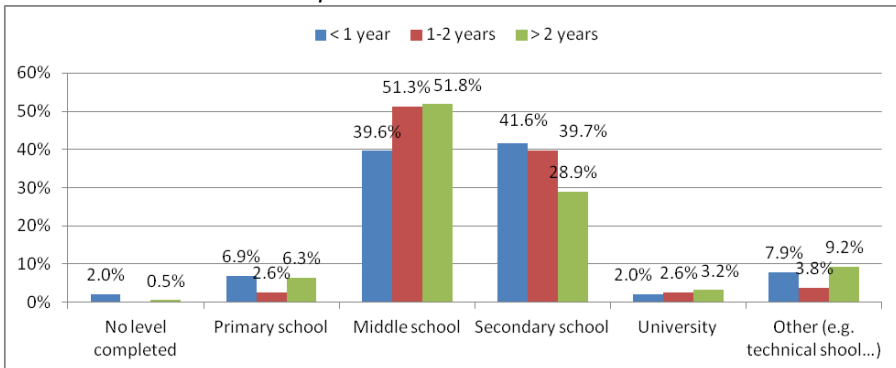


Figure 2.6 analyzes the education level of users who have been in Ser.t and compares them with those who have never been in such a public service. A remarkable difference can be found only in the case of university graduation.

**Figure 2.7. education level of Ser.T patients related to the length of treatment in Ser.T 559 respondents**



The education of patients who have been in Ser.T for a brief period of time is slightly higher than the education of the other users. People in treatment for more than 2 years (green color) have generally had shorter school careers (only 28.9% had obtained a secondary school diploma). However fewer “less-than-a-year” patients have attended middle school, if compared to “longer-stayers” (51.3 % and 51.8 %).

The relation between the education level of users and their criminal history is described in tables 2.2, 2.2bis, 2.3, 2.3bis and 2.4 .

**Table 2.2. education level related to arrest history (joint distribution) 697 respondents**

		Arrested				Total
		Never	Yes, for dealing	Yes, for others crimes	Yes, both for dealing and others crimes	
Educational Level.	No level	0.1%	0.1%	0.3%	-	0.6%
	Primary school	1.4%	0.7%	2.6%	1.0%	5.7%
	Middle school	15.9%	8.9%	15.1%	9.5%	49.4%
	Secondary school	16.4%	5.2%	9.2%	2.6%	33.3%
	University	1.7%	0.6%	0.6%	0.3%	3.2%
	Other (e.g technical school...)	3.0%	1.6%	2.3%	1.0%	7.9%
Total		38.6%	17.1%	30.0%	14.3%	100.0%



**Table 2.2bis. education level related to arrest history (conditional distributions)**

		Arrested				Total
		Never	Yes. for dealing	Yes. for others crimes	Yes. both for dealing and others crimes	
Educational Level.	No level	25.0%	25.0%	50.0%	-	100.0%
	Primary school	25.0%	12.5%	45.0%	17.5%	100.0%
	Middle school	32.3%	18.0%	30.5%	19.2%	100.0%
	Secondary school	49.1%	15.5%	27.6%	7.8%	100.0%
	University	54.5%	18.2%	18.2%	9.1%	100.0%
	Other (e.g technical school...)	38.2%	20.0%	29.1%	12.7%	100.0%
Total		38.6%	17.1%	30.0%	14.3%	100.0%

Around half of graduates and people who completed secondary school had been arrested; all those with a low education level reported higher percentages of arrest . Only 0.3 % of users arrested for both kinds of crime have a university degree. Looking at the column concerning those arrested for both trafficking and other crimes (Table 2.2), the great majority is

composed of people with middle school level as their highest qualification (66% considering the ratio between 9.5 % and the total in the column 14.3 % ). They are the most important group also for the other two kinds of arrest.

Those who have been arrested for only one crime have mostly reported a middle school level (52.1% for trafficking and 50.2% for others crimes).

In conclusion, those who have never been arrested, have higher educational qualifications than those who have been arrested; those who have been arrested for only one crime (trafficking or other crimes) have higher educational qualifications than those arrested for both types of crimes (Table 2.2.bis).

Table 2.3 and 2.3bis concerning Ser.T patients (the greatest population) who have been arrested or not.

**Table 2.3. education level of Ser.T users to incarceration history (conditional distributions) 591 respondents**

		Prison			
		No	Yes, for dealing	Yes, for others crimes	Yes, both for dealing and others crimes
Educational level	No level	0.7%	-	0.5%	1.0%
	Primary school	3.3%	4.2%	9.3%	7.3%
	Middle school	41.5%	55.2%	52.2%	63.5%
	Secondary school	40.1%	31.3%	30.2%	17.7%
	University	4.7%	1.0%	2.4%	2.1%
	Other (e.g technical school...)	9.7%	8.3%	5.4%	8.3%
Total		100.0%	100.0%	100.0%	100.0%

**Table 2.3bis. education level of Ser.T users to prison history (joint distribution) 591 respondents**

		Prison				Total
		Yes. for dealing	Yes. for others crimes	Yes. both for dealing and others crimes	No	
Educational level	No level	-	25.0%	25.0%	50.0%	100.0%
	Primary school	8.6%	48.6%	17.1%	25.7%	100.0%
	Middle school	15.3%	32.7%	17.3%	34.7%	100.0%
	Secondary school	13.3%	26.7%	7.7%	52.3%	100.0%
	University	-	31.3%	12.5%	56.3%	100.0%
	Other (e.g technical school...)	16.7%	18.8%	14.6%	50.0%	100.0%
Total		13.9%	30.4%	13.9%	41.9%	100.0%

Almost the same trend seen here can be found in Table 2.3 and Table 2.3bis: the education level is a strong indicator of lifestyle in particular in relation to criminal activity leading either to arrest without consequences or to incarceration.

**Table 2.4. distribution of patients who obtained or did not obtain alternative sentences to prison according to their educational level. 665 respondents**

		Alternative sentences to prison		Total
		yes	no	
What is your educational level?	No level	0.6%	0.6%	0.6%
	Primary school	4.8%	7.0%	5.9%
	Middle school	41.5%	57.6%	49.5%
	Secondary school	41.2%	24.5%	32.9%
	University	4.8%	1.5%	3.2%
	Other (e.g technical school...)	7.2%	8.8%	8.0%
Total		100.0%	100.0%	100.0%

A last but no less important analysis can be conducted on the subject of those who have obtained an alternative to prison (such as house arrest, house arrest in a therapeutic community or spending time in social services for drug addicts).

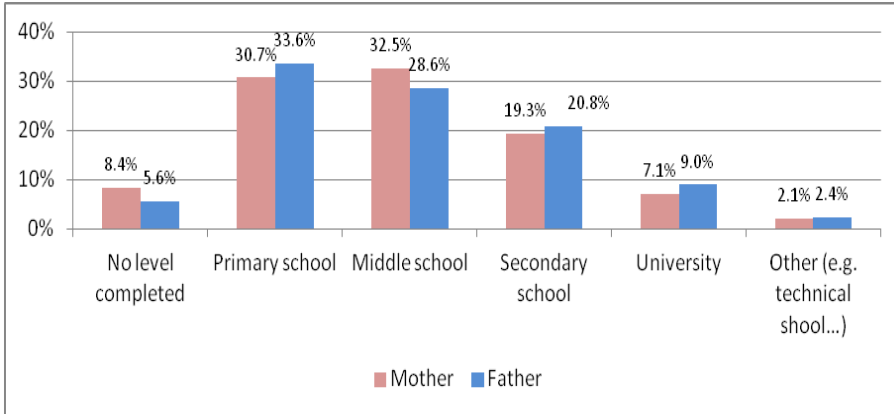
As shown in Table 2.4 those who entered facilities as a substitute to prison tend to be more qualified. 41.2% of those who have served an alternative to prison have a secondary diploma vs 24.5 % of those who served a prison sentence; the greatest differences can be found in the case of a university degree (4.8 % vs 1.5 %).

## 2.2. Education Level of users' parents

Hereby we are going to analyze the relation between the educational qualification of respondents' parents and some variables regarding drug users.

Figure 2.7 shows the distribution of the respondents' parents according to the education level reached.

**Figures 2.7. parents' educational level 706 respondents**



**Figure 2.8. mothers' education level ( LTS or TC)**

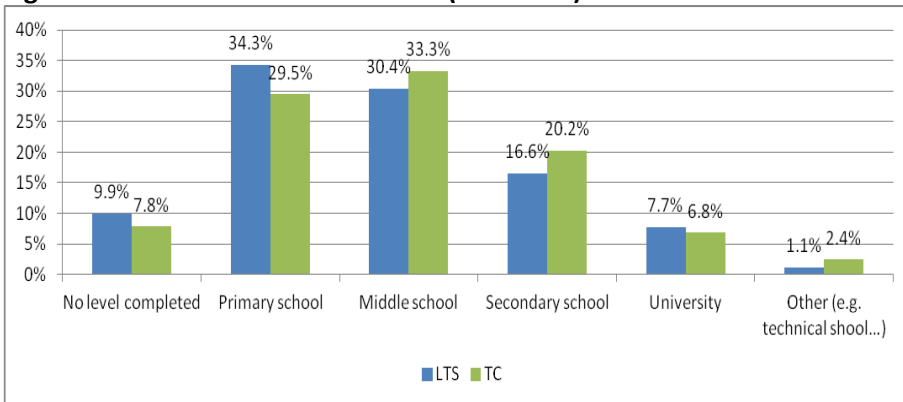
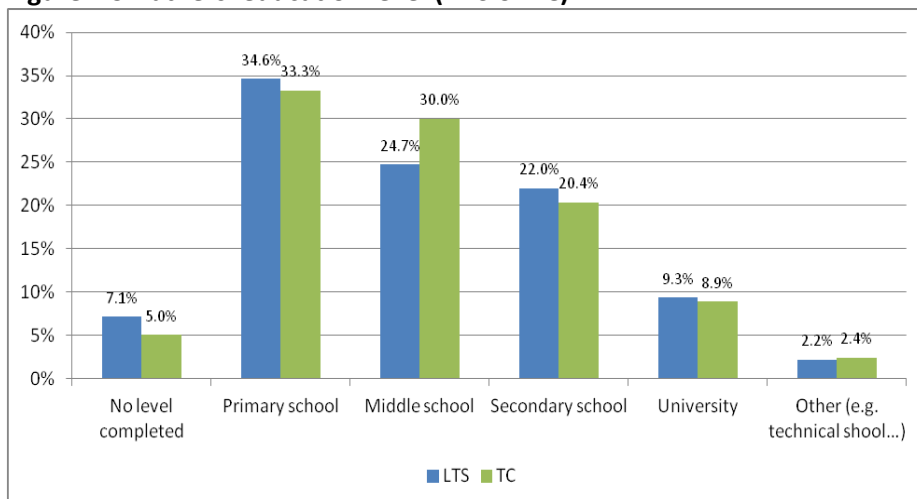


Figure 2.8 is an individual examination of mothers' education level distribution, relative to whether their children are in LTS or TC.

**Figure 2.9. fathers' education level ( LTS or TC).**

In conclusion, mothers of the patients of TC seem to be more qualified than mothers of those in LTS; almost the same model as we see for fathers. Comparing the relation between first use and a mother's education level (Figure 2.10) with the relation between first use and a father's education level (Figure 2.11) a difference seems to emerge: the father of a cannabis first user is generally less qualified than the father of heroin and cocaine first users.

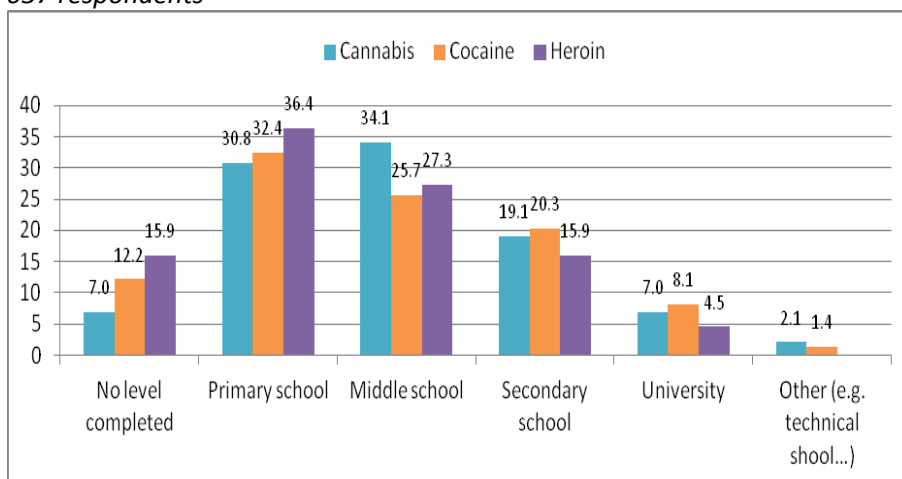
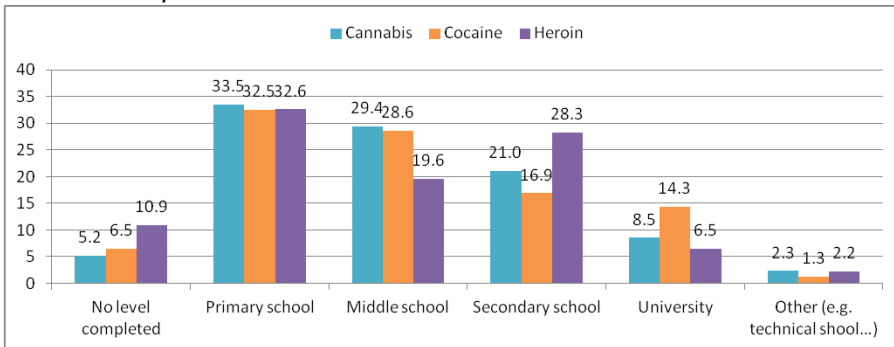
**Figure 2.10. first drug experimented related to mother educational level**  
*637 respondents*

Figure 2.10 underlines the relation between first drug used and the education level of the user's mother. We can see how the mother of a cocaine first user has a higher education level compared to mothers of those who started by consuming heroin and cannabis. 8.1% of them have a university degree and 20.3% have a secondary school diploma.

**Figure 2.11. first drug experimented with related to father's educational level. 637 respondents**



Mothers of heroin users are distinguished by lower educational levels rather than mothers of cannabis and cocaine first-users. They are mostly in the educational group "primary school" (36.4%), then score significant percentages among those without any qualification (15.9%) and those with a middle school diploma (27.3%).

Generally parents of those who used cocaine as a gateway drug are more qualified than parents of those who started with cannabis or heroin.

### 2.3. Employment status

For the purpose of this survey it's important to analyze the working conditions of respondents, especially in understanding lifestyles of users and their purchasing power.

The specific work categories with the largest number of respondents among LTS and TC users were "occasional job" (28.8%) and "long term job" (24.8%), followed by "short term job" (20.6%) and "self-employed" or "professional work" (17.5%). 3.8% of users reported they were students or student workers while 4.5% reported that they had never been employed.

**Table 2.5. Last employment situation (LTS and TC) 713 respondents**

	Last work situation							Total
	Long term contract	Short term contract	Self-employed or professional work	Occasional worker	Never employed	Student	Student worker	
LTS	16.1%	19.4%	15.1%	40.3%	4.8%	2.2%	2.2%	100.0%
TC	27.9%	21.1%	18.4%	24.7%	4.4%	1.7%	1.9%	100.0%
Total	24.8%	20.6%	17.5%	28.8%	4.5%	1.8%	2.0%	100.0%

TC users seem to be more stable and the long-term contract had the greatest rate of respondents (27.9%).

**Figure 2.12. last employment situation of LTS users by gender 186 respondents**

Figure 2.12 shows the distribution of the last employment situation for LTS users. Higher rates of occasional workers were reported from the female population (51.7%). “Occasional worker” is the modal category also for men (38.2%) but compared to women, they are distributed more among other employed status groups.

Thus we have more men in stable jobs (18.5 %) rather than women (3.4%).



**Figure 2.13. last employment situation of TC users by gender 527 respondents**

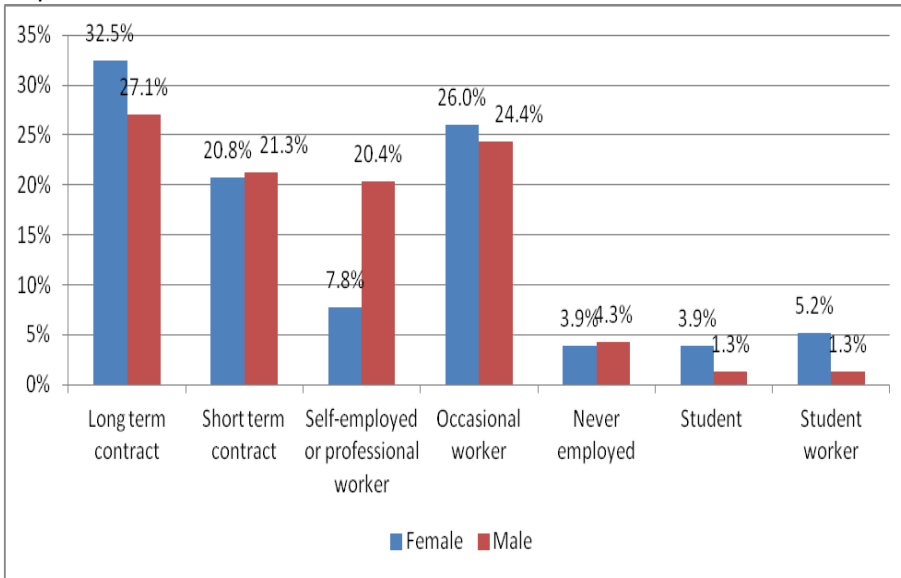


Figure 2.13 shows a situation that is completely different for TC, the most significant disparity between men and women is in the self-employed category (20.4% vs 7.8 %).

Men who cite “never employed” are more highly represented than women (4.3% and 3.9% respectively) among TC users, but the figures for women reach 10.3% vs 3.8 % among LTS users (Figure 2.13).

**Table 2.6. last employment situation of TC and non-TC users 713 respondents**

		Therapeutic community		Total
		I've been or I'm in a therapeutic community	I've never been in a therapeutic community	
Work	Long term contract	25.7%	17.1%	24.8%
	Short term contract	20.7%	19.7%	20.6%
	Self-employed or professional worker	18.4%	10.5%	17.5%
	Occasional worker	27.3%	40.8%	28.8%
	Never employed	4.1%	7.9%	4.5%
	Student	1.6%	3.9%	1.8%
	Student worker	2.2%	-	2.0%
Total		100.0%	100.0%	100.0%

Table 2.6 shows the different employment situation of respondents in relation to their contact with therapeutic communities.

Users who have never been in therapeutic communities report lower percentages of users with long-term employment. Conversely higher rates of occasional work were reported from these kind of users (40.8%).

Table 2.7 shows the last employment situation of users according to their possible enrollment in Ser.t. Respondents who were patients in Ser.T had an occasional job rate which is 29%, higher than that of patients who never entered in Ser.T (27.5%). But the category "occasional job", is also the one with the highest frequency of users who have never been in Ser.T.

**Table 2.7. last employment situation of Ser.T and non-Ser.T users 713 respondents**

		Have you ever been in Ser.T?		Total
		No	Yes	
work	Long term contract	22.5%	25.3%	24.8%
	Short term contract	18.3%	21.1%	20.6%
	Self-employed or professional worker	23.3%	16.4%	17.5%
	Occasional job	27.5%	29.0%	28.8%
	Never employed	5.0%	4.4%	4.5%
	Student	2.5%	1.7%	1.8%
	Student worker	0.8%	2.2%	2.0%
Total		100.0%	100.0%	100.0%

Figure 2.14 shows that patients who had been treated in Ser.T for more than 2 years have more stable employment than other patients within the sample. Patients treated in Ser.T for less than one year reported mostly occasional and short term employment (31% and 22% respectively).

**Figure 2.14. last employment situation of Ser.T users according to the length of treatment in Ser.T 552 respondents**



**Table 2.8. last employment situation of users related to their contact with prison (column conditional distributions) 689 respondents**

		Prison			
		Never	For dealing	For other crimes	Both for dealing and other crimes
work	Long term contract	31.1%	27.1%	20.2%	16.0%
	Short term contract	20.3%	19.8%	22.2%	20.2%
	Self-employed or professional worker	16.2%	16.7%	16.7%	21.3%
	Occasional worker	24.0%	30.2%	32.5%	33.0%
	Never employed	2.7%	5.2%	5.4%	6.4%
	Student	3.7%	-	1.0%	-
	Student worker	2.0%	1.0%	2.0%	3.2%
Total		100.0%	100.0%	100.0%	100.0%

**Table 2.8bis. last employment situation of users related to their contact with prison (row conditional distributions)**

		Prison				Total
		For dealing	For other crimes	Both for dealing and other crimes	Never	
Work	Long term contract	14.9%	23.6%	8.6%	52.9%	100.0%
	Short term contract	13.3%	31.5%	13.3%	42.0%	100.0%
	Self-employed or professional worker	13.6%	28.8%	16.9%	40.7%	100.0%
	Occasional worker	14.7%	33.5%	15.7%	36.0%	100.0%
	Never employed	16.7%	36.7%	20.0%	26.7%	100.0%
	Student	-	15.4%	-	84.6%	100.0%
	Student worker	7.1%	28.6%	21.4%	42.9%	100.0%
Total		13.9%	29.5%	13.6%	43.0%	100.0%

Those who had never been imprisoned (Table 2.8 and Table 2.8bis), had the highest percentage for “long term contract” (31.1 %). Also those who have been incarcerated for dealing have a high percentage of employment with a long-term contract (27.1%) but most of them are in the group “occasional workers” (30.2%).

Users who have been in prison for others crimes as well as those imprisoned for both types of crime present important rates whether in the category of occasional workers (32.5% and 33% respectively) or in the group of temporary workers (22.2% and 20.2%).

Data shows that those who have never been incarcerated present lower rates of “never employed” (2.7%) compared to others (around 5%).

**Table 2.9 last employment situation related to the use of alternatives to prison 660 respondents**

		Alternative sentences to prison		Total
		No	yes	
work	Long term contract	29.3%	19.9%	24.7%
	Short term contract	20.7%	21.8%	21.2%
	Self-employed or professional worker	16.5%	18.4%	17.4%
	Occasional worker	25.7%	31.0%	28.3%
	Never employed	3.6%	5.8%	4.7%
	Student	2.4%	.9%	1.7%
	Student worker	1.8%	2.1%	2.0%
Total		100.0%	100.0%	100.0%

Table 2.9 reports the frequency of patients who received alternative sentences listing them according to their last working condition.

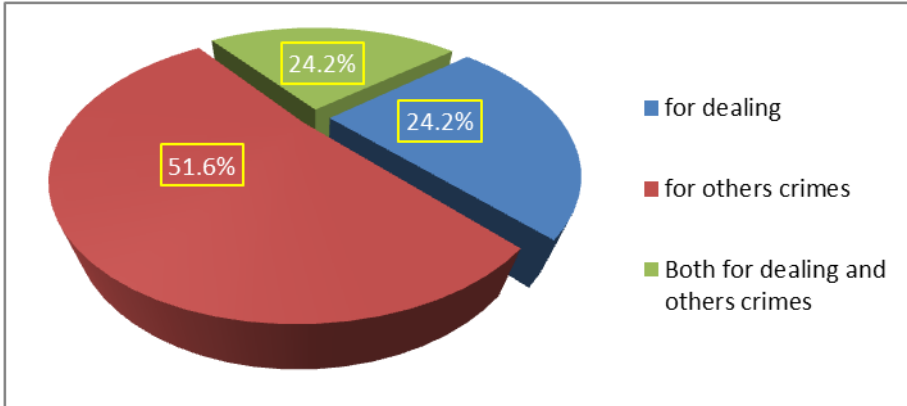
## 2.4. Contact with Prison

More than half of the respondents (57.1%) have been incarcerated (Table 2.10) and more than half of them had been convicted for crimes not related to drugs (29.5% in Table 2.10 and 51.6 % in Figure 2.15).

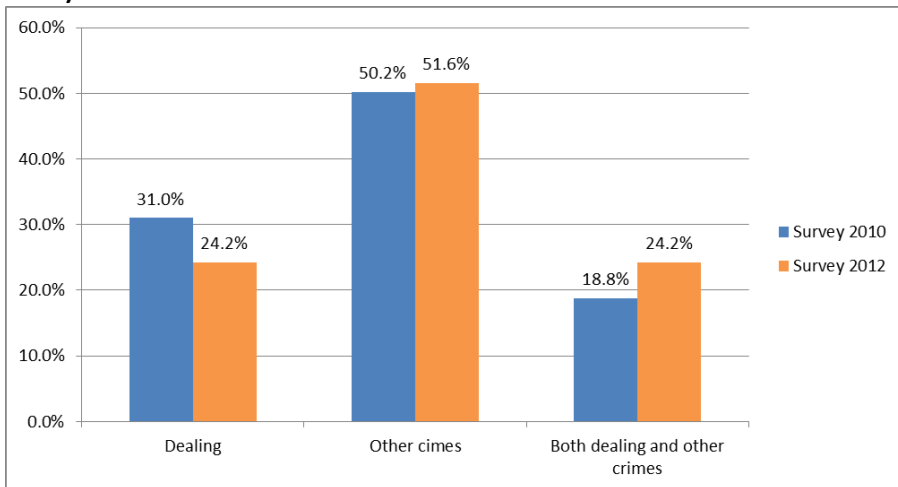
**Table 2.10. typology of crime committed 696 respondents**

Prison				
Never	For dealing	For other crimes	Both for dealing and other crimes	Total
42.9%	13.8%	29.5%	13.8%	100%

**Figure 2.15. typology of crime committed**



**Figure 2.16. typology of crime committed (SURVEY 2010 and SURVEY 2012)**



The number of users incarcerated for crimes related to drugs in 2010 (31%) was higher than in 2012 (24.2%). Though higher than in 2010, the 2012 rates of users convicted for crimes not related to drugs increased by a small but statistically significant percentage of 1.4 points. Those who had been convicted both for dealing and others crimes increased by 5.4 points in 2012 compared to the 2010 survey.

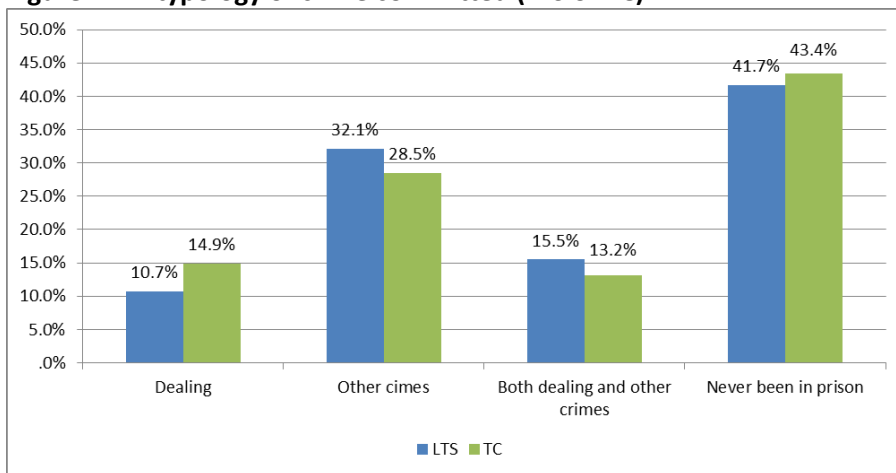
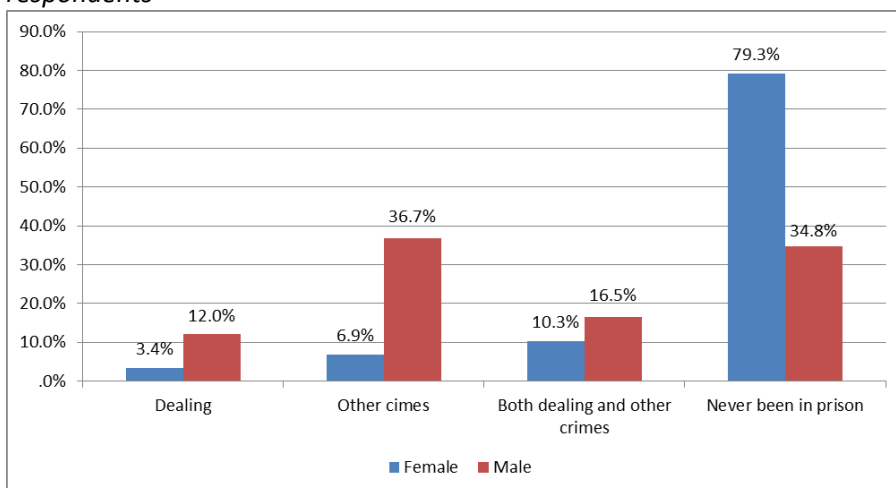
**Figure 2.17. typology of crime committed (LTS or TC)**

Figure 2.17 displays the prevalence rates for each specific typology of crime that was committed by LTS and TC respondents.

LTS and TC respondents report almost the same proportion for “never been in prison” as for “imprisoned”. Among imprisoned people TC respondents report a higher proportion “for drug crimes”, that reduces the relative frequency of other crimes, but the distributions of LTS and TC remain similar.

**Figure 2.18. typology of crime committed by gender (LTS) 187 respondents**



When distinguishing by gender in each crime category we see that over 75% of women in LTS have never been in prison, just 34.8% men. A relatively high percentage of women have committed both dealing and others crimes (10.3%).

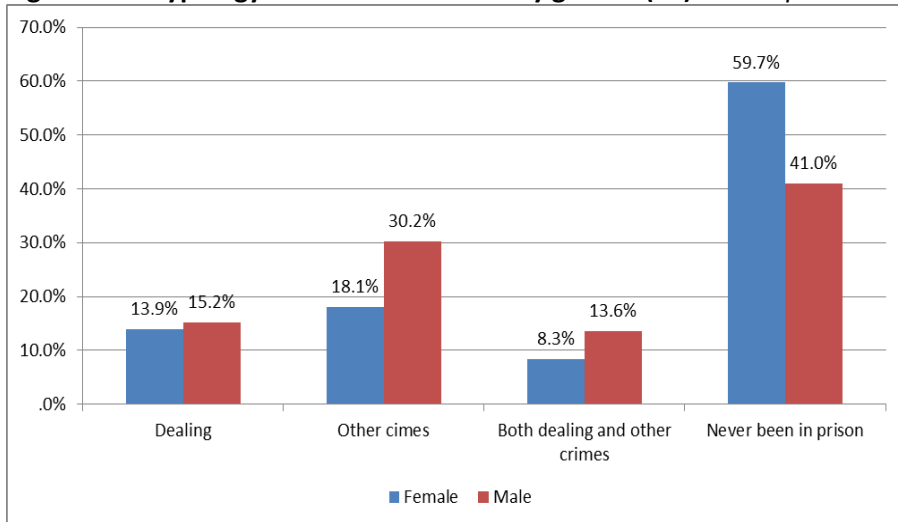
Figure 2.20 shows a prevalence of male LTS patients in every category implying at least one type of crime was committed by many respondents. The class with the highest frequency of men is “for others crimes” (36.7%), higher than the class “never been in prison” (34.8%).

Even among users in TC (Figure 2.19) the difference between men and women is quite relevant. 59.7% women and 41.0% of men have never been in prison.

Crimes not related to drugs are the most usual offense (18.1% women and 30.2% men) followed by dealing (13.9% women and 15.2% men) and dealing and other crimes (8.3% women and 13.6% men).

In conclusion, females are less frequently incarcerated than males.

**Figure 2.19. typology of crime committed by gender (TC) 509 respondents**



**Table 2.11. typology of crime committed by age 685 respondents**

		age						Total
		<17	18-24	25-34	35-44	45-54	>55	
Prison	For dealing		9.7%	16.2%	12.6%	15.4%	11.8%	14.0%
	For other crimes		22.6%	24.3%	35.4%	29.8%	17.6%	28.9%
	Both for dealing and other crimes		3.2%	12.6%	14.2%	21.2%	11.8%	13.6%
	Never	100.0%	64.5%	47.0%	37.8%	33.7%	58.8%	43.5%
Total			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Looking at Table 2.11, where three values are evidenced by yellow highlighting, a first analysis of the trend in each single row leads us to the conclusion that the first crime category – in the case of prison - is “other crimes”; “dealing” is more important for the age group 25-34; the probability of having committed a crime increases year by year, but in this case the age group “> 55” reported less crime than others, maybe because of the low number in our sample: 17.

**Table 2.12. Typology of crime committed (Ser.T and non-Ser.T users) 696 respondents**

				Total
		I’ve never been in Ser.T	I’ve been/I’m in Ser.T	
Prison	For dealing	13.5%	13.9%	13.8%
	For other crimes	24.0%	30.4%	29.5%
	Both for dealing and other crimes	13.5%	13.9%	13.8%
	Never	49.0%	41.9%	43.0%
Total		100.0%	100.0%	100.0%

Table 2.12 presents the frequency distribution of users according to their past or current treatment in Ser.T and listing them by the type of crime committed.

## 2.5. Alternative Sentencing

After having analyzed the interviewed relations with prisoners it is interesting to proceed elaborating the characteristics of users who received an alternative sentence.

**Figure 2.20. patients who got obtained alternative sentence or not, related to the typology of alternative 665 respondents**

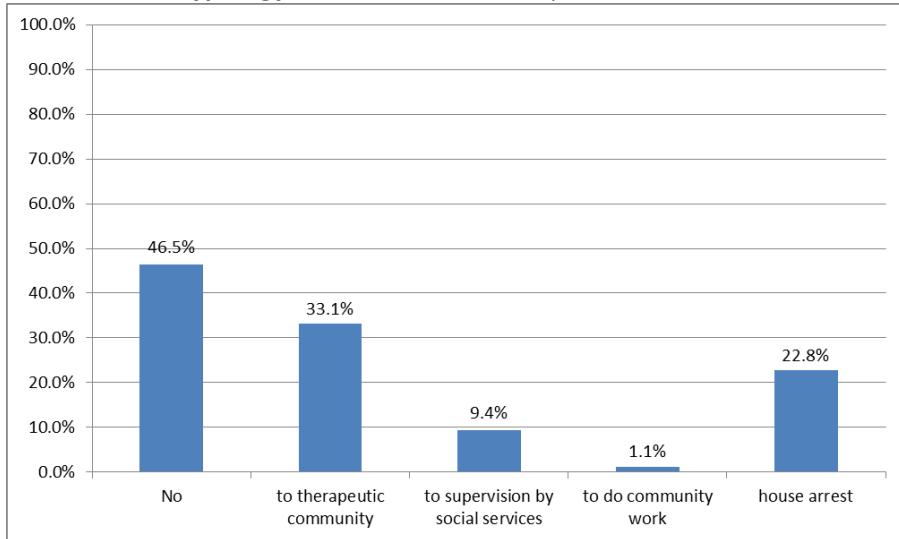
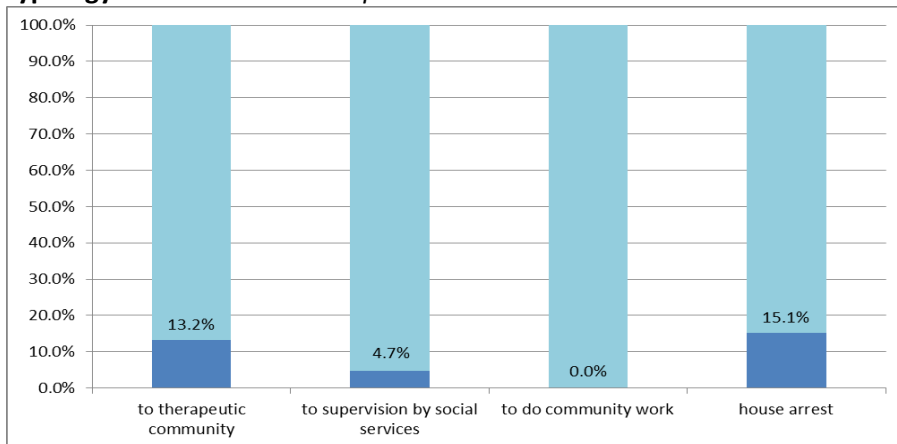


Figure 2.20 shows that nearly half of the respondents (46.5%) couldn't obtain any sort of alternative to prison. The most popular alternative, received by 33.1% of those who could skip prison, consists of therapeutic community. Next we have house arrest with a rate of 22.8% respondents. Being under supervision by social services was reported by 9.4%. Those attending community and social jobs are very few, just 1.1% of the total respondents who obtained an alternative sentence.

It's important to notice that compared to the 2010 survey, the number of users who benefited from alternative sentencing in 2012 has increased approximately by 20%.

Only around 17.4 % respondents reported to have got an alternative sentence more than once.

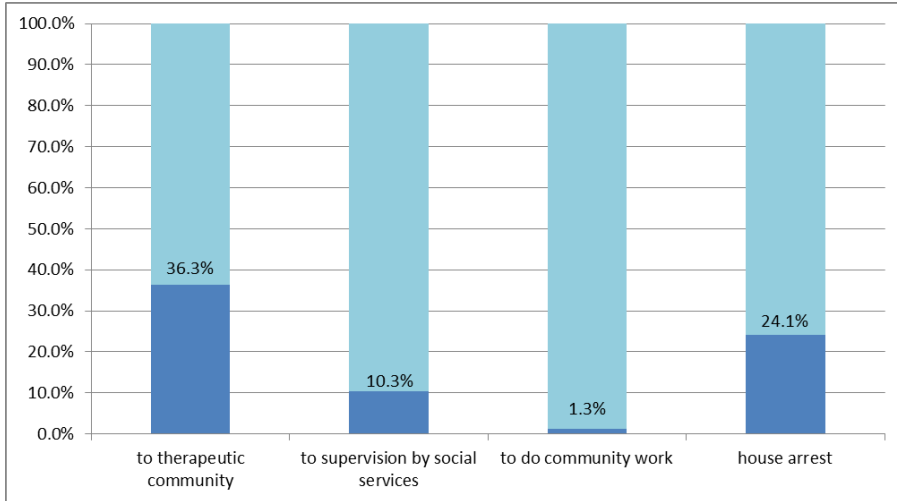
**Figure 2.21. female patients who got alternative sentence related to the typology of alternative 95 respondents**



Figures 2.21 and 2.22 take into consideration only the users who benefited from alternative sentences, distinguishing them by gender.

In general men report a higher percentage among all the types of alternative classes than women. The most frequent alternative choice for men is the therapeutic community (36.3%) while women mostly reported the home arrest option. This latter alternative is the second most frequently chosen alternative by men. Following that we have supervision by social services and community work. The second most common alternative for women is therapy in the community followed by supervision by social services. No women reported to have received “community work” as a sentence.

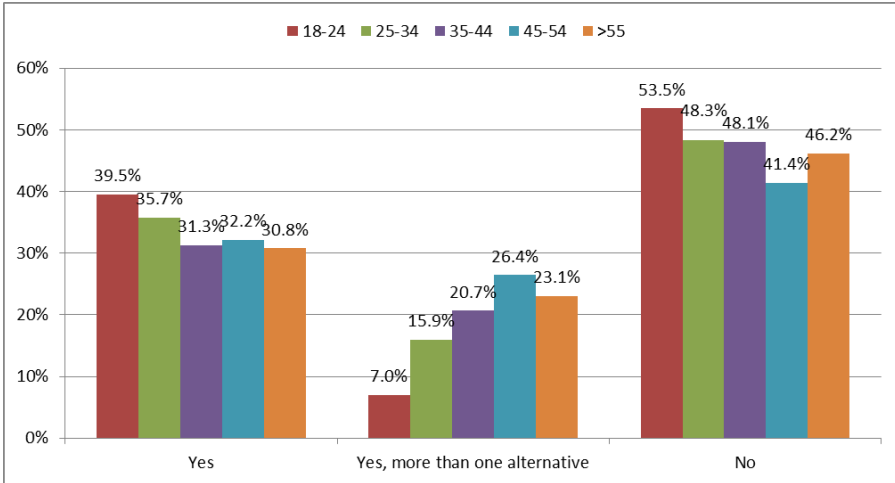
**Figure 2.22. male patients who got alternative sentence related to the typology of alternative 567 respondents**



The data from figure 2.23 allows us to document how many users received alternative in relation to their age.

From the histogram we can see those who most frequently made use of alternatives are those patients aged between 45 and 54, whereas younger respondents used them less often. Data shows that rates of users younger than 34 peak among those who weren't allowed any alternative (53.5% of under 18s and 48.3% of users aged between 25-34). This analysis must take into consideration the logical possibility that younger patients might have faced justice in fewer cases than the older patients.

**Figure 2.23. patients who received an alternative sentence related to the number of reported alternatives by age 653 respondents**



# CHAPTER 3

## Consumption, Doses, Prices

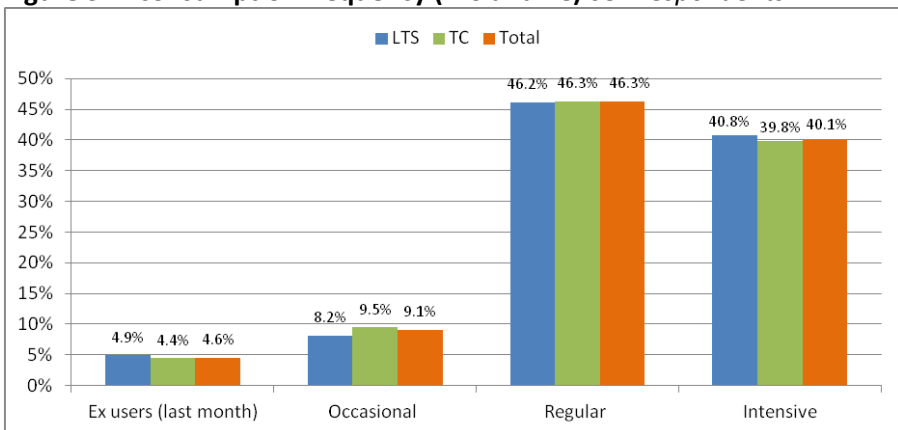
### 3.1. Drug consumption

This chapter concerns the consumption analysis in the last 30 days for LTS patients, in the case of TC patients it refers to the last month before entering the current therapeutic community.

Therefore it is possible to have 4 different categories: ex users, occasional users (1-5 times in the last 30 days), regular (6 – 19 times) and intensive (20 times and more).

The last month is not always a month of high consumption because the patients could already be in treatment (for detoxification) before starting a treatment period in a TC or they might be simply reducing their normal consumption whilst keeping in touch with an health care structure.

**Figure 3.1. consumption frequency (LTS and TC) 681 respondents**

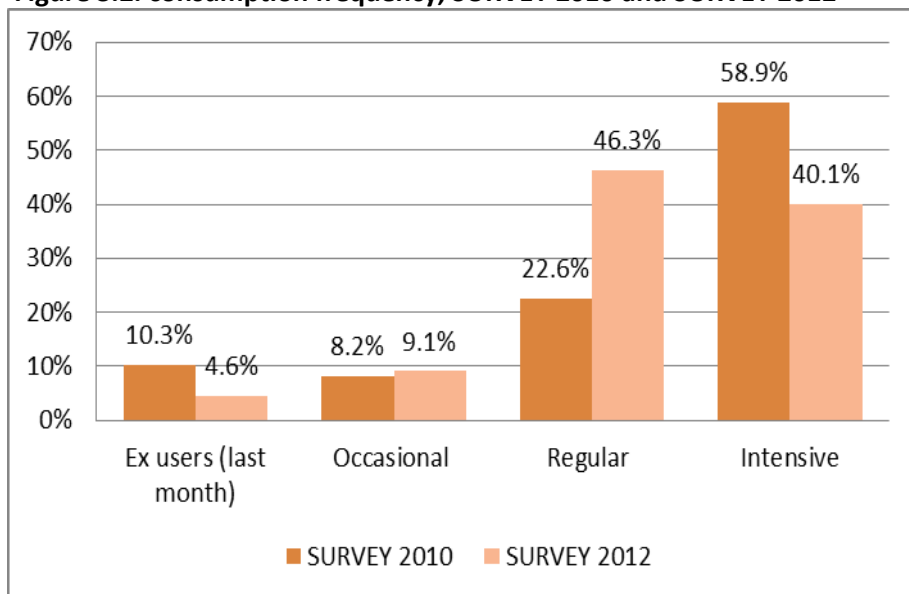


Ex users or temporary “ex” users represent 4.6% of the respondents. Among “regulars” there are no relevant differences between LTS and TC patients (46%, Figure 3.1). The intensive consumers make up around 40% and the occasional users between 8.2 % and 9.5 % of the total.

This survey reports very different results in comparison with those from 2010, especially for regular and intensive users: the first ones had more than doubled and the second ones had been reduced from 58.9 % to 40.1% in this survey (Figure 3.2) .

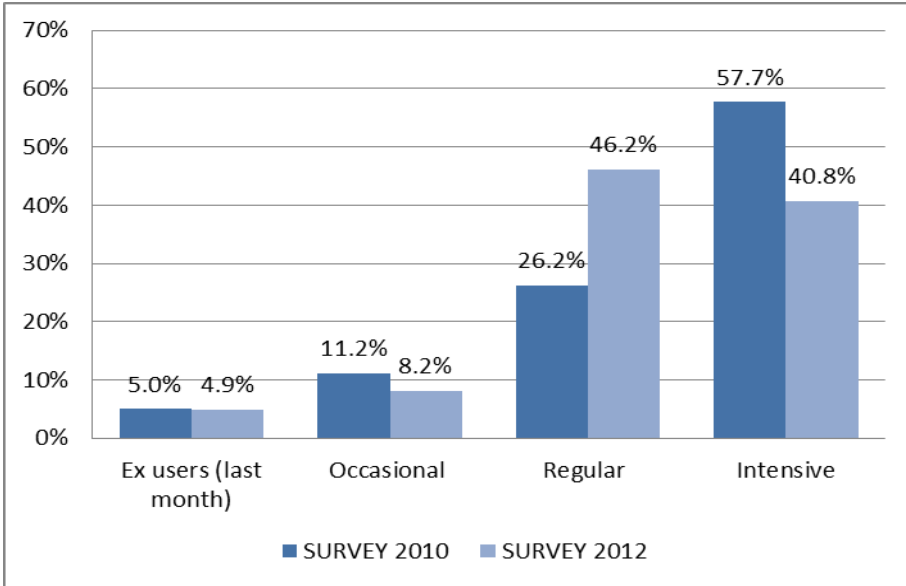
Almost the same trend is reported in the comparison of both services (Figure 3.3 and 3.4).

**Figure 3.2. consumption frequency, SURVEY 2010 and SURVEY 2012**

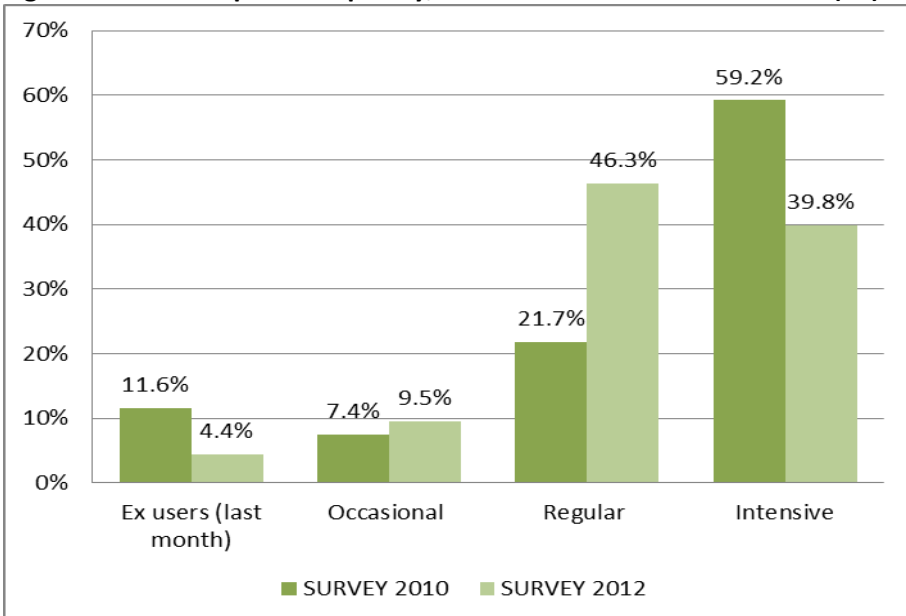




**Figure 3.3. consumption frequency, SURVEY 2010 and SURVEY 2012 (LTS).**



**Figure 3.4. consumption frequency, SURVEY 2010 and SURVEY 2012 (TC).**



In Table 3.1 rate of consumption is reported distinguished by gender and service used.

**Table 3.1. consumption frequency of LTS and TC users distinguished by gender 678 respondents**

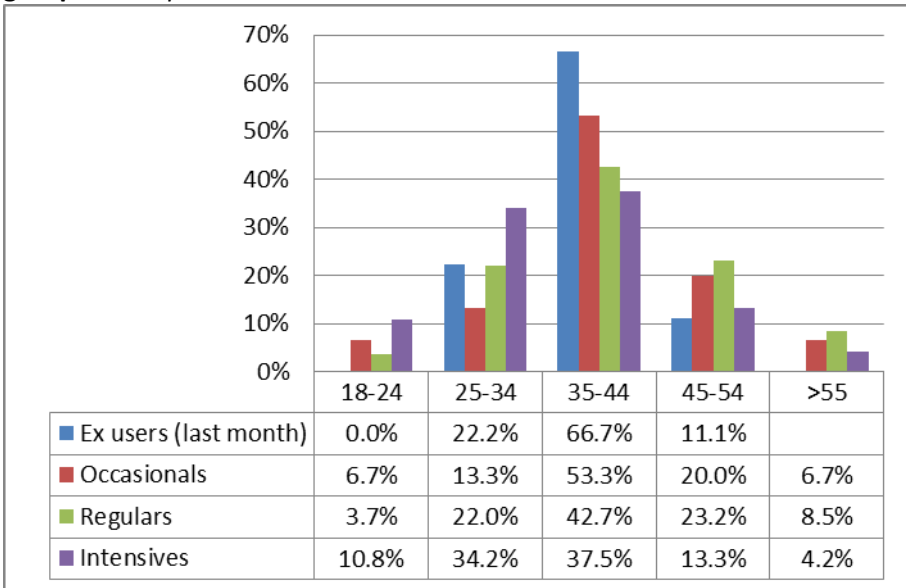
	LTS		TC	
	Female	Male	Female	Male
Ex users (last month)	10.3%	3.9%	4.1%	4.5%
Occasional	13.8%	7.1%	8.1%	9.8%
Regular	24.1%	50.3%	41.9%	47.1%
Intensive	51.7%	38.7%	45.9%	38.6%
Total	100.0%	100.0%	100.0%	100.0%

Among LTS patients, a high rate of women were intensive consumers (51.7%). A similar situation was reported by women in TC services (45.9%). In contrast the modal value is for regular consumers in both LTS and TC services (50.3% and 47.1% respectively) for men.

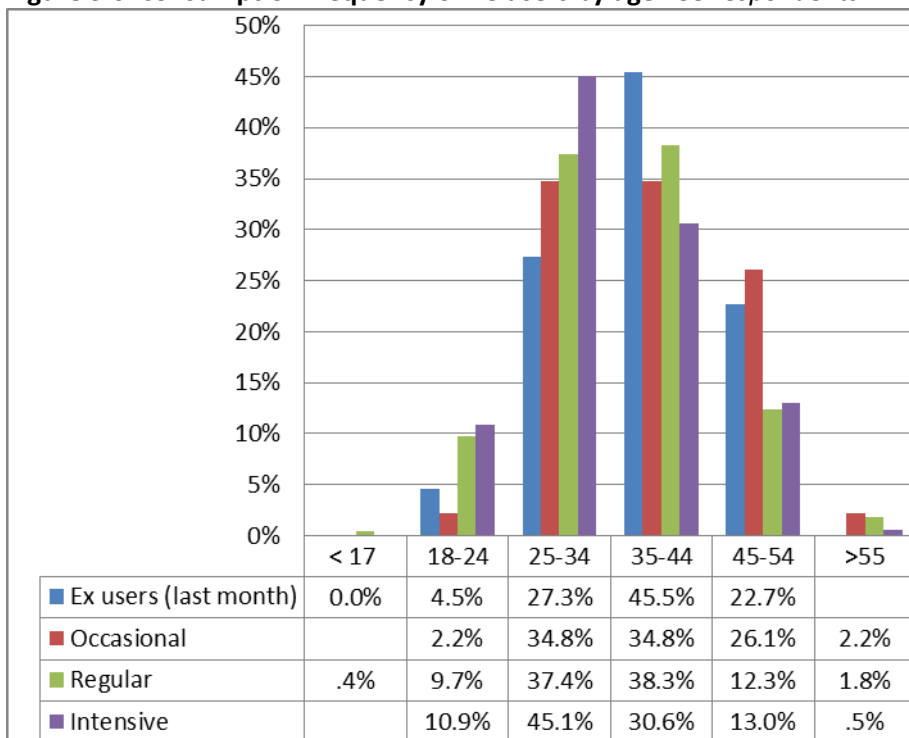
Data also show that women had used drugs more frequently than men in the last month (Table 3.1).

In figure 3.5, LTS “ex-users” (66.7%) and “occasional” users (53.3%) are most common in the age group 35 – 44.

**Figure 3.5. consumption frequency of LTS patients related to their age group 180 respondents**



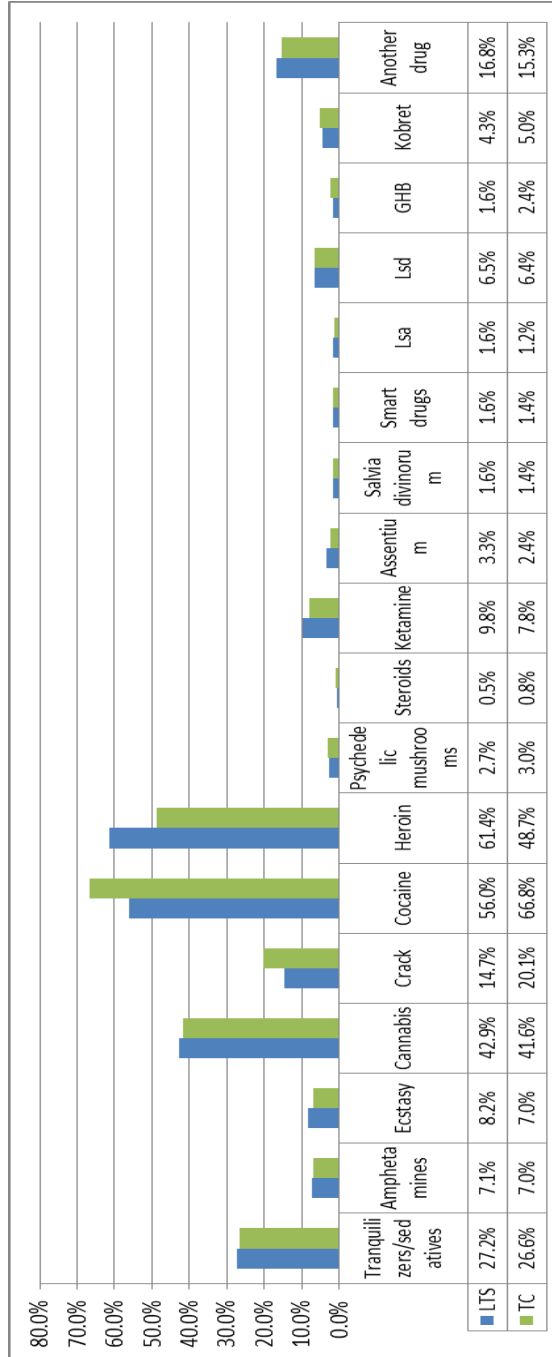
In figure 3.5 high rates of regular consumers among users older than 35 can be seen, while higher rates of intensives are present among those younger than 34 (these percentages are high in comparison to the age distribution of the sample population, Figure 1.1). In conclusion we can observe that most of the younger LTS users can be classified as intensive consumers, while the older are regular drug consumers for the most part.

**Figure 3.6. consumption frequency of TC users by age 488 respondents**

Trends are dissimilar across the different services. As shown in figure 3.6 (which refers to TC patients) most ex-users are aged 25-44 (72.8% of the total of ex users). The remaining 27.2% of these users are aged from 45 to 54 (22.7%) and a small percentage from 18 to 24 (4.5%).

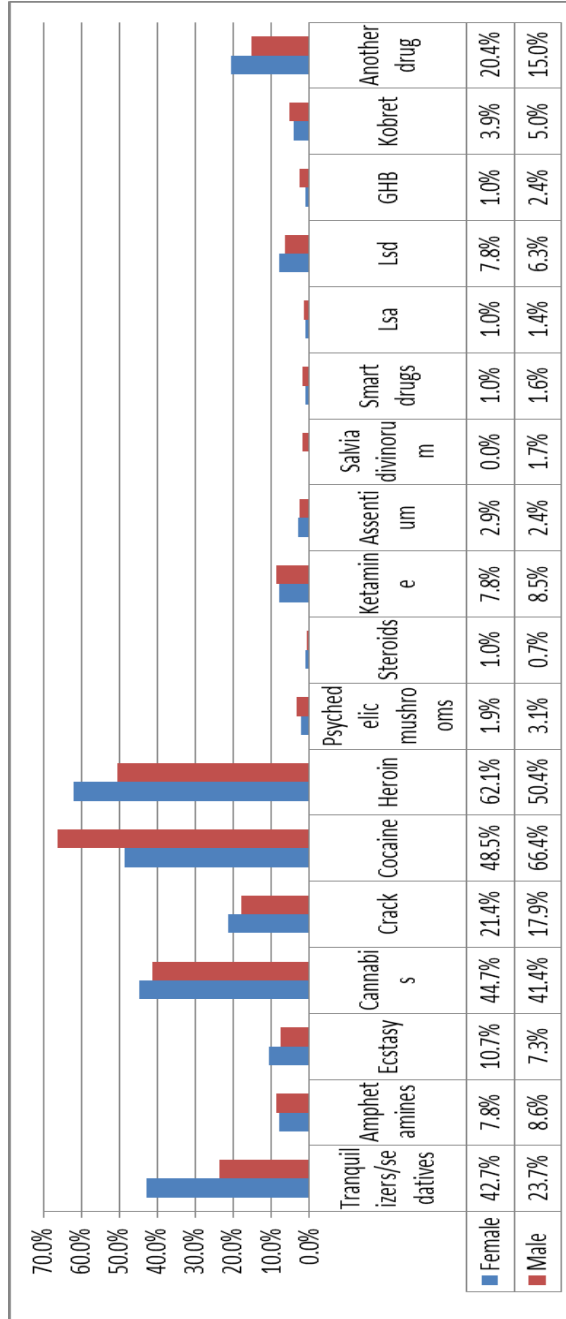
Looking at occasional consumers, higher rates were reported by users aged 25-44 (69.6%). But the most interesting data can be found among regular and intensives consumers. Most intensives users are aged 25-34 (45.1%). Regular users are fairly evenly spread among consumers aged 25-44. There's an inverse relation between the consumption classes "frequency" and "age", so that frequency of higher classes of consumption increases when the age of users decreases.

**Figure 3.7. last month'a drug consumption (LTS and TC patients).**  
681 respondents



Cocaine and heroin continue to be the most popular drugs (Figure 3.7). Cocaine was more appreciated by TC patients (66.8% of TC users vs 56% of LTS users) while heroin was favored by LTS patients (61.4% vs 48.7%). Percentages of cannabis users are spread among LTS and TC patients (42.9% and 41.6%). Consumption of tranquillizers and sedatives are also relevant. These substances comes immediately after cannabis (27.2% for LTS and 26.6% for TC). To be considered in descending order are: crack, ketamine, amphetamines, LSD and kobret. with regard to these types of drug there's a relevant difference between LTS and TC patients when considering the consumption of crack (used more often by TC patients) and ketamine (used more by LTS patients).

**Figure 3.8. frequency distribution of the last month's drug consumption by gender. 678 respondents**



Distinguishing consumers by gender, Figure 3.8 reports a considerable difference between men and women. Heroin is the most used drug by women (62.1% vs 50.4% of men), followed by cocaine (48.5%) and cannabis (44.7%). Other differences between males and females are observed in the use of tranquillizers or sedatives. For this substance women have higher consumption rates (42.7%) than men (22.7%). Regarding crack, amphetamines, ecstasy and LSD consumption women are the main consumers. Men are more used to consuming cocaine (66.4%). Cannabis is used by the same percentage of women and men (44.7 and 41.4%). "Other drugs" (that often concern alcohol) are used mostly by women (20.4% vs 15%).

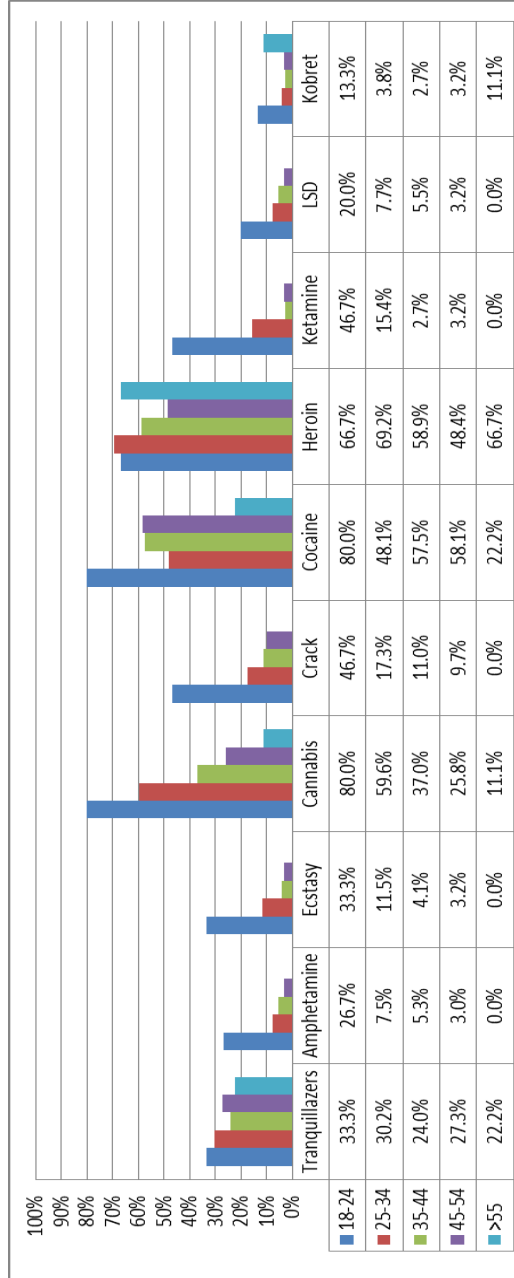
Another study can be done by distinguishing users by age and analyzing what different types of drug have been used by respondents during the last month of consumption. Figure 3.9 reports the rates of drug consumption among LTS patients: young patients are the most significant consumers of every kind of drug.

Cocaine and cannabis are used by 80% of individuals in the younger age group (18-24), but the younger reported a greater percentage of use more than the other groups also for the other drugs, with the exception of heroin that is used more by the age group 25 – 34 (69.2%)

Data about amphetamine, ecstasy, crack, Ketamine, Lsd and kobot consumption among young adults are a good indicator of how widespread poly-drug use is among these young adults.



**Figure 3.9. frequency distribution of the most used drugs during the last month by age group - LTS 184 respondents**

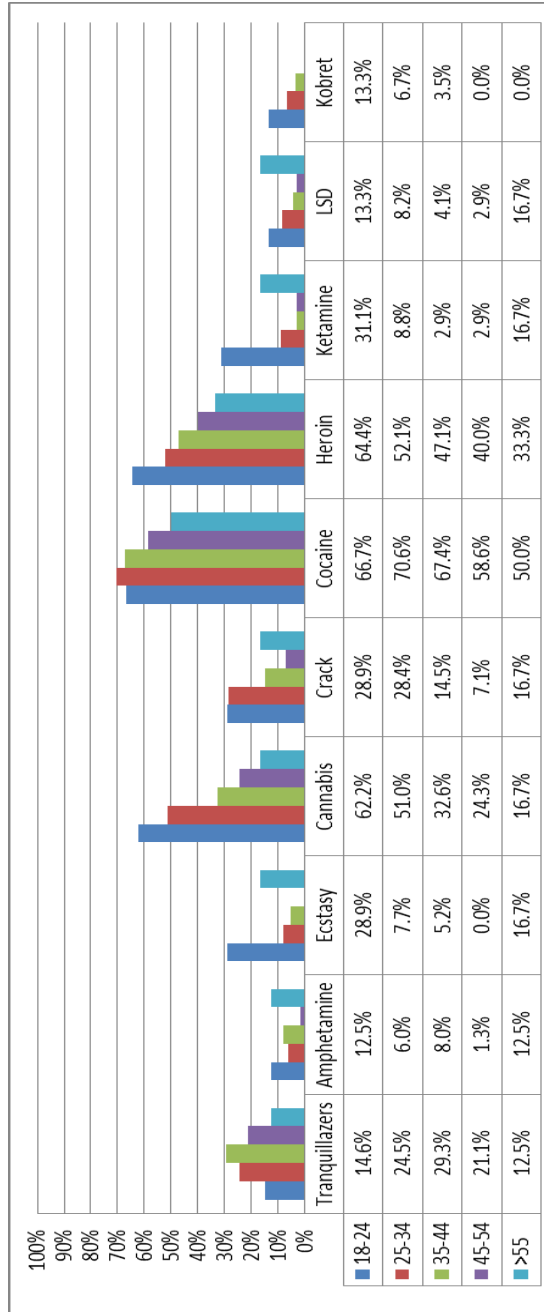


The other age groups reported a prevalence of heroin with the exception of the age group 45 -54, where cocaine is prevalent over heroin (58.1% vs. 48.4%). Cannabis use sharply descends in relation to age.

Young users in TC (Figure 3.10) reported a slightly lower percentage of consumption than those in LTS. However the trend is similar and young adults (18 -24 years old) are again the most important poly users (Figure 3.10).

The prevalence of cannabis use decreased with the increase of age, 62.2% (18-24), 51% (25-34), 32.6% (35-44), 24.3% (45-54), 16.7% (54 and older). A similar trend was found in the prevalence of ecstasy.

**Figure 3.10. frequency distribution of the most used drugs during the last month by age group - TC 497 respondents**



Poly use is the most common also for LTS and TC patients, who should be close to reduction in their last month of use (Table 3.2).

'One drug consumed' (or reported) was indicated by just 34.3% of respondents and among them only cocaine was used by 13.2 %, only heroin by 9.3% and only cannabis by just 3.1 %.

Cocaine and heroin together were also used by 34.8% of respondents: just cocaine and heroin 9.3%; cannabis, cocaine and heroin 4.3%; cocaine, heroin and other drugs (\*) 5.9%; all together (\*\*) 15.3%.

The prevalence of hard drugs is quite important within this population.

The same data from table 3.2 is reported in Figure 3.11 to allow a better and more efficient analysis.

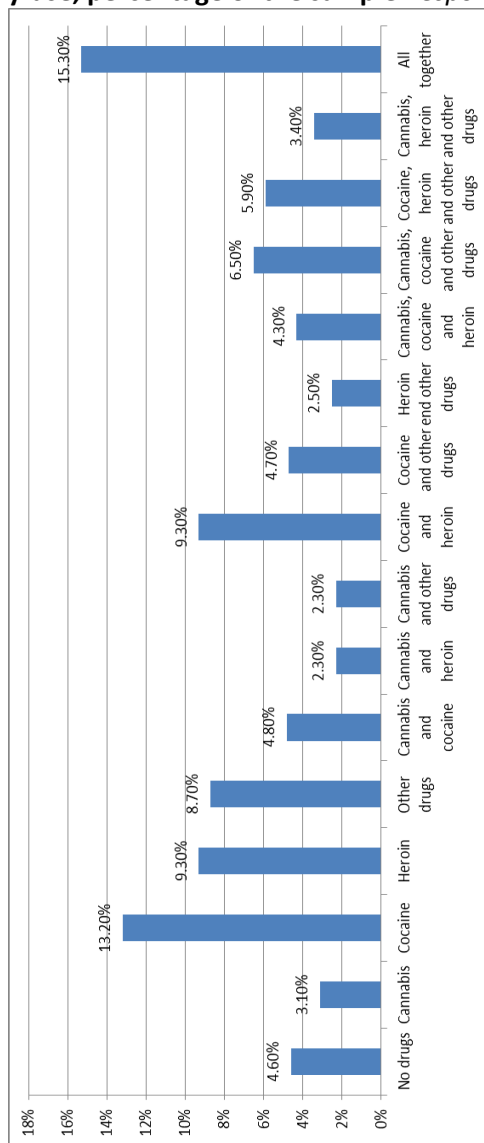
**Table 3.2. the poly-use. percentage of the sample respondents 681**

	%
No drugs	4.6
Cannabis	3.1
Cocaine	13.2
Heroin	9.3
Other drugs (*)	8.7
Cannabis and cocaine	4.8
Cannabis and heroin	2.3
Cannabis and other drugs	2.3
Cocaine and heroin	9.3
Cocaine and other drugs	4.7
Heroin and other drugs	2.5
Cannabis. cocaine and heroin	4.3
Cannabis. cocaine and other drugs	6.5
Cocaine. heroin and other drugs	5.9
Cannabis. heroin and other drugs	3.4
All together (**)	15.3
<b>Total</b>	<b>100.0</b>

\*" Other drugs" means that at least one of the drugs listed other than the main three (cannabis, cocaine and heroin) is consumed.

\*\* All together includes consumers of cannabis, cocaine, heroin and at least one of the "other drugs".

Figure 3.11. poly-use, percentage of the sample Respondents 681

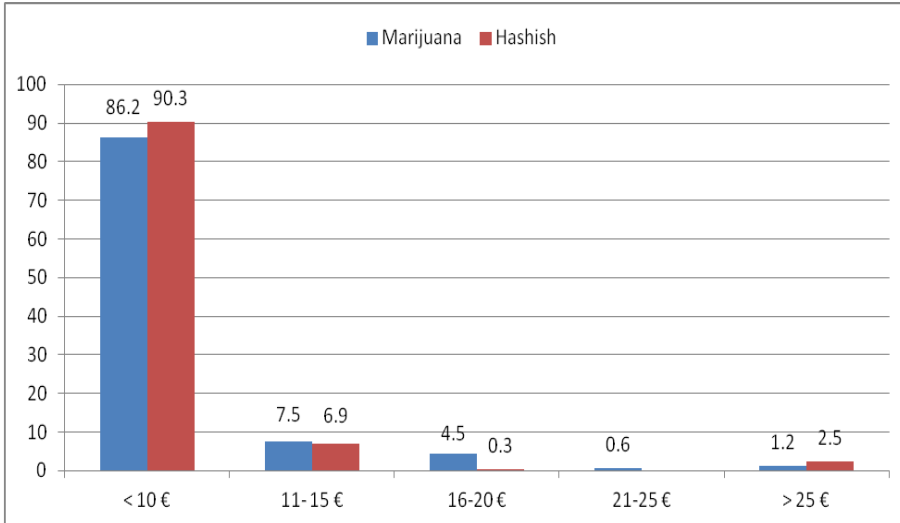


### 3.2. Prices and substances

Information on drug prices comes from the answers to question number 23 of the questionnaire. Users were asked to indicate the latest known prices per dose, gram or pill from a list of 9 main drugs.

They were also asked to distinguish the prices of poor and top quality cocaine and heroin.

**Figure 3.12. price for 1 gram of marijuana and 1 gram of hashish 333 respondents**



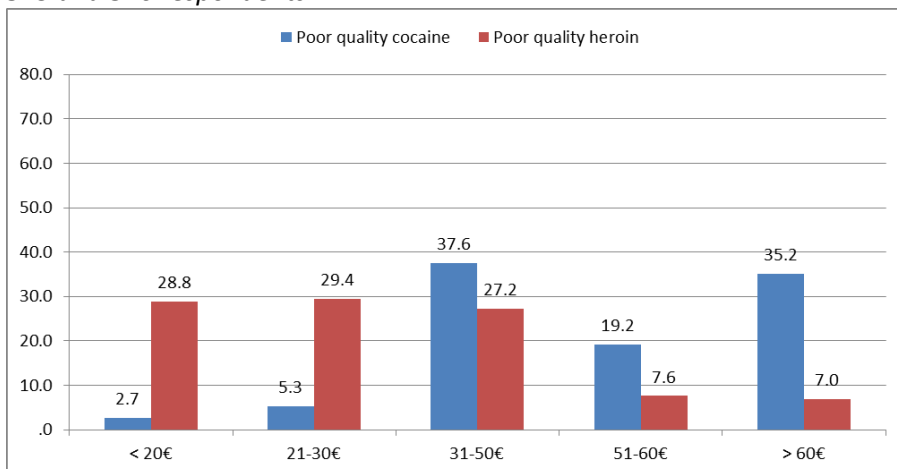
Around 90% of respondents indicated the prices of marijuana and hashish at less than 10 €. A small percentage of users (7.5% for marijuana and 6.9% for hashish) reported a price of between 11 and 15 €. The remaining users priced the two substances at over 15 € per 1 gram and are absolutely negligible (Figure 3.12).

Low quality cocaine was priced by most of respondents at between 31 - 50 € (Figure 3.13) while the reported price of top quality cocaine was 71-90 € (Figure 3.14).

Looking at poor quality cocaine distribution, 35.2% of users assigned to this drug a price higher than 60 € while 19.2% a price of between 51-60 €. The rest of the sample said the latest known price of poor cocaine was lower than 50 € per gram.

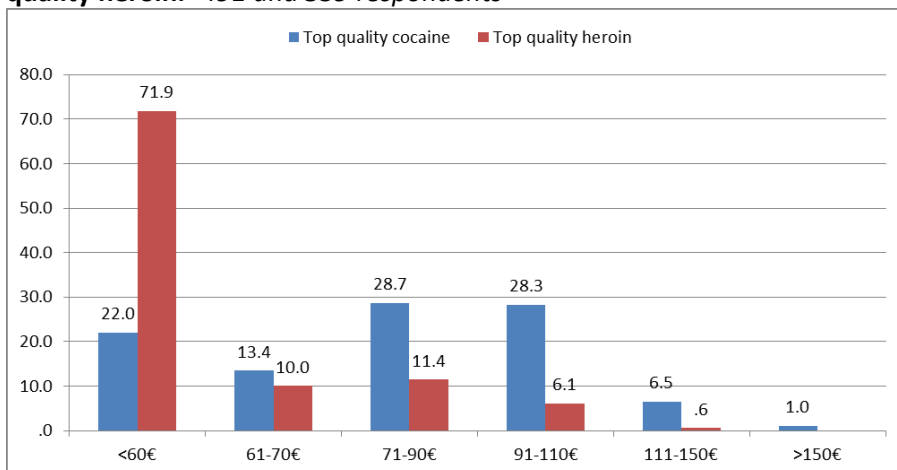
The majority of users estimated a price between 71 and 110 € for top quality cocaine. 28.7% estimated a price between 71 and 90 € while 28.3% between 91 and 110 €. High rates of users also reported top-quality cocaine price under 60 € (22%).

**Figure 3.13. price for 1 gram of poor cocaine and 1 gram of poor heroin**  
375 and 316 respondents



As for top quality cocaine, the price distribution of poor cocaine is varied. The price of poor quality cocaine is certainly higher than 30 € per gram while the top quality cocaine price is lower than 110 € per gram.

**Figure 3.14. price for 1 gram of top-quality cocaine and 1 gram of top quality heroin.** 491 and 359 respondents



The modal value of poor quality heroin is within the class 21-30 € (29.4%). Top quality heroin is indicated by 71.9% respondents in the “less than 60 €” price range.



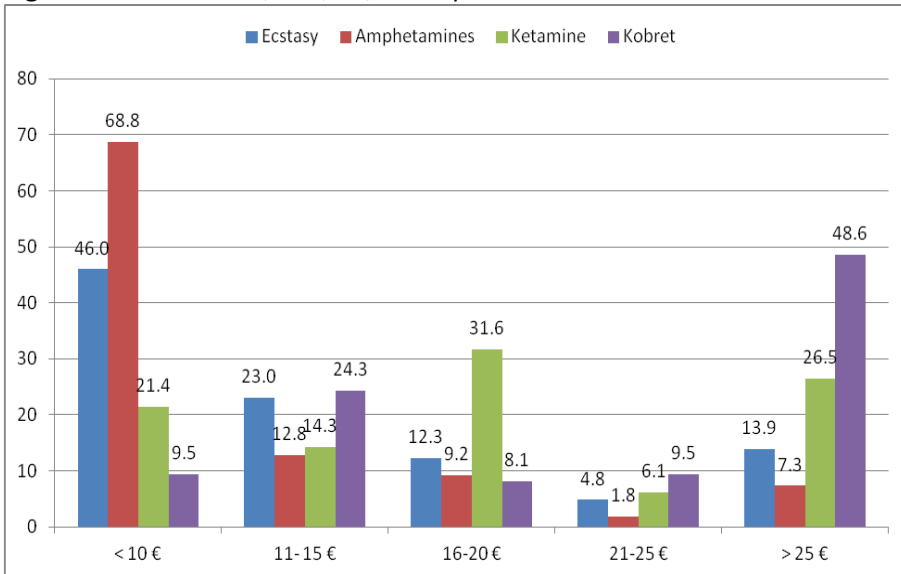
Most respondents (68.8%) said the price of amphetamine was < 10 € per pill whereas 12.8% of users estimated amphetamine prices between 11 and 15 €. Just 9.1% reported a pill price higher than 21 € (Figure 3.15).

The price of ecstasy has its modal value in the same class as amphetamines, < 10 (46%), and another large group indicated a price between 11 and 15 € (23%).

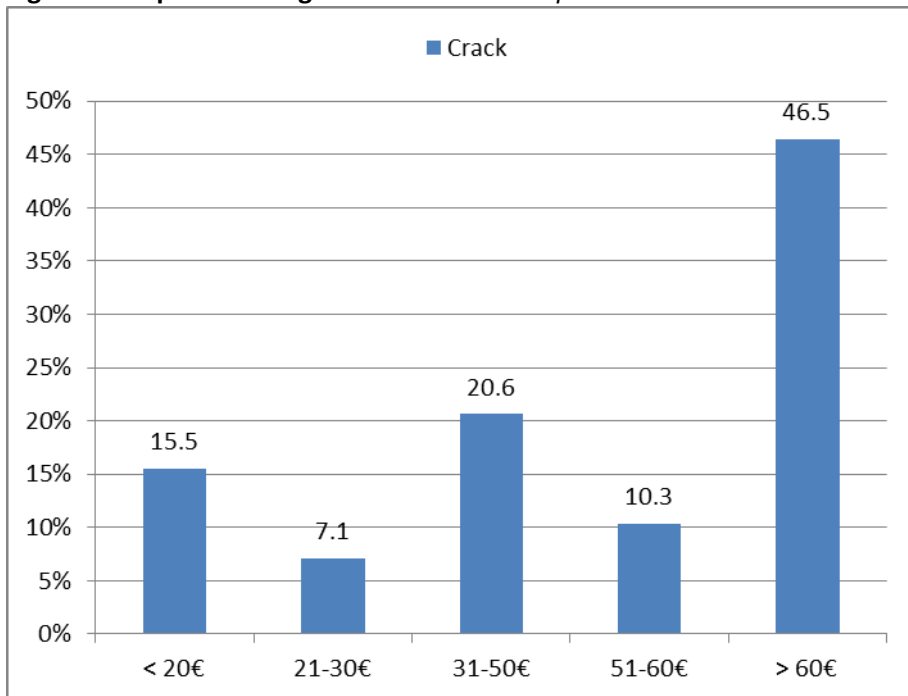
Almost half of users (48.6%) indicated the kobret price > 25 € per gram, but the second modal value (24.3%) was a price between 11 and 15 €.

The price of ketamine seems to be the most variable: 31.6% of respondents indicated between 16 and 20 €; 26.5% > 25 € and 21.4% < 10 €.

**Figure 3.15: price for 1 pill of ecstasy, amphetamine and ketamine and for 1 gram of kobret. 187, 109, 98, 74 respondents**



As is shown in figure 3.16 for crack the modal value is “higher than 60 €” per gram.

**Figure 3.16: prices for 1 gram of crack 155 respondents**

Further analysis can be done drawing from data surveyed separately for occasional, regular and intensive consumers. The aim is to obtain estimation of prices from those who had more recent experience.

**Table 3.6. estimated price for 1 gram of marijuana expressed by cannabis consumers according to their consumption frequency**

		< 10 €	11-15 €	16-20€	21-25€	> 25 €	Total
<b>Cannabis consumers</b>	Occasional	84.8%	9.1%	3.0%	3.0%		100.0%
	Regular	86.5%	5.4%	5.4%	0.9%	1.8%	100.0%
	Intensive	81.5%	9.9%	7.4%		1.2%	100.0%

Table 3.6 displays estimated prices the users gave to marijuana according to their consumption habit.

Most respondents, whether they are occasional, regular or intensive marijuana users, estimated the price of marijuana at less than 10 €. A considerable level of intensive users declared a price between 11-15 € (almost 10%).

**Table 3.7. estimated price for 1 gram of hashish expressed by cannabis consumers according to their consumption frequency**

		< 10 €	11-15 €	16-20€	21-25€	> 25 €	Total
<b>Cannabis consumers</b>	Occasional	89.3%	3.6%			7.1%	100.0%
	Regular	88.6%	8.6%			2.9%	100.0%
	Intensive	91.4%	7.4%			1.2%	100.0%

**Table 3.8. estimated price for poor heroin and poor cocaine per 1 gram, expressed by consumers of these substances according to their consumption frequency**

		< 20€	21-30€	31-50€	51-60€	> 60€	Total	
<b>Cocaine and heroin consumers</b>	Poor cocaine	Occasional	2.7%	2.7%	35.1%	29.7.0%	29.7%	100.0%
		Regular	1.3%	2.7%	42.3%	20.8%	32.9%	100.0%
		Intensive	4.1%	4.1%	36.1%	18.6%	37.1%	100.0%
	Poor heroin	Occasional	34.4%	9.4%	28.1%	12.5%	15.6%	100.0%
		Regular	33.6%	26.2%	28.0%	2.8%	9.3%	100.0%
		Intensive	24.3%	37.9%	22.3%	11.7%	3.9%	100.0%

Table 3.8 depicts estimated prices of poor cocaine and poor heroin expressed by those who were consumers of these two drugs. Analysis was done distinguishing users according to their consumption frequency.

The estimation price for poor cocaine is higher than 30 €. Levels of occasional, regular and intensive consumers are concentrated in the price class between 30 and more than 60 € per gram. 35.1% of occasional users and 42.3% of regular users reported a price between 31-50 € while 37.1% of intensive users have reported prices higher than 60 €. Data about cocaine in Table 3.8 is confirmed although some differences can be found making a distinction according to user consumption frequency. We see how the modal price class for intensive poor cocaine users is “> 60”. On the other hand for poor heroin/ intensive users the modal class is 21-30 €.

**Table 3.9. Estimation price for top quality heroin and top quality cocaine per 1 gram, expressed by consumers of these substances according to their consumption frequency**

		<60€	61-70€	71-90€	91-110€	111-150€	> 150€	Total	
<b>Consumers</b>	Cocaine top quality	Occasional	27.9%	18.0%	24.6%	26.2%	1.6%	1.6%	100.00%
		Regular	22.6%	13.4%	31.7%	23.7%	8.6%		100.00%
		Intensive	18.9%	11.8%	28.3%	33.9%	5.5%	1.6%	100.00%
	Heroin top quality	Occasional	64.9%	13.5%	13.5%	5.4%	2.7%		100.00%
		Regular	76.2%	6.6%	10.7%	6.6%			100.00%
		Intensive	67.5%	11.4%	12.3%	8.8%			100.00%

In Table 3.9, for top quality cocaine, the modal price class varies according with the typology of consumers. For intensive users it is 91-110 € (33.9%), for regular users it is 71-90 € and for most occasional users the price is less than 60 € per gram. The trend for top quality heroin is different. The modal class for all consumers is “less than 60 €”.

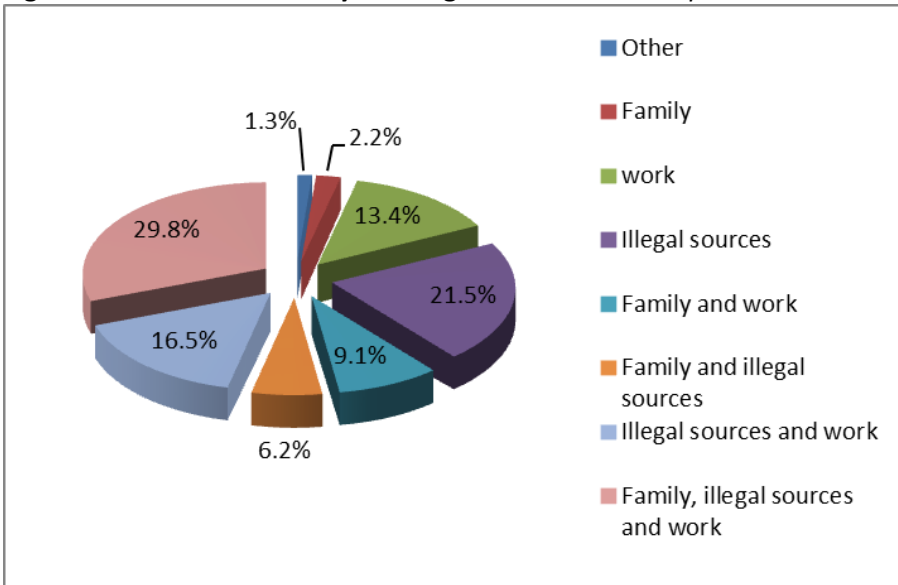
Aside from intensive users there are those who cited higher prices and this tendency must be taken into consideration because intensive users could have more information on the drug market than regular and occasional users.

# CHAPTER 4

## Legal and illegal sources of revenue for drug addicts

This paragraph aims to identify the sources of income (legal and illegal) through which users obtain the money to buy drugs. The issue of income sources is strongly correlated with the question of the funding of illicit drugs. There are three main sources of revenue that users invest in drug purchases: money from family, work and illegal activities. The question “How did you usually get money to buy drug(s)?” could be answered choosing more than one answer. That has allowed the aggregation of the respondents into 8 categories in which all the three main sources identified are combined .

**Figure 4.1. sources of money for drug consumers 695 respondents**

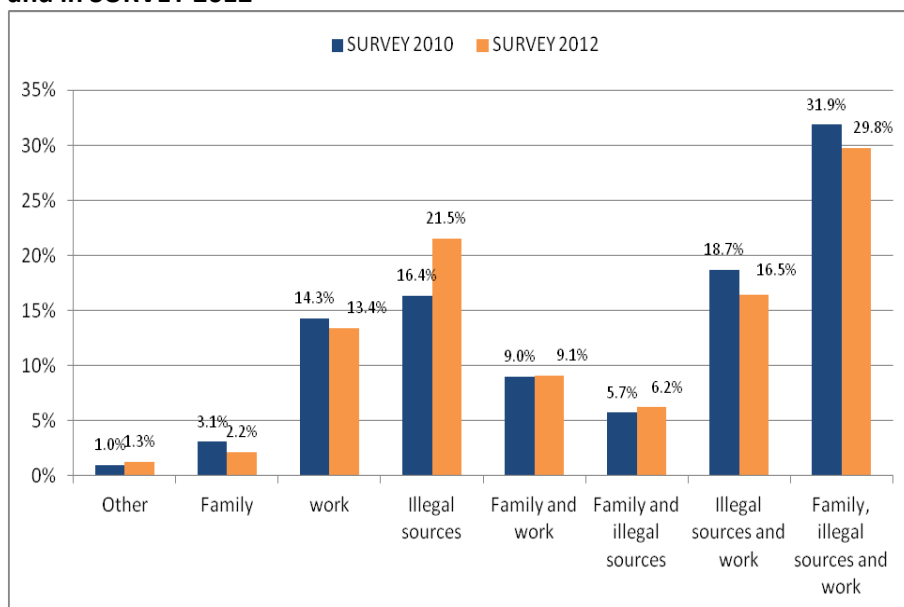


“Family” alone is the income source of 2.2% of users. 9.1% collected money from family and their work salary while 6.2% got money from family and illicit activities. Families have a powerful prevalence as income for drug addicts. 47.3% respondents draw from family savings, 45.1 % always in conjunction with other sources. This demonstrates that money from family is not enough to maintain the level of consumption for most users, so they necessarily have to draw from other sources.

Work is an important source of income for buying drugs for 13.4% of users. It is important to highlight that the main source after “family support” is “illegal activities”: 21.5% of respondents could rely just on crime without drawing from other sources.

Although over one-quarter of the respondents (29.8%) use the three income sources all together to get money to spend on drugs 16.5% cite the two income sources “illegal activities” and “work” and 6.2 % cite “family” and “Illegal activities” (Figure 4.1).

**Figure 4.2. comparison between users’ sources of money in SURVEY 2010 and in SURVEY 2012**



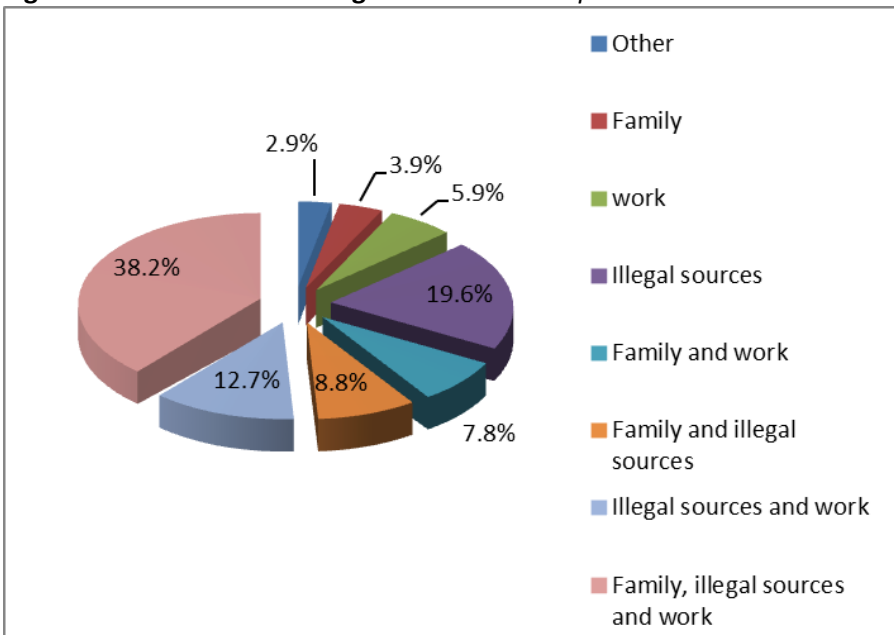
Looking at the sources of funding variation over the years 2010-2012 important differences can be seen in the rate of illegal activities to gain money. The rate of these activities increased by 5 percentage points: from 16.4% in SURVEY 2010 to 21.5% in SURVEY 2012 (Figure 4.2).

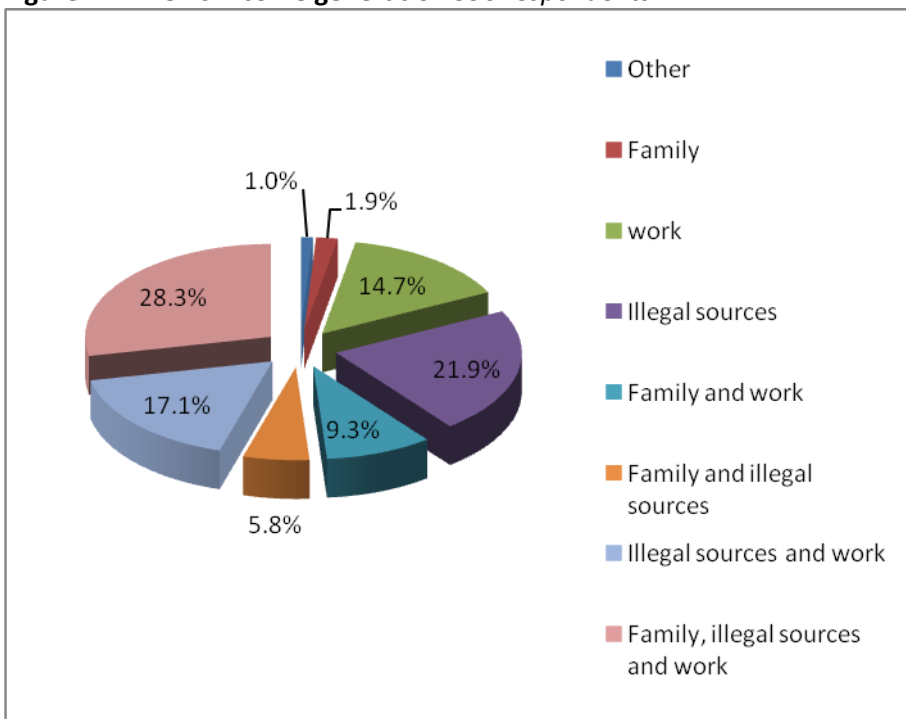
The importance of illegal activities is confirmed by the reduction of family and work as single sources.

The income sources of women are different from those of men: family is more important for women (Figure 4.3) than for men. The pie chart in Figure 4.4 (only for men) displays a split distribution among four main categories (family, work and illegal activities: 28.3%; illegal activities 21.9%; work and illegal activities 17.1% and work 14.7%) while for women distribution was apportioned among all income groups with an important concentration (38.2%) on “family, work and illegal activities” together.

Further, 19.6% of women reported income from illegal activities, 12.7% reported work and illegal activities, 8.8% reported family and illegal sources and 7.8% family and work. Only 5.9% (vs 14.7 of men) cited work as a singular source.

**Figure 4.3. women’s income generation 102 respondents**



**Figure 4.4. men's income generation 590 respondents**

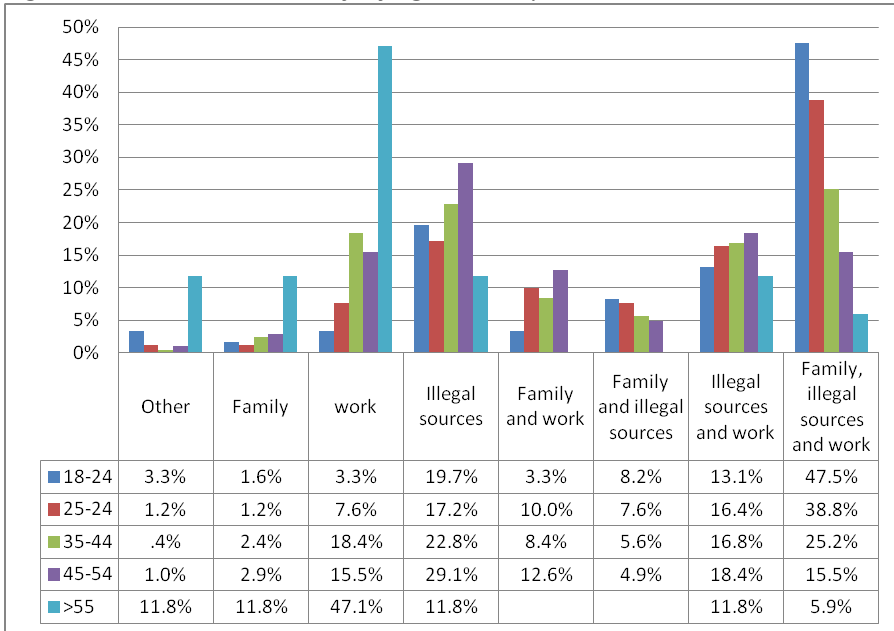
Other important features can be observed in relation to the age of the respondents.

47.5% of young adults aged 18-24 (Figure 4.5) received revenue from “family, illegal activities and work” and another 19.7% of them from only “illegal activities” .

Looking at the 25-34 age group, “family, illegal activities and work” was still the modal value but less important (38.8%) than for the younger group; work (7.6%) and illegal activities combined with work (16.4%) become more important than for the younger group; illegal activities as the only one source of income slightly decreases with respect to the younger group (17.2%).

As the age increases, the responses are more evenly distributed among classes of combined sources of income except for respondents over the age of 54 years. For these users there is a level of concentration in the income category “work”. Users over 54 are also the most likely to rely on family resources as the only one source of money to finance their addiction.

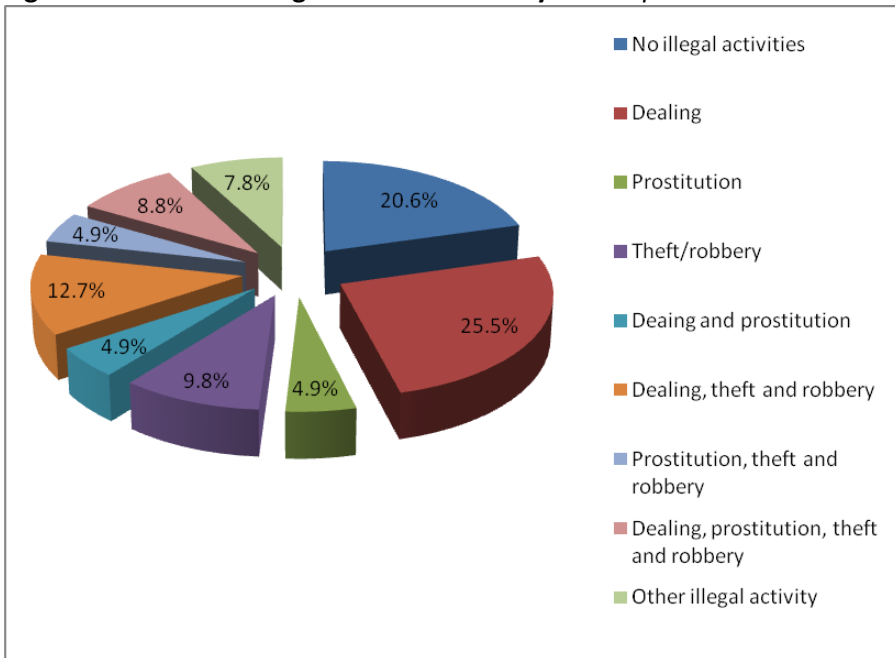


**Figure 4.4. sources of money by age 682 respondents**

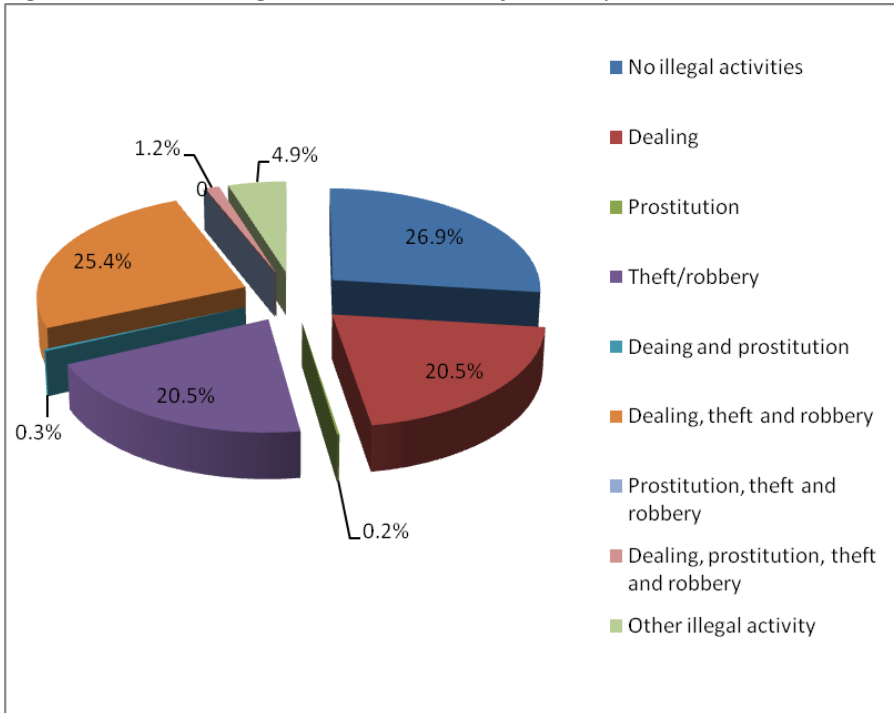
The survey also allows a deeper analysis concerning the main illegal activities: dealing, prostitution and theft/robbery. In order to better understand the phenomenon we built seven different clusters containing one or more of the above-mentioned activities in accordance with the multiple or single choices of respondents.

Figure 4.5 displays the illegal sources of funding for females. Their main illegal source of revenue is drug dealing (25.5%), while 4.9% of them combine dealing and prostitution, 12.7% with robberies and thefts and 8.8% performed all of these activities.

Prostitution is the only illegal activity for 4.9% of women while theft or robberies are, after drug dealing, the only illegal activity for 9.8% women. It is interesting to note that 7.9% of women declared “other illegal activities” while only 4.9% men cited this category.

**Figure 4.5. women's illegal sources of money 102 respondents**

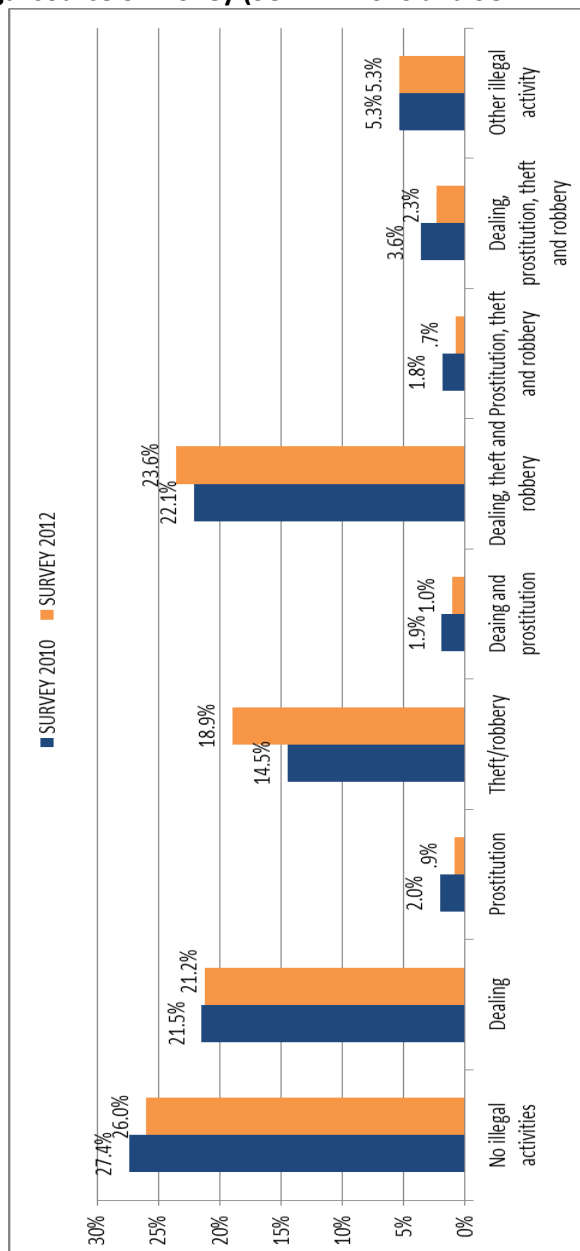
**Figure 4.6. men's illegal sources of money 590 respondents**



The illegal activities of men are more concentrated in three categories: “dealing, theft and robbery” (25.4%); “dealing” (20.5%); “theft and robbery” (20.5%).

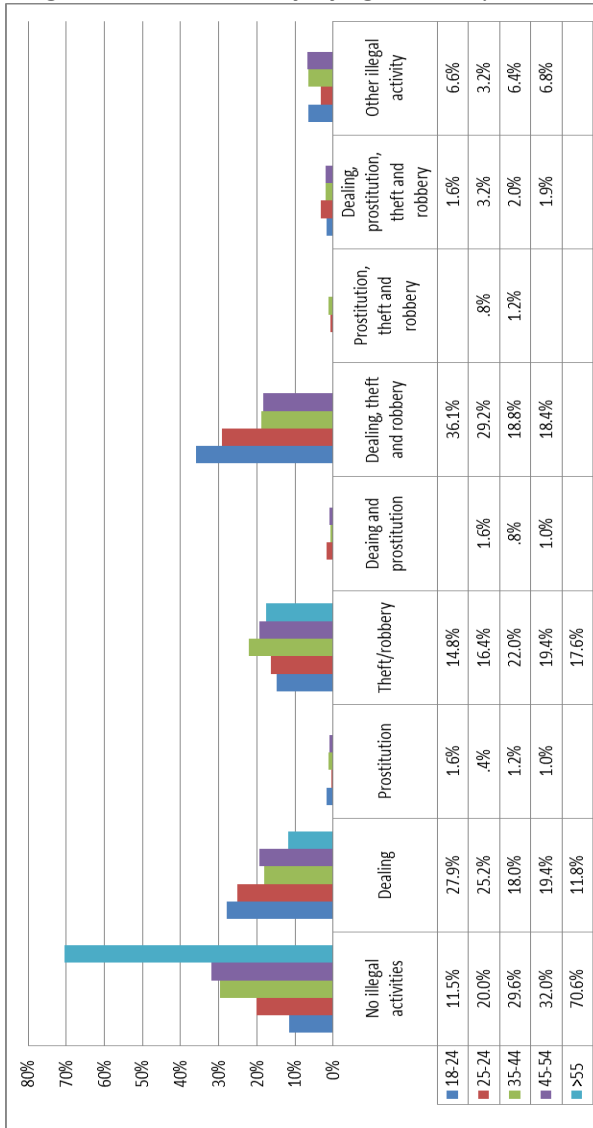
Data not insignificant: prostitution was declared by 0.5% men (summing up “prostitution” alone and “dealing and prostitution”).

Figure 4.7. illegal source of money (SURVEY 2010 and SURVEY 2012).



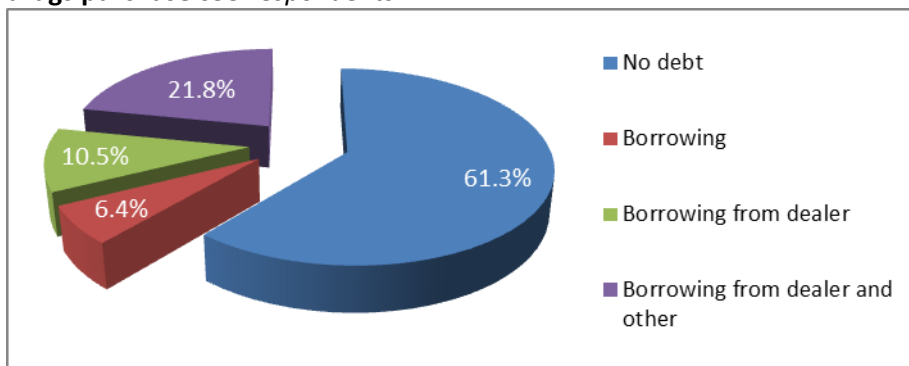
The comparison between SURVEYS 2010 and 2012 shows a decrease in drug dealing and prostitution and an increase of the rates of users involved in theft or robbery (from 14.5% in 2010 to 18.9% in 2012).

Figure 4.8. Illegal sources of money by age 682 respondents



Drug dealing and theft, on the individual level, are among the main activities used as an illegal income source to purchase drugs. That applies to all of the age groups. Drug dealing is still more widespread among the younger generation, especially combined with theft and robbery activities. Prostitution is more frequent among young adults aged 18-24 years old.

**Figure 4.9 distribution of respondents who contracted a debt or not for drugs purchase 695 respondents**



Among those who borrowed money to buy drugs, 21.8% had borrowed both from dealers directly and from other subjects, 10.5% reported to have borrowed money just from a dealer and 6.4% only from other subjects. The majority of the respondents (61.3%) have never received a loan to buy drugs.

**Figure 4.10. distribution of respondents who contracted a debt or not for drugs purchase by gender 692 respondents**

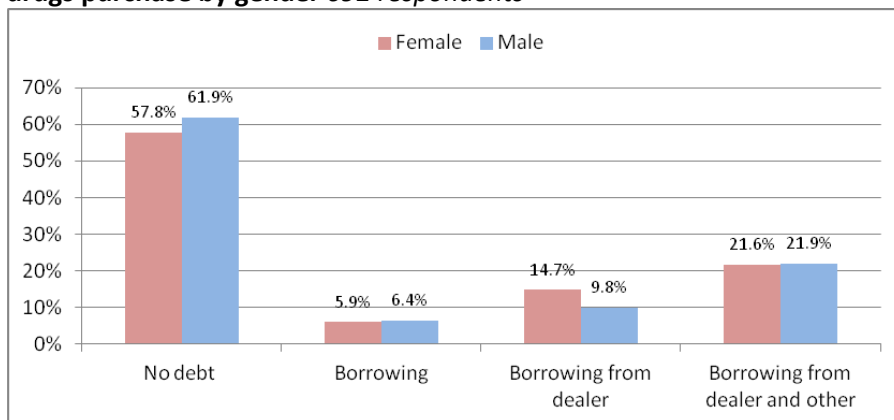
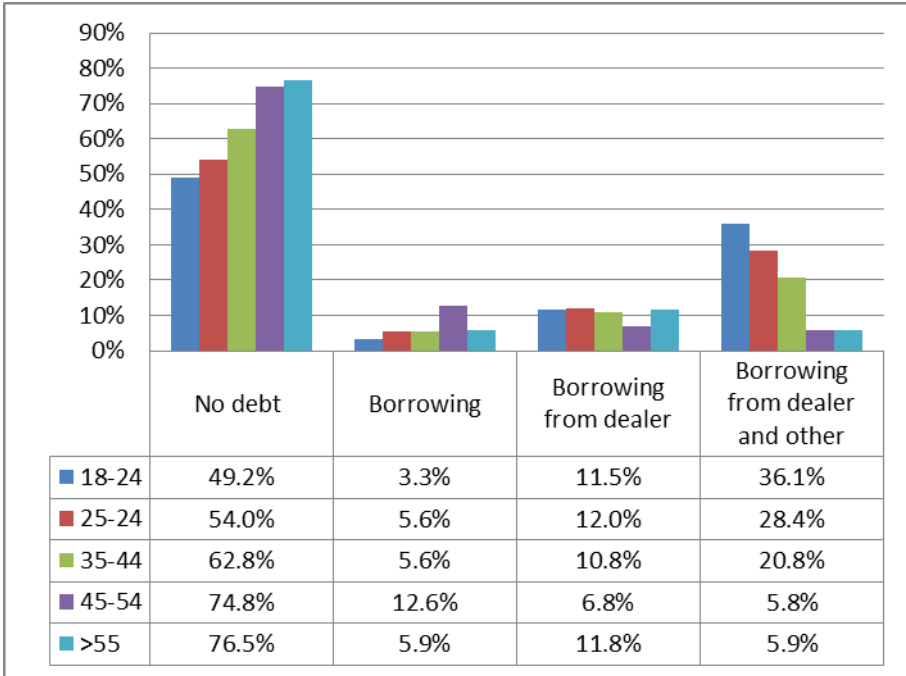


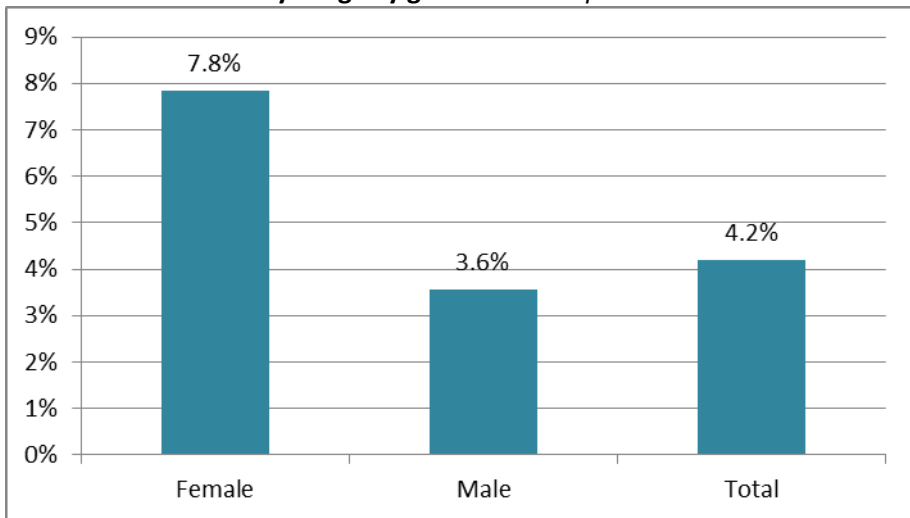
Figure 4.10 displays users' distribution by gender and the way to borrow money as a means of purchasing drugs. The data shows the difference between men and women in the category of those who used to borrow from a dealer: here women are the majority (14.7% against 9.8% of men). In fact, women had incurred more debt than men.

**Figure 4.11. distribution of respondents who contracted a debt or not for drugs purchase by age 682 respondents**



The younger the users are the more they asked for a loan to finance their addiction (Figure 4.11).

**Figure 4.12. distribution of respondents who used contributions from social assistance to buy drugs by gender 692 respondents**



A last analysis can be conducted on those who used contributions from social assistance to spend on the illicit drug market. They amount to 4.2% of the whole sample and they are mostly women (7.8% of the whole female sample); men comprise 3.6% of the whole male sample.





# CHAPTER 5

## Evaluation of Services

Patient satisfaction is the major indicator of the quality of services provided by a health facility. In this chapter the aim is to assess the level of patient satisfaction within the various aspects of the health care in said facilities.

### **5.1. Satisfaction with services**

Respondents were asked about the usefulness of assistance received during their treatment program in care facilities. The usefulness of services has been expressed through a utility score ranging from 1 to 5, where 1 represents the minimum benefit and 5 the maximum one. Services under assessment are: psychological assistance, medical assistance, the chance of sharing experiences with others, getting back to living according to rules, access to drug substitutes and assistance in job hunting.

**Figure 5.1. average score of patient satisfaction with health care services**  
 585, 522, 580, 555, 506, 557 respondents

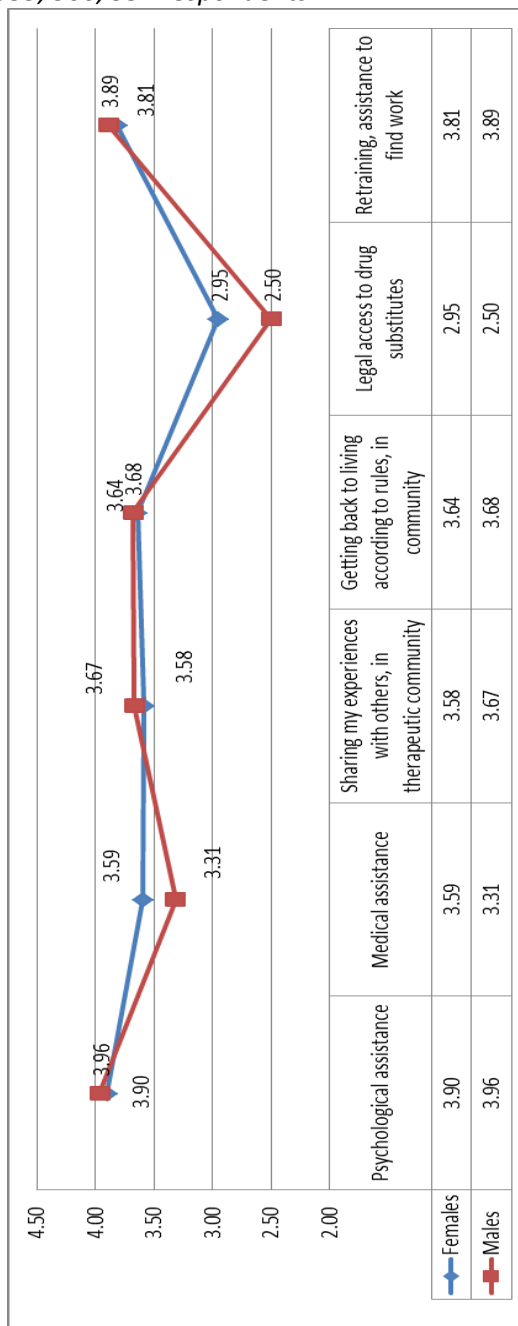


Figure 5.1 shows the average satisfaction expressed by female and male respondents and there are no relevant differences.

Table 5.1 gives more details about the distribution of these evaluations: psychological assistance (51.4%) and social and work reinstatement assistance (52.1%) receive the highest percentage on the maximum utility score (5 points). About 18% of users evaluated the utility of these two services to be lower than 2 points.

“Sharing experience with others” and “getting back to living according to rules” are particular services issued in the treatment centers. They also received high scores. Around 42% of users rated these services at 5 points, while about 35% of respondents rated them from 3 to 4.

In contrast the legal access to drug substitutes got the lowest appreciation rates (53.4% gave it no more than 2 points); medical assistance does not receive an enthusiastic evaluation (with a controversial score: 30% gave not more than 2 points and, on the other side, 32.9 % 5 points).

Only for “medical assistance” and “drug substitute”, women expressed evaluations more positive than men (Figure 5.1).

**Table 5.1. evaluation of services usefulness [1= lowest rating - 5 = highest rating] 587, 523, 581, 557, 507, 559 respondents**

	<i>Psychological assistance</i>	<i>Medical assistance</i>	<i>Sharing my experiences with others, in therapeutic community</i>	<i>Getting back to living according to rules, in community</i>	<i>Legal access to drug substitutes</i>	<i>Retraining, assistance to find work</i>
Values						
1	8.9	17.0	14.5	13.6	40.0	14.8
2	7.8	13.0	7.6	8.4	13.4	4.3
3	14.5	20.5	17.9	17.8	15.8	12.0
4	17.4	16.6	18.2	17.6	11.0	16.8
5	51.4	32.9	41.8	42.5	19.7	52.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

Further analysis can be undertaken distinguishing users between those who have never entered a therapeutic community and those who have been a patient in these structures at least once in the life.

**Table 5.2. evaluation of service usefulness by TC patients, at least in the past [1= lowest rating - 5= highest rating] 535, 471, 532, 511, 458, 504 respondents**

	<i>Psychological assistance</i>	<i>Medical assistance</i>	<i>Sharing my experiences with others, in therapeutic community</i>	<i>Getting back to living according to rules, in community</i>	<i>Legal access to drug substitutes</i>	<i>Retraining, assistance to find work</i>
Values						
1	8.4	17.4	11.0	11.0	40.6	14.5
2	7.9	13.4	8.6	8.6	14.2	4.4
3	14.4	22.1	18.2	18.2	15.9	12.5
4	17.4	17.0	18.0	18.0	10.7	16.7
5	52.0	30.1	44.2	44.2	18.6	52.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

The service considered to be the most useful by both TC residents and non-TC residents, is "Retraining - Assistance to seek jobs". Percentages of users who gave this service the maximum utility score are the same among these two kinds of patients.

Psychological assistance is more appreciated by those who have been in therapeutic communities (52% of users assigned the maximum score). On the contrary the never-been- in-TC assigned lower satisfaction rates to psychological services and the minimum values to "sharing experience" (1 point 36.7 %) and "getting back to following the rules"(43.5 %).

The never-been-in-TC sample gave more importance to medical assistance (5 points 57%) whilst "legal access to drug substitutes" received poor judgements . The "means of utility" score given by non-TC users is 3.7 against 3.97 given by TC patients.

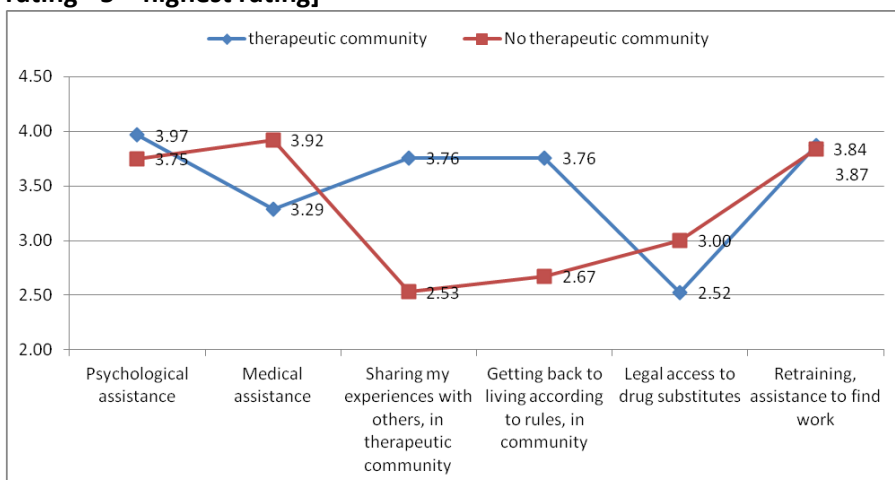
The medical approach is perceived useful mostly by those who have never been in TC and psychological assistance, especially the other treatments based on it, is appreciated only by TC patients, probably because they have already experienced or are experiencing these services.

**Table 5.3. evaluation of services by never in TC [1= lowest rating - 5= highest rating] 52, 52, 49, 46, 49, 55 respondents**

	<i>Psychological assistance</i>	<i>Medical assistance</i>	<i>Sharing my experiences with others, in therapeutic community</i>	<i>Getting back to living according to rules, in community</i>	<i>Legal access to drug substitutes</i>	<i>Retraining, assistance to find work</i>
Values						
1	13.5	13.5	36.7	43.5	34.7	18.2
2	7.7	9.6	16.3	6.5	6.1	3.6
3	15.4	5.8	16.3	13.0	14.3	7.3
4	17.3	13.5	18.4	13.0	14.3	18.2
5	46.2	57.7	12.2	23.9	30.6	52.7
Total	100.0	100.0	100.0	100.0	100.0	100.0

Tables 5.2 and 5.3 show that TC and non-TC patients appreciate psychosocial services (“Sharing experiences...” and “Getting back to life...”). TC users gave more importance to these services than non-TC respondents. Margins between the average scoring given by TC and non-TC users are considerable: 3.76 vs. 2.53 from non-TC users for “Sharing experiences...” and 3.76 vs. 2.67 for “Getting back to life...”.

**Figure 5.2. average evaluations according to enrollment in TC [1= lowest rating - 5 = highest rating]**



**Figure 5.3. comparison between SURVEY 2010 and SURVEY 2012, regarding average evaluations of service usefulness by TC patients [1= highest rating \_ 5= lowest rating]**

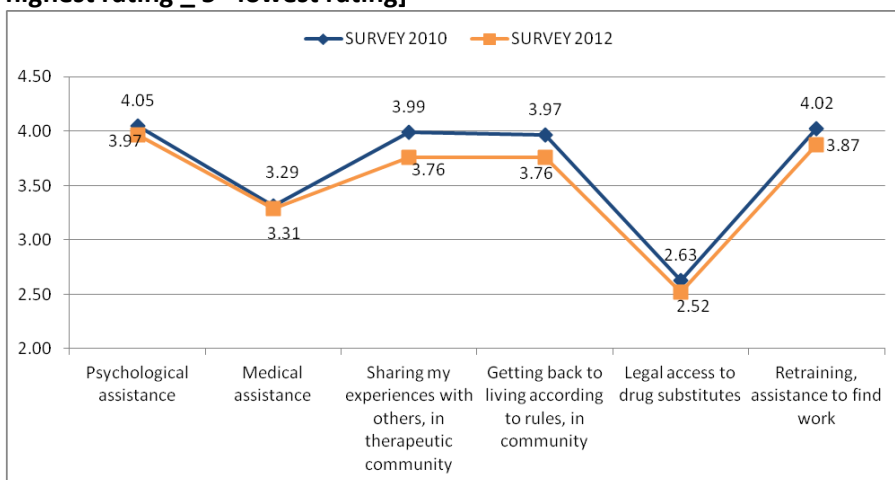
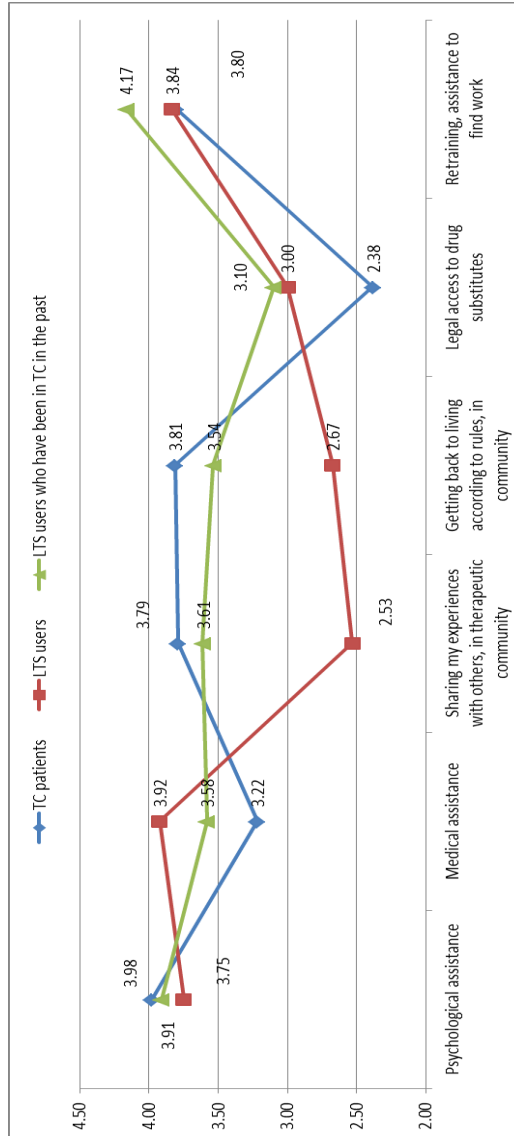


Figure 5.3 shows the changes in evaluation from SURVEY 2010 to SURVEY 2012. The only notable differences can be found regarding the considerations about “Sharing experiences...” and “Getting back to living...” The appreciation of these services has decreased over the years: from an average of nearly 4 in 2010 to 3.76 in 2012.

**Figure 5.4. comparison of the evaluations by TC patients, LTS users and LTS users been in TC, regarding the utility of services [1= lowest rating \_ 5= highest rating]**



Comparing differences in patient characteristics and average utility scoring among the three patient groups reported in figure 5.4, we can suppose that the low evaluation for the psycho-social treatments is given for ignorance: LTS patients who have experienced these kinds of treatments

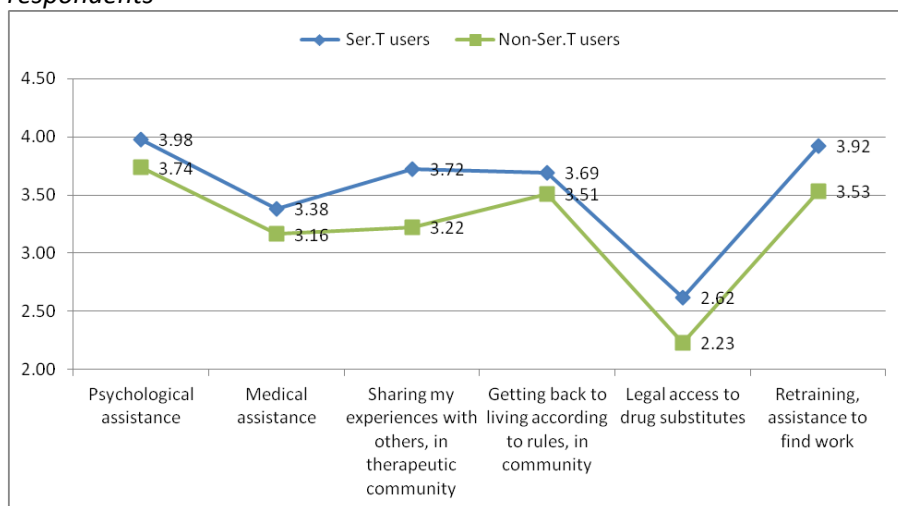
have a more positive opinion of psychological assistance and related treatments.

The three groups of users are nearly equivalent in their strong appreciation for retraining services.

Users who have been both in TC and LTS gave a lower rating to medical assistance rather than those who have experienced only LTS.

Figure 5.5 shows the average evaluation of services distinguishing users who used Ser.T services and those who didn't. Data displays the same trend with regard to ranking services but the averages of utility scoring expressed by non-Ser.T patients are always lower than those assessed by Ser.T users.

**Figure 5.5. average score for services by Ser.T and non-Ser.T patients [1= lowest rating \_ 5= highest rating]** 587, 523, 581, 557, 507, 559  
*respondents*





**Table 5.4. evaluation of services by non-Ser.T patients [1= lowest rating - 5= highest rating] 76, 67, 81, 73, 66, 77 respondents**

	<i>Psychological assistance</i>	<i>Medical assistance</i>	<i>Sharing my experiences with others, in therapeutic community</i>	<i>Getting back to living according to rules, in community</i>	<i>Legal access to drug substitutes</i>	<i>Retraining, assistance to find work</i>
Values						
1	11.8	23.9	24.7	23.3	53.0	22.1
2	9.2	19.4	9.9	6.8	7.6	6.5
3	19.7	9.0	17.3	9.6	13.6	13.0
4	11.8	11.9	14.8	16.4	15.2	13.0
5	47.4	35.8	33.3	43.8	10.6	45.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

**Table 5.5. evaluation of services by users who have used Ser.T at least once [1= lowest rating \_ 5= highest rating] 511, 456, 500, 484, 441, 482 respondents**

	<i>Psychological assistance</i>	<i>Medical assistance</i>	<i>Sharing my experiences with others, in therapeutic community</i>	<i>Getting back to living according to rules, in community</i>	<i>Legal access to drug substitutes</i>	<i>Retraining, assistance to find work</i>
Values						
1	8.4	16.0	12.8	12.2	38.1	13.7
2	7.6	12.1	7.2	8.7	14.3	3.9
3	13.7	22.1	18.0	19.0	16.1	11.8
4	18.2	17.3	18.8	17.8	10.4	17.4
5	52.1	32.5	43.2	42.4	21.1	53.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

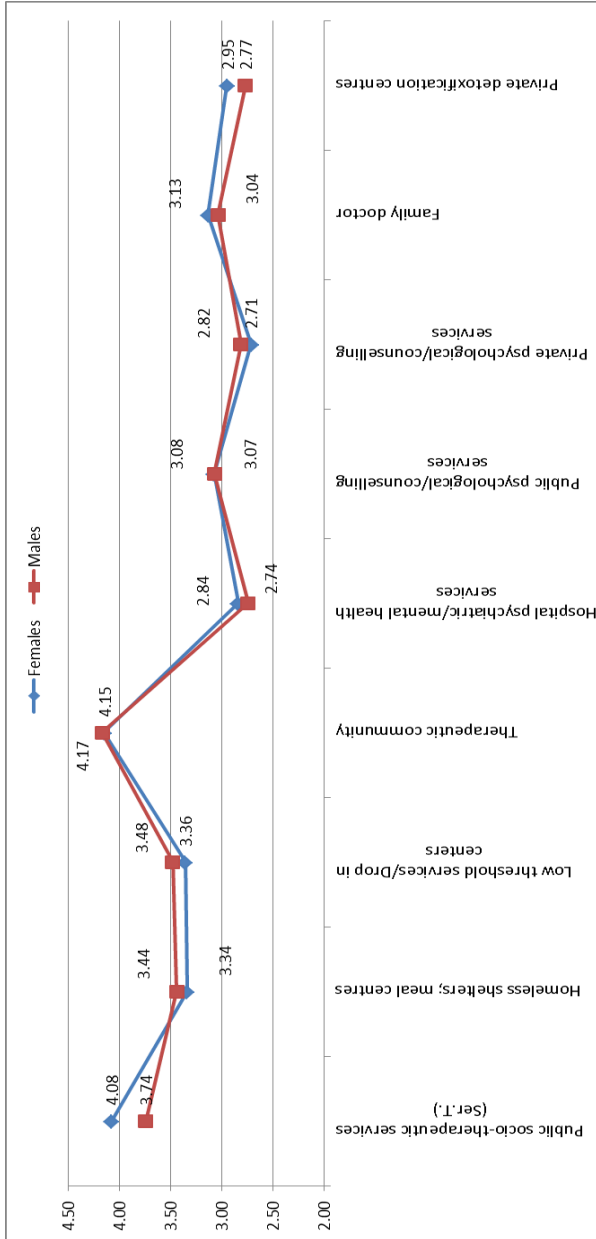
Legal access to drug substitutes is considered to be a better service by Ser.T users rather than non-Ser.T respondents. 53% of non-Ser.T users expressed very negative evaluations about this kind of service. Those who have been in Ser.T considered psychological assistance and retraining services to be useful more than non-Ser.T users. Over a half of Ser.T

patients gave to these two services the highest utility score while Ser.T patients evaluations are more varied, although there's a prevalence of scores at level "5".

Medical assistance is more appreciated by Ser.T patients. In fact we can see how high rates of non-Ser.T users evaluated this service as barely useful. Services typical of therapeutic communities are considered by Ser.T users to be very useful: almost 6 out of 10 Ser.t users attributed a score of between 4 and 5 to the two services "Sharing ... " and Getting back to ... ". Among non-Ser.T patient positive evaluations were given to the chance of getting back to life according to the rules (with 43.8% giving it the maximum score). Though there is a considerable percentage of non-Ser.T users giving the lowest rating to this service (23.3%). Average evaluation is positive as well by Ser.T patients.

## 5.2. Satisfaction with Institutes

**Figure 5.6.** average score of patient satisfaction for typology of institute  
*Female min. 20, max 91 respondents; male min. 91, max 507 respondents*



In this kind of evaluation, men and women do not show evident differences in response (Figure 5.6).

55% of respondents gave TC the maximum quality scores and another 21.6% gave 4 points.

Ser.T follows TC with excellent scores: 44.5% of patients gave 5 points and another 17 % gave 4.

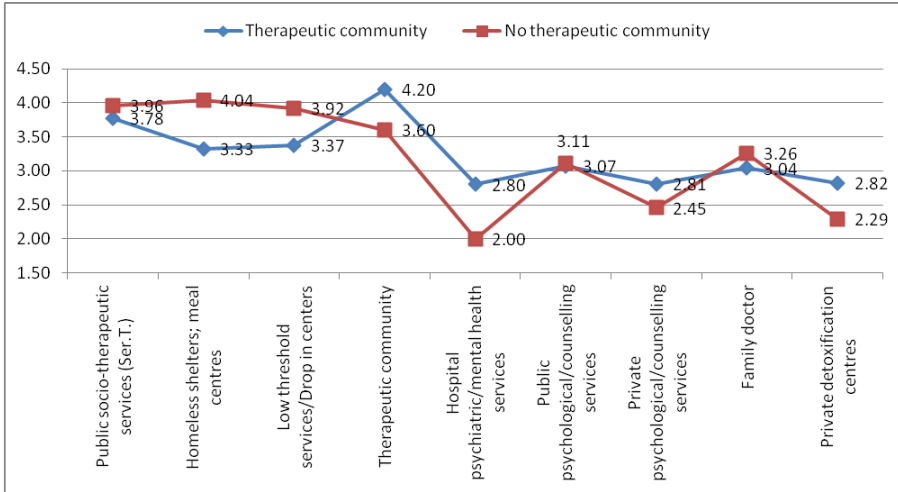
**Table 5.6. evaluation of service quality by whole sample [1= lowest rating - 5 = highest rating]**

	Sert	Homeless shelters; meal centres	Low threshold services	Therapeutic community	Hospital psychiatric/mental health services	Public psychological/counseling services	Private psychological/counseling services	Family doctor	Private detoxification centres
Values									
1	8.2	14.9	14.5	4.7	25.0	18.6	28.3	20.4	31.3
2	10.0	13.3	12.7	5.9	20.9	18.6	18.8	19.7	17.0
3	20.3	18.5	20.6	12.5	24.4	25.0	20.3	20.4	18.8
4	17.0	21.0	16.4	21.6	12.8	12.2	11.6	12.5	8.0
5	44.5	32.3	35.8	55.3	16.9	25.6	21.0	26.9	25.0
Total	100	100	100	100	100	100	100	100	100

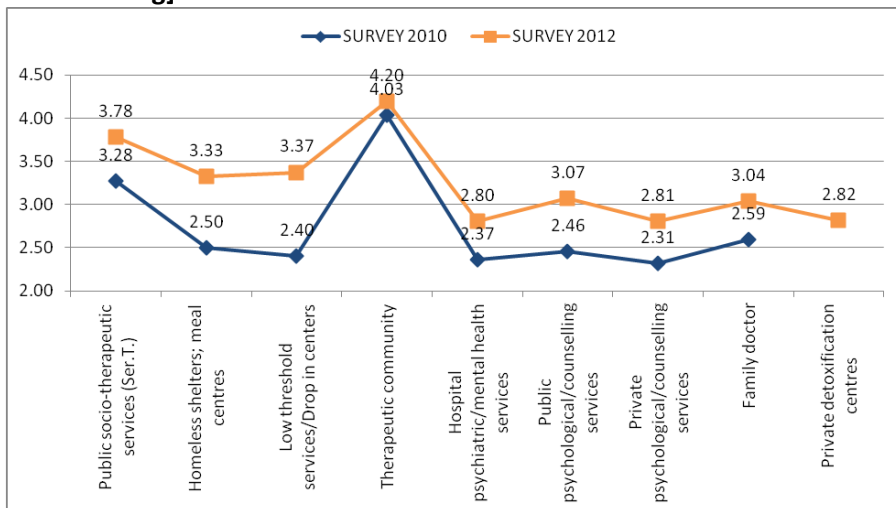
Institutes such as psychiatric hospitals are the worst. About 7 users out of 10 scored the quality of these structures at under 3 points.

Private structures such as detoxification centers and private psychological and counseling services have an average quality score below 3 points.

**Figure 5.7. difference between TC and non-TC users services evaluation [1= lowest rating - 5 = highest rating]**



**Figure 5.8.comparison between SURVEY 2010 and SURVEY 2012, regarding average evaluations of service quality [1= highest rating -5= lowest rating]**



A certain increase in the score given to of all the institutes can be noticed in 2012 with respect to 2010. Quality assessment for the therapeutic community remains at the top with the lowest increase of satisfaction (Figure 5.8).

**Table 5.7. evaluation of institute by TC patients [1= lowest rating - 5= highest rating]**

	Sert	Homeless shelters; meal centres	Low threshold services	Therapeutic community	Hospital psychiatric/mental health services	Public psychological/counseling services	Private psychological/counseling services	Family doctor	Private detoxification centres
Values									
1	8.5	16.1	14.4	4.3	23.5	18.2	27.6	20.3	29.5
2	10.3	14.9	14.4	5.6	21.0	19.5	18.9	20.7	18.1
3	19.9	19.0	23.0	12.4	24.7	24.7	19.7	19.9	19.0
4	17.6	20.2	15.8	21.5	13.6	12.3	12.6	12.9	7.6
5	43.8	29.8	32.4	56.2	17.3	25.3	21.3	26.2	25.7
Total	100	100	100	100	100	100	100	100	100

Tables 5.7 and 5.8 make a comparison between quality evaluation expressed by users who have tried therapeutic community services and by those that never made use of such facilities. As we said before, those who have never been in a therapeutic community gave a very negative evaluation of private centers for psychological assistance and detoxification.

**Table 5.8. evaluation of institutes by non-TC patients [1= lowest rating \_ 5= highest rating]**

	Sert	Homeless shelters; meal centres	Low threshold services	Therapeutic community	Hospital psychiatric/mental health services	Public psychological /counseling services	Private psychological/counseling services	Family doctor	Private detoxification centres
Values									
1	5.4	7.4	15.4	12.0	50.0	22.2	36.4	21.7	57.1
2	7.1	3.7	3.8	12.0	20.0	11.1	18.2	8.7	14.3
3	25.0	14.8	7.7	16.0	20.0	27.8	27.3	26.1	14.3
4	10.7	25.9	19.2	24.0	-	11.1	-	8.7	-
5	51.8	48.1	53.8	36.0	10.0	27.8	18.2	34.8	14.3
Total	100	100	100	100	100	100	100	100	100

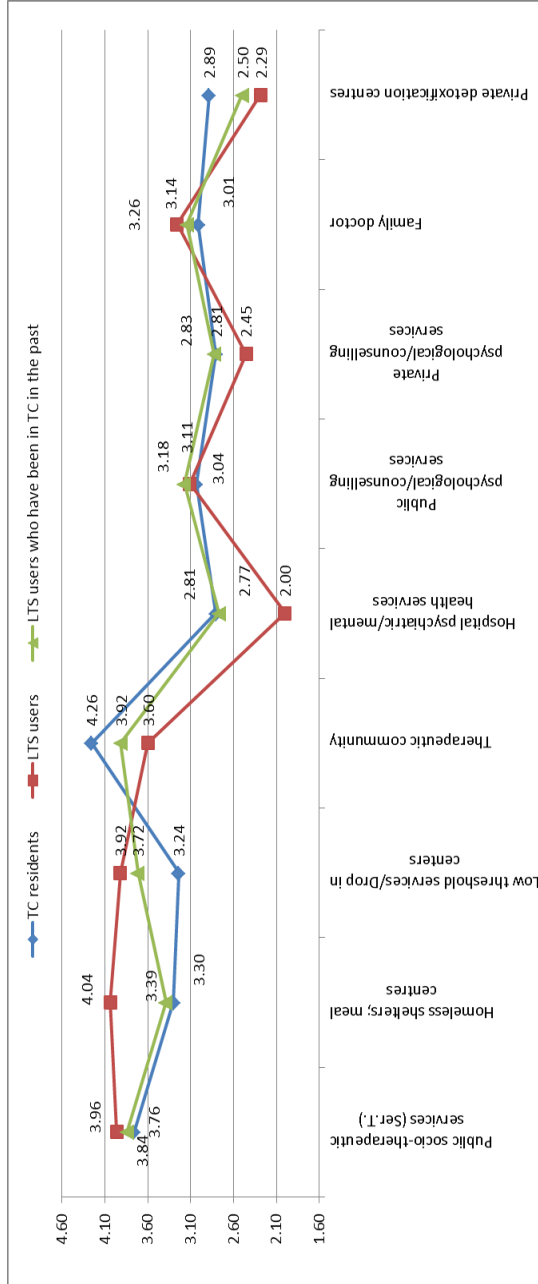
For those who have never been in TC the best quality services are provided by low threshold structures and Ser.t: 5 users out of 10 gave the maximum quality score to these two facilities. For the patients of therapeutic communities' the best quality structures are the therapeutic communities themselves.

The satisfaction regarding psychiatric hospitals is very negative for non-TC users: just 10% of them scored the quality of this public service between 4 and 5 points. Although there is a considerable percentage of those who evaluated psychiatric hospitals a positive service (30.9% scored them as between 4 and 5 points), patients of TC expressed negative scores for hospital services.

Speaking about psychological and counseling services, TC users gave good evaluation to public provisions. Non-TC residents instead gave a better evaluation of public psychological assistance. Private centers of counseling are evaluated as bad by most non-TC users.



**Figure 5.9. average score for the evaluations by TC patients, LTS users and LTS users been also in TC, regarding the quality of services [1= lowest rating - 5= highest rating]**



In figure 5.9 we isolated from LTS users those subjects who attended a TC structure in the past.

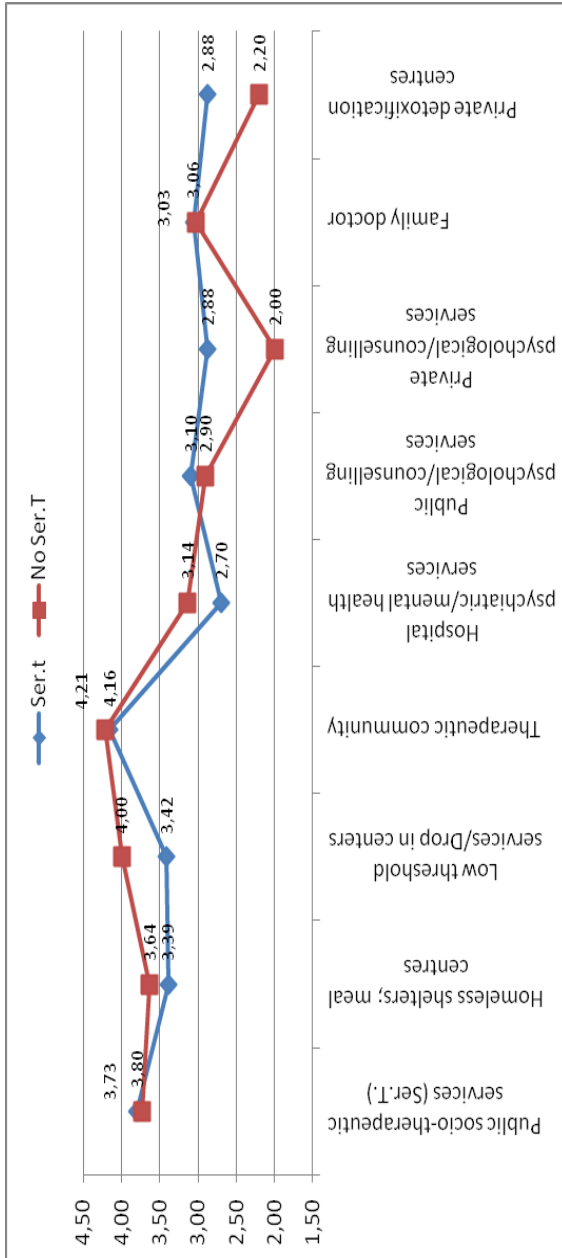
The evaluation of those who attended both TC and LTS structures tends to follow the assessment line of TC patients except for the evaluation of the same structures in which they were patients.

Among those patients who have attended both LTS and TC structures, LTS services have been perceived in a more positive way compared to the feedback provided by attendees of solely TC services. On the contrary, the opinion on TC services by patients of both LTS and TC structures was more negative than that given by those who attended only TC services.

Figure 5.10 looks at the tendency towards an average quality score given by Ser.T and non-Ser.T users to the services provided by addiction treatment facilities.

Ser.T users evaluated the quality of LTS, drop in centers and psychiatric hospitals better than non-Ser.T users. Services provided by private structures such as Psychological counseling services and private detoxification centers received a better evaluation from Ser.t users. Other services are equally evaluated by the two kinds of respondents.

**Figure 5.10. average score for services by Ser.T and non-Ser.T patients according to their experience [1= lowest rating - 5= highest rating]**





## APPENDIX 1 – Question 8: drugs used along three periods.

During the first year of use - After three years of use - Last time  
Question 8 is the first multiple question of the questionnaire. It was asked, which drugs have been used in three different periods and how much in each period.

The question aimed to investigate the doses taken and the level of tolerance.

*The descriptive analysis.*

Almost every respondent answered this question, but just half of the respondents declared the daily doses for each period and for each drug. The maximum number of respondents had been reached within the first year of use in the case of cannabis (395).

The case of cannabis is quite interesting because the number of respondents decreases across the three periods and this confirms that cannabis is a drug for beginners and it is less appreciated among intensive users of hard drugs.

Just around one hundred respondents had been collected for Amphetamine, Tranquillizers, Ecstasy, Crack and Methadone. LSD also had around one hundred respondents for the 1<sup>st</sup> and 3<sup>rd</sup> year but decreased to 50 respondents for the most recent period, maybe because LSD was more available previously. The reported answers for the other drugs in the list are very residual.

Among "other drugs" many respondents declared alcohol and some pharmaceuticals.

Looking at the different distributions for Heroin, Cocaine and Cannabis – that are not presented at the moment, because a deeper analysis has been required - there are slight differences among the three periods, the modal values are almost the same for Cocaine and Heroin, Cannabis has a modal value for the the most recent period at just one dose that confirms it to be a "drug for beginners".

- *A better description of tolerance.*

To give a better description of the tolerance three new variables can be introduced.

Given X= doses used in the first year; Y= doses used in the third year; Z= doses used most recently:

$(A1) = (Y-X)/X * 100$  measures if the consumption is increased or decreased between the first and the third year;

$(A2) = (Z-Y)/Y * 100$  measures if the consumption is increased or decreased between the third year and the most recent period;

$(A3) = (Z-X)/X * 100$  measures if the consumption is increased or decreased between the first and most recent period. The comparison of A1, A2, A3 is an attempt to have a possible idea of the tolerance induced by the use of each drug.

Cannabis seems to generate a low degree of tolerance or a great possibility of being substituted; Heroin on the contrary, especially in the third year, decreased just for 3% of respondents.

## APPENDIX 2 – Question 26: How many doses sold weekly?

This question had been answered by 355 respondents, 50% of the sample. It is assumed (but just for statistical convenience) that non-respondents have never sold drugs and this assumption can be considered a good proxy of the real situation.

Almost all the dealers sell at least 2 drugs; nobody had sold steroids and the most usual drugs are: Cocaine (by 55.2% of the respondents); Heroin (by 52.9%); Cannabis (by 51.7%).

Other drugs are less available to the respondents: Ecstasy (by 15%); Crack (by 9.8%); LSD (by 8.1 %); Amphetamine (by 7.6 %); Ketamine (by 7 %).

A particular case is Methadone that had been sold by 12.7 % of respondents.

In the following Table A2.1 doses and respective percentages of dealers of the main drugs are listed.

In the table A2.1, a very simple classification of dealers is proposed, but it is just to highlight how important the single dealer is in the market.

**Table A2.1. weekly doses sold by respondents 355 respondents**

	% on dealers population	Ecstasy		Cannabis		Cocaine		Heroin	
		doses	% dealers	doses	% dealers	doses	% dealers	doses	% dealers
			15.77%		51.27%		55.21%		51.55%
	% on sample population		7.75%		25.17%		27.11%		26.00%
small dealers		5	0.8%	1	0.3%	1	0.3%	2	0.6%
		10	0.8%	2	0.3%	3	1.1%	3	0.6%
		15	0.3%	3	0.3%	5	2.0%	4	0.6%
		20	0.8%	5	0.6%	10	4.8%	5	1.7%
		25	0.3%	10	2.3%	11	0.3%	6	0.6%
		30	1.7%	14	0.3%	13	0.3%	10	1.7%
				15	1.1%	20	4.8%	13	0.3%
			17	0.3%	24	0.3%	15	1.4%	
			20	2.5%	25	1.1%	20	4.5%	
			25	0.3%	30	3.4%	25	1.7%	
			30	2.0%			26	0.3%	
							30	3.7%	
	<b>Sub-total</b>		<b>4.8%</b>		<b>10.1%</b>		<b>18.3%</b>		<b>13.8%</b>
Street dealers		40	0.8%	40	1.1%	35	0.3%	35	0.8%
		50	0.3%	50	3.9%	40	2.8%	40	2.8%
		60	0.8%	60	0.3%	50	8.2%	45	0.3%
		70	0.3%	70	0.6%	55	0.3%	50	7.3%
		100	1.7%	80	0.6%	60	0.3%	70	0.3%
		150	0.3%	100	9.0%	70	0.8%	75	0.3%
				140	0.6%	90	0.6%	80	0.8%
			150	1.1%	100	6.5%	100	6.8%	
	<b>Sub-total</b>		<b>4.2%</b>		<b>17.2%</b>		<b>19.7%</b>		<b>19.4%</b>

expert dealers	Ecstasy		Cannabis		Cocaine		Heroin	
	300	0.8%	200	3.38%	150	1.4%	120	0.3%
	500	1.7%	250	1.41%	160	0.3%	150	2.0%
	600	0.3%	300	1.97%	200	3.7%	180	0.3%
	1000	0.6%	400	0.28%	210	0.3%	200	2.3%
			500	5.92%	230	0.3%	204	0.3%
			700	0.28%	250	0.6%	210	0.6%
			750	0.28%	300	1.4%	250	0.3%
			800	0.85%	400	0.8%	300	1.7%
			1000	4.23%	500	2.8%	350	0.6%
			1400	0.28%	700	0.8%	400	0.6%
			1500	0.85%	800	0.3%	500	2.5%
			2000	0.56%	900	0.3%	700	0.6%
			3000	1.41%	1000	1.4%	800	0.6%
			3500	0.28%	1400	0.3%	1000	1.7%
			4000	0.28%	1500	0.3%	1300	0.3%
			5000	0.28%	3000	0.3%	10000	0.3%
			7400	0.28%	5000	0.3%		
			10000	0.56%	6000	0.3%		
	<b>Subtotal</b>	<b>3.4%</b>		<b>23.4%</b>		<b>15.8%</b>		<b>14.6%</b>

The specialization in the market is also another factor and the “poly-dealing” is described in Table A2.2. It is remarkable that the modal class for those who deal drugs is “three or more substances” similar to poly-using.



**Table A2.2. composition of the dealer market by number of substances sold**

Sold substances	% on sample population
Zero substances	50.90%
Only cannabis	5.39%
Only cocaine	6.50%
Only heroin	5.95%
Only methadone	0.28%
Only other substances	2.49%
Cannabis and cocaine	2.90%
Cannabis and heroin	2.07%
Cannabis and methadone	0.00%
Cannabis and other substances	1.38%
Cocaine and Heroin	3.60%
Cocaine and methadone	0.14%
Cocaine and other substances	0.97%
Heroin and methadone	0.28%
Heroin and other substances	1.38%
Methadone and other substances	0.00%
Three or more substances	15.77%
Total	100.00%



## APPENDIX 3 – Question 38: the characteristics of users older than 25 years

This multiple question was the most complex; it was successful considering its position at the bottom of the questionnaire.

At least 2 out of 3 of the possible respondents for this question (> 25 years old) answered all the details of this complex question.

Also for this question it was necessary to generate new variables for a simple description of the data.

<b>1. Civil status - parameters</b>	
Single 1	
Married /living together with a partner 2	
Divorced/widow 3	
NO ANSWER 5	
First position	Age of first use
Second	25 years old
Third	35
Fourth	Now

68% of 503 respondents are single at the age of first use and remain single.

7.7% get married around 25 years old, but more than half of them are widowed or divorced at around 35 years old.

5.5% have been married since the age of first use.

3% are widowed/divorced since the age of first use.

### 2. Children

69.3% of 501 respondents have never had children.

### 3. How do you live? And where?

A percentage of 18.85 % live alone when they first use. Just 4.1 % continue to live alone at 25 years old.

67.5 % live with parents at first use; at 25 years old 24 % continue to live with their parents; 11.7 % don't continue and go and live alone; 9.6 % go to live with their own family.

Only 44 % continue to live in their own house at 25 years old and just 16 % always continue to live in their own house.

56 % respondents don't come back home and the majority of them prefer not to answer.

#### **4. Employment**

Just 1.6% of respondents have a permanent job for all of their life.

11.8 had a permanent job at the age of 25 years old and only 10 % at 35 years old.

The complexity of the question could be summarized by an index of marginalization that could combine the four variables here considered.

## APPENDIX 4 – Main parameters of the collected sample

Age by gender (years)	Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
Male	36.18	8.76	36	29	42	14	75
Female	35.36	9.79	35	28	42.75	18	67

Age at first use by gender (years)	Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max	
First use drugs	Male	14.38	5.40	15	13	16	10	29
	Female	14.51	5.33	14.5	13	17	3	25
First use hard drugs	Male	15.82	7.8	17	15	19	12	33
	Female	14.66	7.74	16	13	18	10	40
First time dealing drugs	Male	17.9	4.21	17	15	19.75	10	41
	Female	18.95	5.37	18	16	20	10	41
Latency (hard – soft drug use)	Male	1.45	8.86	2	0	4	0	30
	Female	0.15	7.98	1	0	3	0	17

Prices	Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
Marijuana	9.06	2.88	10	7	10	3	20
Hashish	8.87	5.22	10	5	10	3	40
Cocaine	66.68	20.05	75	55	80	12.50	105
Heroin	39.55	16.68	35	30	50	12.50	90
Amphetamine	13.54	11.82	10	10	15	3	70

Age at first contact (years)	Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
Street units	27.67	8.86	26	20.5	36	17	45
Sert (public service)	26.86	7.51	25	20	32	18	43
Therapeutic communities	28.24	7.84	26	21	36	17	44
Private detoxification centers	29.05	6.57	28	24.5	34	20	44





## PART 3

### Czech Survey

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Sampling design, data collection, data entry and analysis have been conducted by the Easy and Faster s.r.l. working group coordinated by Roberto Ricci and composed of: Francesco Fabi, Umberto Ialiccio, Claudia Musella and Claudia Restelli.





# INTRODUCTION

## **1. Methodology of the sampling**

The research methodology used in this study is based on a sample composed of those who approached socio-sanitary structures to deal with their drug addiction.

These patients can be divided into three groups, which have been described in the Introduction. As the categories remain the same for the Czech Republic, just for a recall the categories are:

- 1. Users who enter the socio-sanitary circuit autonomously*
- 2. The patients of LTS might only have the intention of avoiding a worsening of their situation and may not be truly determined to quit substance abuse.*
- 3. Users who enter the health care structures as an alternative sentence.*

## **2. Typology of services**

In the Czech Republic most care structures for people with disorders related to illegal drugs are non-residential (outpatient) facilities, and they are substantially cheaper than residential facilities with comparable results for most of the cases. They exist for people who don't want to enter into a residential therapeutic center and you can meet young beginners and old users. Most patients are still using substances.

LTS are services aiming at reaching more addicts and remaining in contact without requesting abstinence, as in Italy.

If the outpatient services seem to be specialized in the first phase of treatment, the inpatient services are more specialized in the final phase, but as we have already underlined it is so frequent to fall again into use that sometimes, also in the case of a residential patient of a TC, the final stage of rehab is never completely reached.

Residential structures (inpatient facilities) are limited to detoxification departments in medical hospitals, a few rehabilitation centers in psychiatric hospitals, and therapeutic communities. Some of them are run by medical hospitals, others by non-medical staff, and some other (such as Teen Challenge) are run by religious-oriented associations. However, there are no large communities but rather smaller facilities with 10-20 clients as maximum. The development of the TC model is not based on large Communities in the Czech Republic where the largest community is run by Podane Ruce, but is not comparable with Italian organizations such as CEIS or Saman.

Inpatient facilities are drug-free environments distinguished by a residential long-term approach, where drug addicts live in an organized and structured way, in order to get ready for a drug-free life. TCs provide addicts with psychotherapeutic support under psychiatric supervision concerning, namely, the creation of the conditions for their social reintegration.

In any case - whether a residential or non-residential service - it's important to specify that these services cannot grant a different and specifically designed help protocol for each and every case of problematic consumption.

### **3. Care phases**

The treatment plan offered by the available services can be articulated into four main steps:

1. First contact
2. Detoxification
3. Psychological treatment
4. Social reintegration

These steps can be processed either in residential or non-residential programs. The latter 3 services can be provided both by non-residential structures and by therapeutic communities. 'First contact' is more common in non-residential structures.

Usually the first step consists of drug treatment (detoxification) which is considered to be the beginning of the treatment path.

During detoxification, substitutive drugs dispensation is applied, with a consequent diminution in discomfort. Detoxification is a difficult process for poly-drug users to go through, since this type of subject is more prone

to relapse. Even those who find a way to detoxify by using methadone find it really hard to successfully reach their final goal.

As said in the previous chapters, psychological treatment aims to give solid instruments to avoid relapse. The last step consists of social reintegration, which could be provided by therapeutic communities or by other specific structures. Here patients are supported in work and social rehabilitation.

#### 4. Sample structure

The targeted number of actual interviews was 148 across most regions of the Czech Republic. Users were contacted through public and private-social organizations that provide services for drug addicts.

Information about the structures was obtained by studying various centers' web pages. This exploration was based on distinguishing the main activities of the centers as well as of the specific area of their work and the approximate number of clients/patients.

In a first selection we identified various centers such as charity or religious institutions which are working partially in the field of drug dependence. However, only the centers which are focused on drug dependency and prevention exclusively were selected for this survey. The biggest centers as well as some small centers were contacted:

- **Laxus** works with: first contact, street work, assistance for clients in prison, ambulance advice, social prevention, family advice and research. They have a network in various regions in the Czech Republic.
- **Magdaléna** : primary prevention, street work, ambulance advice, residency in a therapeutic community, protected residency, reintegration into work, ambulance rehabilitation, outpatient care. They have a network in various regions of the Czech Republic.
- **Renarkon** is focused on primary prevention and street work. They provide contact centers, therapeutic community, reintegration into work and an absolvence club. They have a network in various regions across the Czech Republic. They already have experience with international collaboration (EU programs) in the field of teacher training for elementary and high schools regarding prevention, a program for the development of financial skills for clients with debts and the project "social firm".
- **Most k naději** offers the following services: contact center, street workers, primary prevention, medical assistance, hygiene services,

laundry, food, tests HIV, HCV and OPL, family advisory . They have a network in various regions of the Czech Republic.

- **Prevent** undertakes street work, rehabilitation, contact centers, prevention, substitutive therapy, educational activities. They have a network in various regions of the Czech Republic.
- **Světlo o.s.** is a contact center which provides prevention, re-socialization, street workers.
- **White Light I.** is a contact center, therapeutic community, rehabilitation center, requalification center. They have a network in various regions of the Czech Republic.
- **Agarta** has a contact center and street workers in various regions of the Czech Republic.
- **A Kluby ČR** have two centers in Brno: a Center for Therapy and the Center for Employment Support. Their activities include: first contact, internet advisory center, reintegration to work, ambulance therapy.
- **Arkáda – sociálně psychologické centrum, o.s.** works with crisis advice, contact center, rehabilitation, substitution therapy. They have headquarters in two cities – Písek and Milevsko.
- **o. s. KAPPA – HELP** is active in the field of primary prevention, street workers, contact center, therapeutic community educational programs.
- **Progressive o. s.,** has a lot of centers in Prague which work in the areas of street work, contact center, low threshold services.
- **o. s. Krok** is active in the fields of therapeutic community, psychological rehabilitation (residency in a therapeutic community), sociotherapy, family advisory – reconstruction of family contacts, civil advisory.

13 structures were contacted. Some of the centers contacted cover both LTS and TC services.

Sample size in each kind of structure		
LTS	TC	Total
114	34	148

# CHAPTER 1

## Characteristics of Users

### 1.1 Age, gender and first use

Table 1.1. displays the proportion of male and female users from the sample. Males are in the majority (66%). Females represent 36.8% of those in the LTSs and 24.2% of those in the TCs.

**Table 1.1. gender distribution (LTS and TC) 147 respondents**

	Low Threshold	Therapeutic Communities	Total
Female	36.8%	24.2%	34.0%
Male	63.2%	75.8%	66.0%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

**Figure 1.1. age distribution (LTS and TC) 141 respondents.**

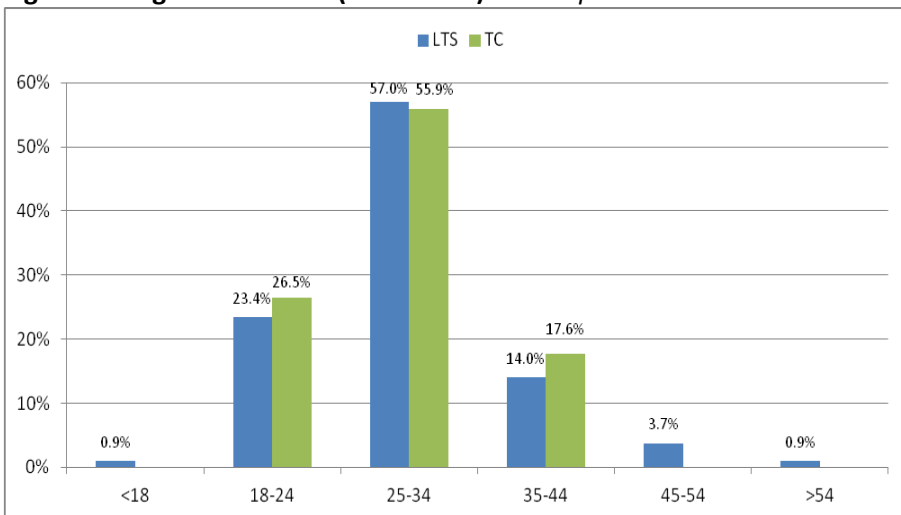
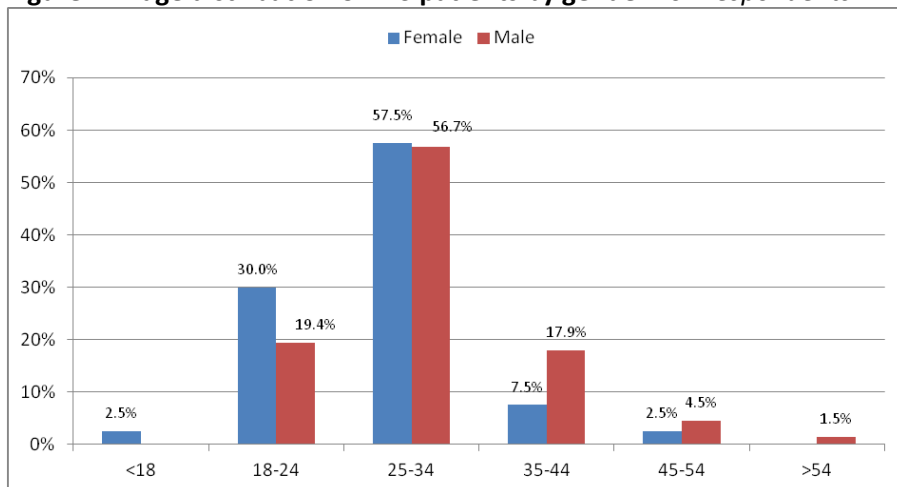


Figure 1.1 shows the frequency distribution of the respondents by age in each service.

Respondents aged 25-34 make up the majority for both services; 57% of all LTS users and 55.9% of all TC patients. The second biggest age group concerns users aged 18-24. Again there is not a great difference between TC and LTS (23.4 % and 26.5 % respectively).

The patients of therapeutic community services are a little younger than the patients of low threshold services.

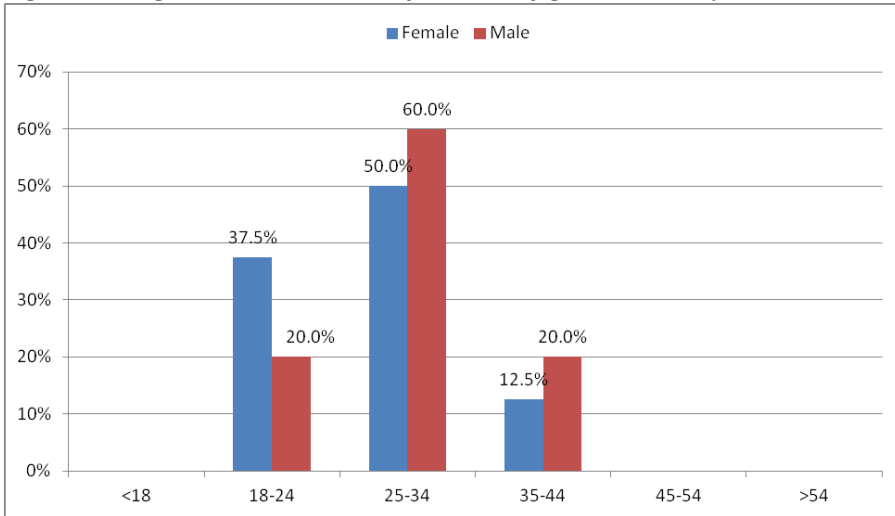
**Figure 1.2. age distribution of LTS patients by gender 107 respondents**



Most men (Figure 1.2) approaching LTS are between 25-34 years old (56.7%). This class is followed by the age class 18-24 (19.4%) and by the 35-44 age group (17.9%).

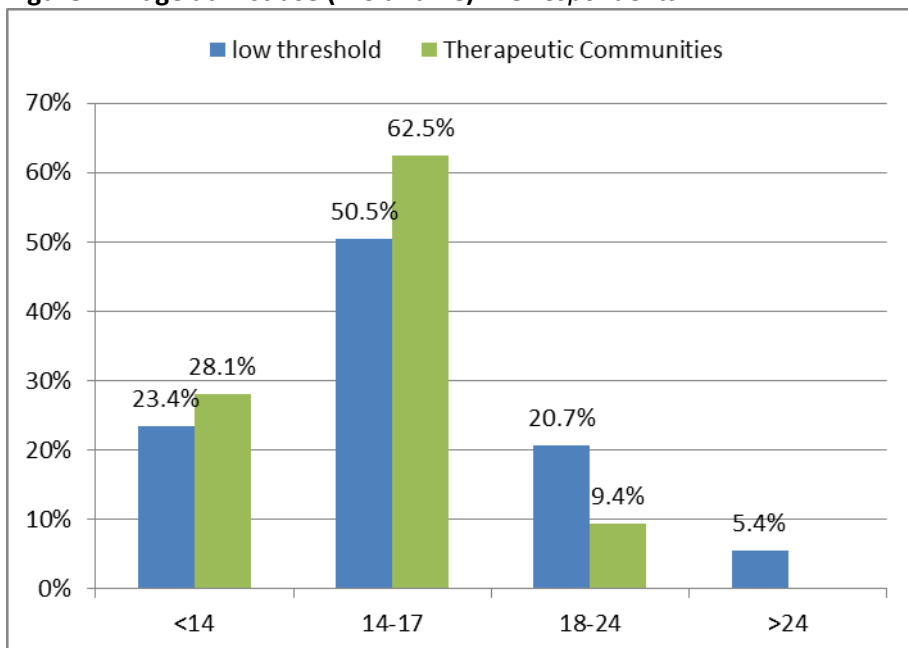
The age distribution of women displays another scenario. The modal value is always in the age cohort between 25-34 (57.5%), followed by 30% for younger subjects aged between 18-24 and there is a remarkable presence (7.5%) in LTS of older women aged 35-44.

90% of female users are represented in the age classes under 34 years old while men older than 35 are in the majority with a percentage of 23.9% with respect to 10% of women users.

**Figure 1.3. age distribution of TC patients by gender 33 respondents**

Regarding the distribution of Therapeutic community users, (Figure 1.3) the whole TC population is concentrated in the three age classes between 18 and 44 years old.

The modal value is the age group 25-34 years old for both genders. Others male rates are fairly evenly spread between the 18-24 and 35-44 age groups (20%) while the second biggest age group for women concerns users aged 18-24 (37.5%) followed by the 35-44 age group (12.5%). Concerning TC users, women are a little younger than men.

**Figure 1.4. age at first use (LTS and TC) 143 respondents**

First use (Figure 1.4) is widespread among those in the age group 14 to 17, both for LTS (50.5 %) and TC users (62.5 %).

The second biggest age group concerns users less than 14 years old (23.4% of TC and 28.1% of LTS users).

The more the users get older, the more the percentage of those who approach drugs the first time decreases. Moreover (Figure 1.4) the older beginners seem to prefer LST; probably because LTSs are prevalent in the phase of "first contact", before a TC treatment period, or because the "older beginners" are of working age and don't want to stop working and to start a therapeutic period in TC.

For both groups of users (Table 1.2.) cannabis was the most common choice for first contact with illicit drugs. Almost 6 out of 10 users (63.3%) initiated use with this type of illicit drug (58.4% in LTS and 81.8% in TC).

The second most popular drug is Pervitin (16.4% average value between LTS and TC patients). Ecstasy use was reported by 7.1% of LTS patients, and nobody among TC patients had first begun consuming with this drug.

Rates were negligible regarding other drugs on the list: Heroin, LSD and Kobret with rates of use fairly evenly spread among these three types of drug categories (1.4%).



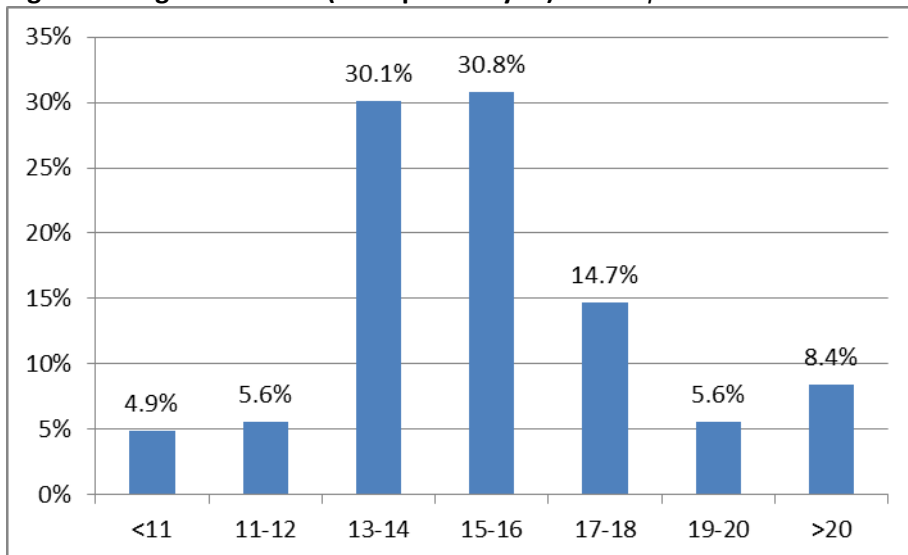
**Table 1.2. first drug experimented (LTS and TC) 146 respondents.**

	low threshold	Therapeutic Communities	Total
* Pervitin	18.6%	9.1%	16.4%
Tranquilizers/sedatives (without medical prescription)	-	3.0%	0.7%
Amphetamines	0.9%	-	0.7%
Ecstasy (MDMA. XTC. etc...)	7.1%	-	5.5%
Cannabis (marijuana. hash. ganja)	58.4%	81.8%	63.7%
Cocaine	.9%	-	0.7%
Heroin	1.8%	-	1.4%
Psychedelic mushrooms	0.9%	-	0.7%
LDS	0.9%	3.0%	1.4%
Kobret	1.8%		1.4%
Street methadone (without prescription)	0.9%	-	0.7%
Another drug	8.0%	3.0%	6.8%
Total	100.0%	100.0%	100.0%

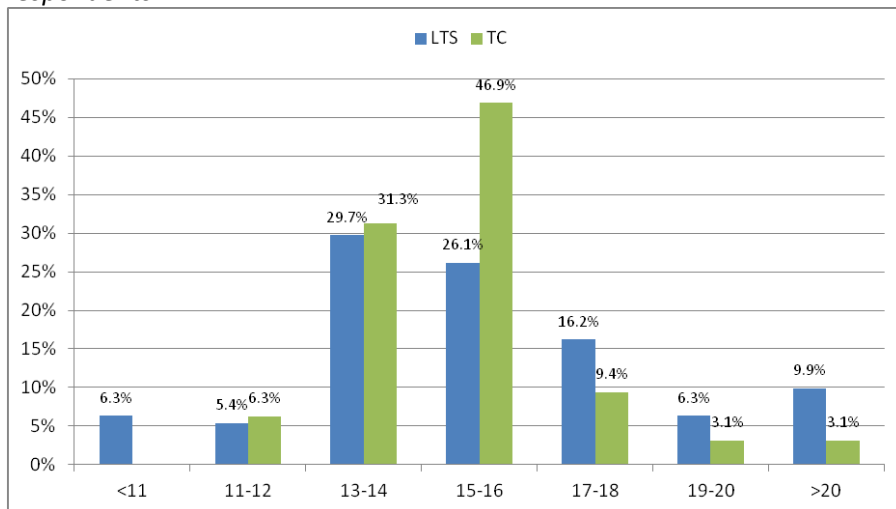
## 1.2 First Contact with Drugs

This section will attempt to provide some further information on the question of age of drug use initiation, and it starts with a more detailed distribution of age (Figure 1.5, 1.6, 1.7).

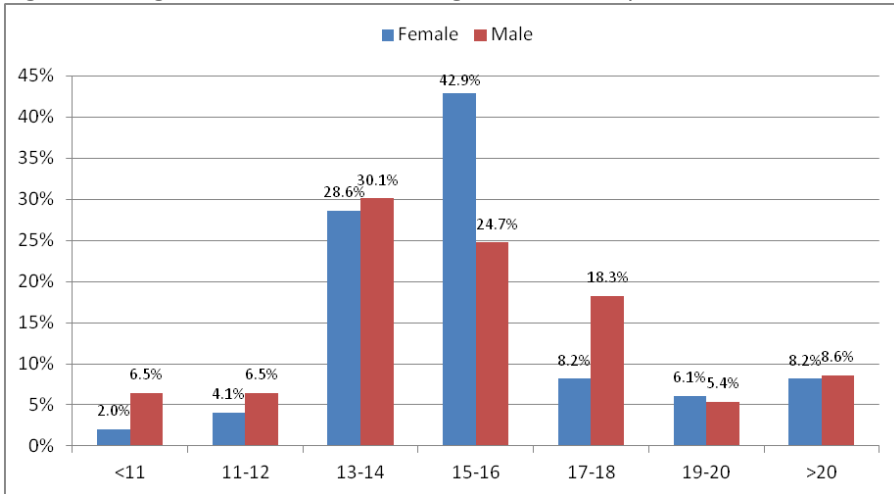
**Figure 1.5. age at first use (a deeper analysis) 143 respondents**



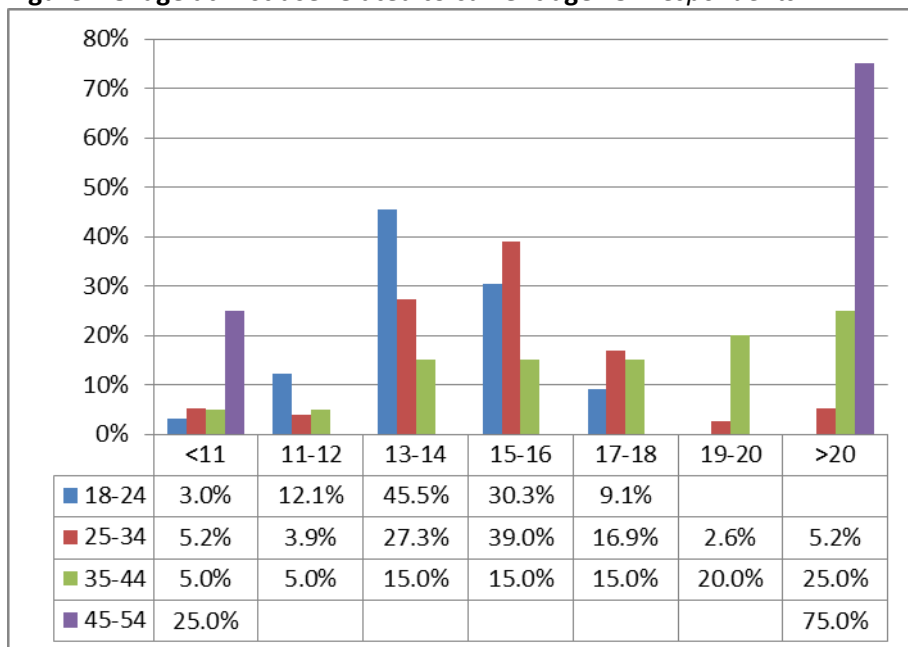
**Figure 1.6. age at first use among LTS patients and TC patients 143 respondents**



TC patients tend to start consuming drugs earlier than LTS users.

**Figure 1.7. age at first use related to gender 142 respondents**

Females interviewed mostly started using drugs at around 15-16 years old (42.9%) while most males started earlier (13-14 years old). It is interesting to note that males are prevalent over females among those who start using later and those who start using earlier, which is the opposite of findings for Italy.

**Figure 1.8. age at first use related to current age 134 respondents**

Around 45% in the age group 18 – 24 started at the age of 13 – 14 years old, a bit more than 30% in the period 15-16 years old and around 12% started at the age of 11-12. Nobody aged 18-24 started to use drugs after they were 19 years old. Those aged 25-34 mostly started consuming in the period between 13 -16 years old while percentages of 35-44 years old patients are spread among the 5 age classes from 13 to over 20 (about 20%).

The population aged 45-54 is prevalent over other age groups among the later users and among earlier users; 75% of them started using drugs after the age of 20 while the remaining 25% started consuming before they were 11 years of age.

**Figure 1.9. - latency period of the changeover from soft to hard drugs (cocaine, heroin, LSD, ecstasy ...) 131 respondents**

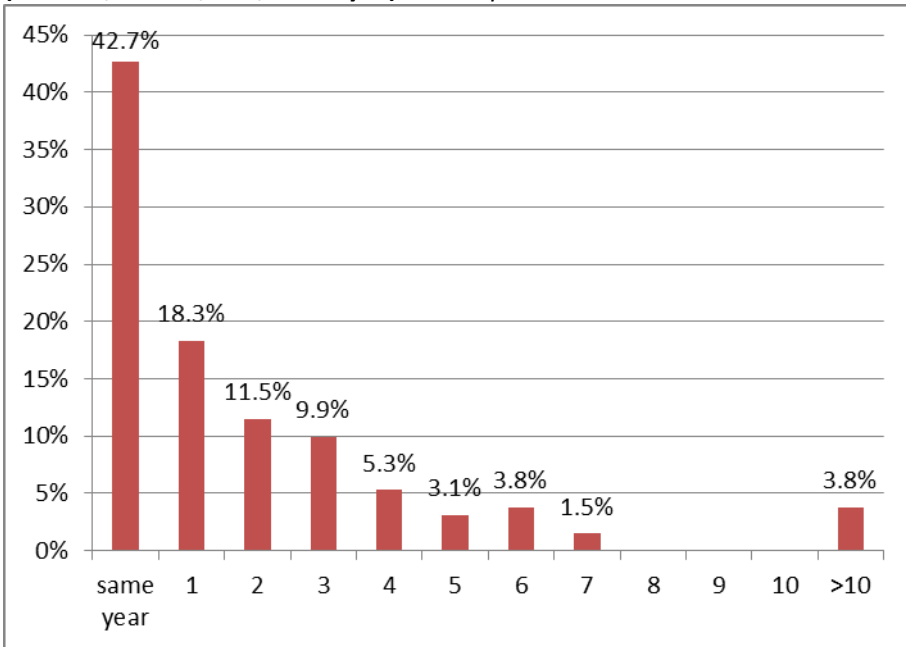


Figure 1.9 shows the period elapsed between the first use of soft drugs and the first use of hard drugs. Most patients have tried hard drugs in the same year of first use: the modal value corresponds to “same year” with 42.7% of respondents. About other 40% of patients changed over to hard drugs from 1 to 3 years after their first use of soft drugs.

The latency of the switchover to hard drugs is influenced by the age at which users have experimented with drugs.

Most patients who tried drugs in advanced age (19-25) changed to hard drugs in the same year that they first tried drugs (Table 1.3.). For 63% of users who tried drugs after 20 years old and the 67.4% who tried drugs when they were 19-20 years old, changeover to hard drugs happened during the same year of first consumption.

Again from Table 1.3. those who first take drugs at about 11-14 years old, pass to hard drugs after 1 to 4 years.

As the age in which users experimented with drug increase, latency rates decrease. The only one nonconforming case is those starting with drugs around 17-18 years old. In fact we see a considerable percentage of these users change over to hard drugs between 5 and 8 years after first use.

Notably, in Table 1.3., the small number of users starting drug use before 10 years old amounts to 1.7% of the whole sample so the analysis of these respondents has no relevant weight.

**Table 1.3. age at initiation of drug use related to latency period of the changeover to hard drugs (joint distribution) 131 respondents.**

		Age of the first drug consumption							Total
		<11	11-12	13-14	15-16	17-18	19-20	>20	
Latency	same year		1.5%	8.4%	18.3%	6.1%	3.1%	5.3%	42.7%
	after 1 year			10.7%	4.6%	1.5%	.8%	.8%	18.3%
	after 2 years		1.5%	3.8%	3.8%	1.5%	.8%		11.5%
	after 3 years	3.1%	.8%	2.3%	2.3%	.8%		.8%	9.9%
	after 4 years	.8%	.8%	3.1%	.8%				5.3%
	after 5 years			.8%		2.3%			3.1%
	after 6 years	.8%	.8%	.8%	.8%	.8%			3.8%
	after 7 years			.8%				.8%	1.5%
	over 8 years			.8%	.8%	1.5%		.8%	3.8%
Total		4.6%	5.3%	31.3%	31.3%	14.5%	4.6%	8.4%	100.0%

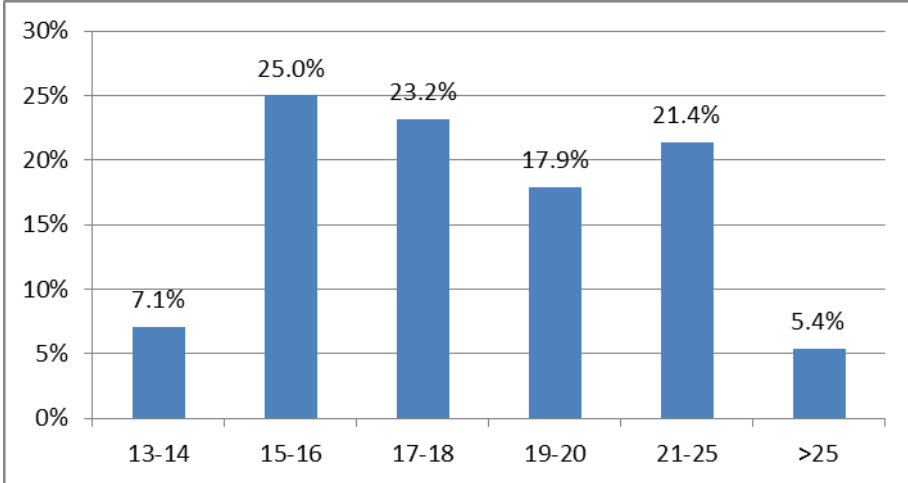
#### 1.4. Age of First Drug Sale

The age of the first illegal drug sale is another important characteristic (Figure 1.10). The modal value is the age 15-16 (25%) followed by the age 17-18 (23.2%).

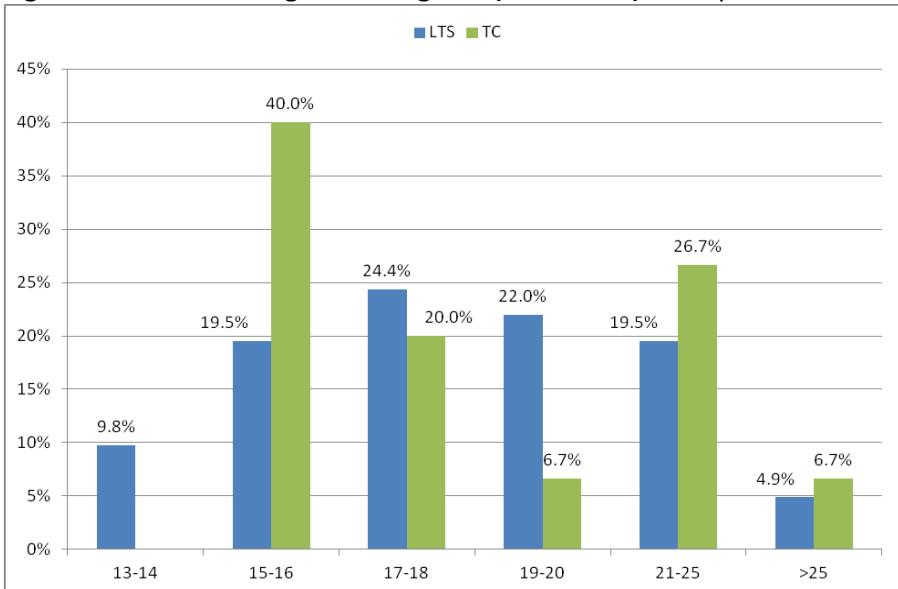
A considerable number of respondents (44.7%) started selling drugs after 19 years old and 7.1% before 14 years of age. Most users sell drugs for the first time during their secondary school years but the high number of those

who sell drugs for the first time after school age must be taken into consideration.

**Figure 1.10. initiation age into drug selling 56 respondents**



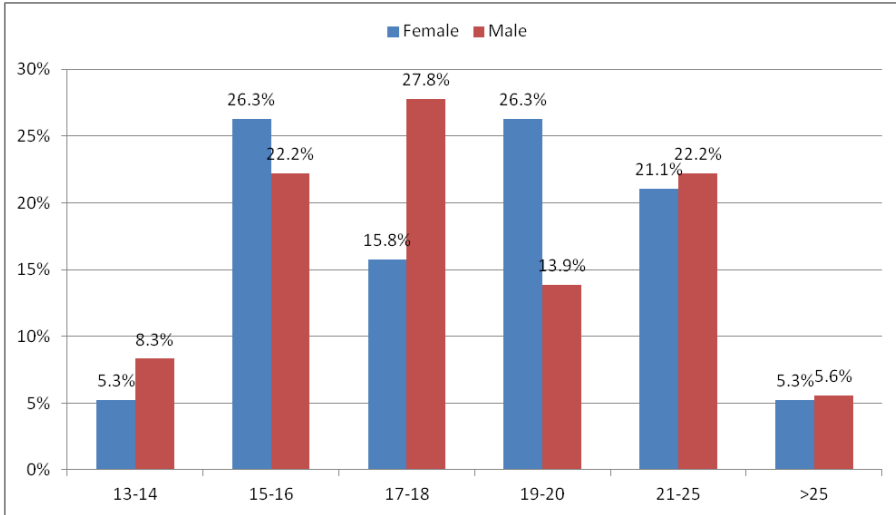
**Figure 1.11. initiation age into drug sale (LTS and TC) 56 respondents**



Patients of TC started selling drugs at a younger age than patients of low threshold services. The higher rates of TC users are in the age group younger than 18 years old (40% 15-16 and 20% 17-18).

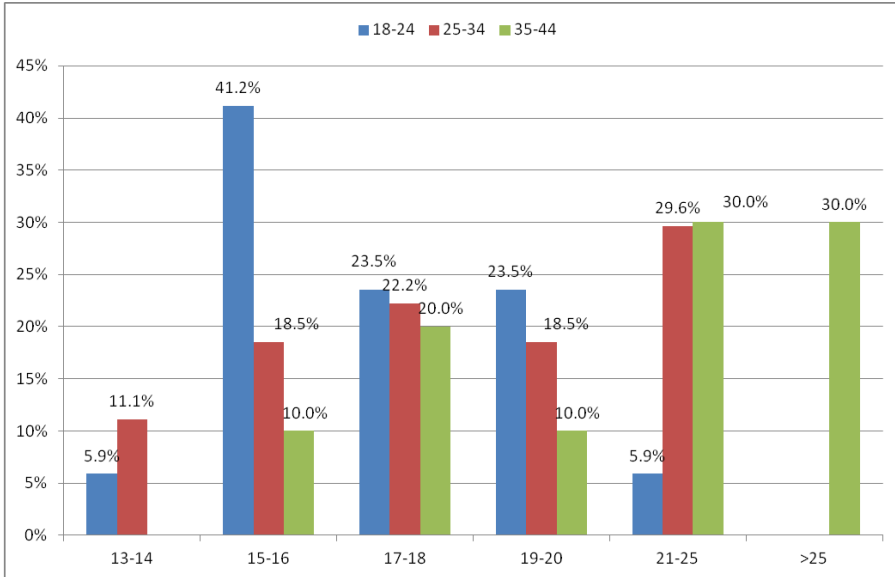
Regarding gender the modal values are in the class of 15 – 16 and 19-20 for males (26.3%) and in the class of 17-18 for females.

**Figure 1.12. initiation age into drug selling by gender 55 respondents**





**Figure 1.13. initiation age into drug dealing related to current age 54 respondents**



Young patients (18-24) started selling drugs at a younger age (the majority started at the age of 15/16 years old).

In contrast, respondents aged 35-44 years old patients started dealing mostly after they were 21 years old. Percentages of 25-34 years old patients are spread among the 4 age classes from 15 to over 25 with a peak of users in the age groups 21-25 (29.6%).

**Table 1.4. initiation age into drug selling related to latency period of the changeover to hard drugs (joint distribution) 54 respondents.**

		Age of first drug sale						Total
		13-14	15-16	17-18	19-20	21-25	>25	
Latency	same year	1.9%	7.4%	9.3%	7.4%	9.3%		35.2%
	after 1 year	1.9%	9.3%	3.7%	3.7%	5.6%		24.1%
	after 2 years		5.6%	1.9%		1.9%		9.3%
	after 3 years		3.7%	5.6%	1.9%	1.9%		13.0%
	after 4 years				1.9%			1.9%
	after 5 years	3.7%					1.9%	5.6%
	after 6 years			3.7%		1.9%		5.6%
	over 7 years					1.9%	3.7%	5.6%
Total		7.4%	25.9%	24.1%	14.8%	22.2%	5.6%	100.0%

### 1.5. Motivations for First Drug Use

Respondents to this survey have been asked to choose 3 among 13 proposed motivations for the first drug experimented with for the first time (Figure 1.14 and 1.15) considering only pervitin and cannabis.

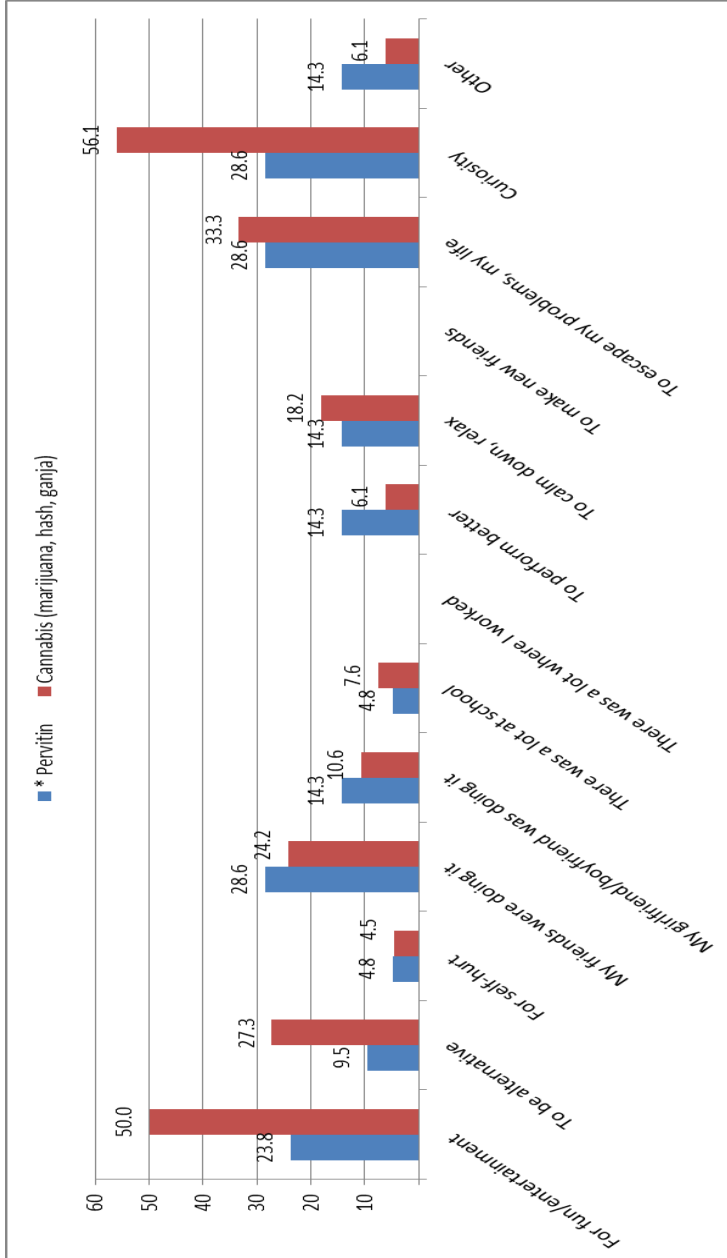
Everybody has cited “positive” or recreational motivations: fun, curiosity and so on.

Consumers who started with pervitin have reported different motivations: LTS patients considered curiosity, emulation of friends and the intent to escape life's problems as main motivations (28.6%, 28.6% and 28.6%); TC patients considered curiosity as a main motivation for their first drug consumption (66.7%). Fun, self-hurt, emulation of friends and the intent to escape life's problems make up equally the second main motivations (33.3% for each of these motivations).

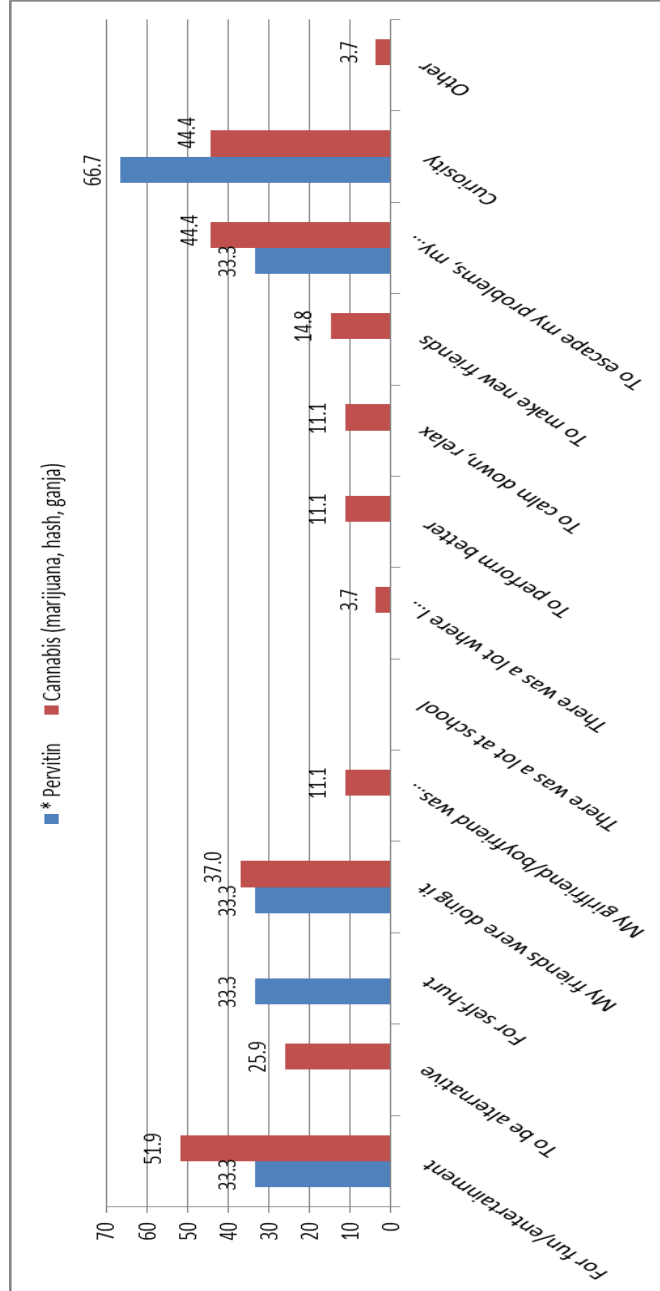
The distribution of cannabis users is similar for LTS and TC users. Most patients from across both services reported having tried cannabis for the first time because of entertainment purpose (55% in LTS and 51.9% in TC), out of curiosity (56.1% in LTS and 44.4% in TC) and to escape life's problems (33.3% in LTS and 44.4% in TC).

The desire to be alternative as a reason for cannabis first use was reported by 25.9% of TC and 27.3% of LTS users. It is also very noteworthy the intent of make new friends; 14.8% of TC users admitted this was a crucial influence but nobody in LTS considered this choice.

Figure 1.14. motivations for starting drug use related to drug experimented with by LTS patients 87 respondents



**Figure 1.15. motivations orf starting drug use related to the kind of drug experimented with by TC patients 30 respondents**



# CHAPTER 2

## Lifestyle:

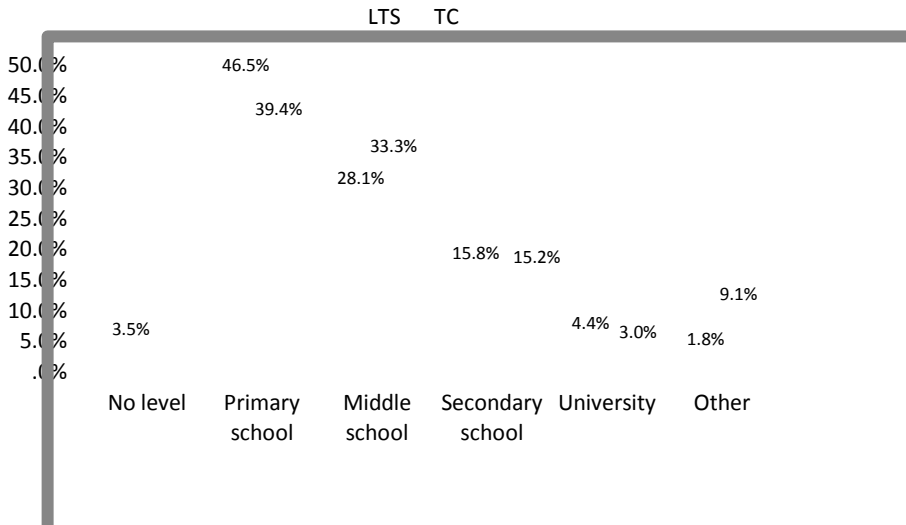
### Education, Work and Contacts with Prison

#### 2.1. Education level of users

**Table 2.1. educational level 147 respondents**

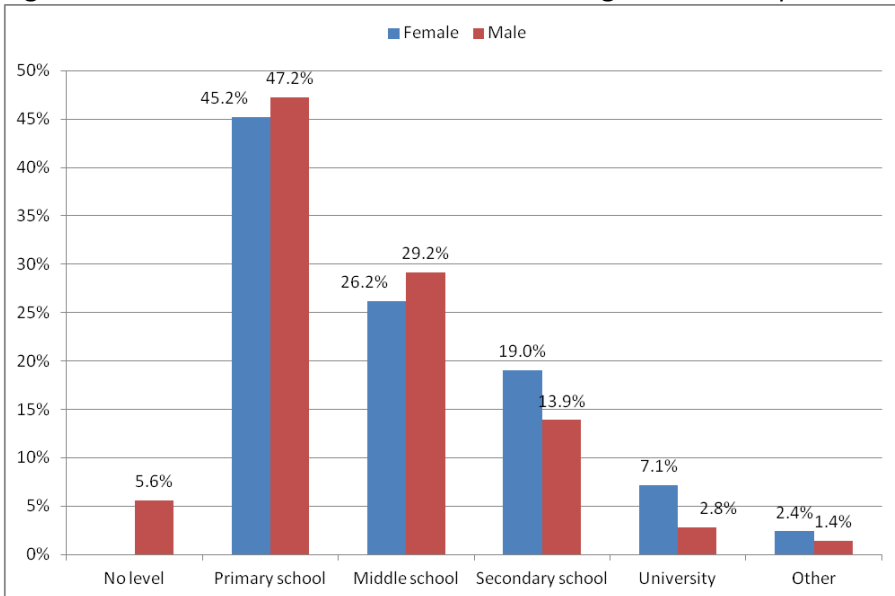
Education level						Total
No level	Primary school	Middle school	Secondary school	University	Other (technical school...)	
2.7%	44.9%	29.3%	15.6%	4.1%	3.4%	100.0%

**Figure 2.1. education level (LTS and TC) 147 respondents**

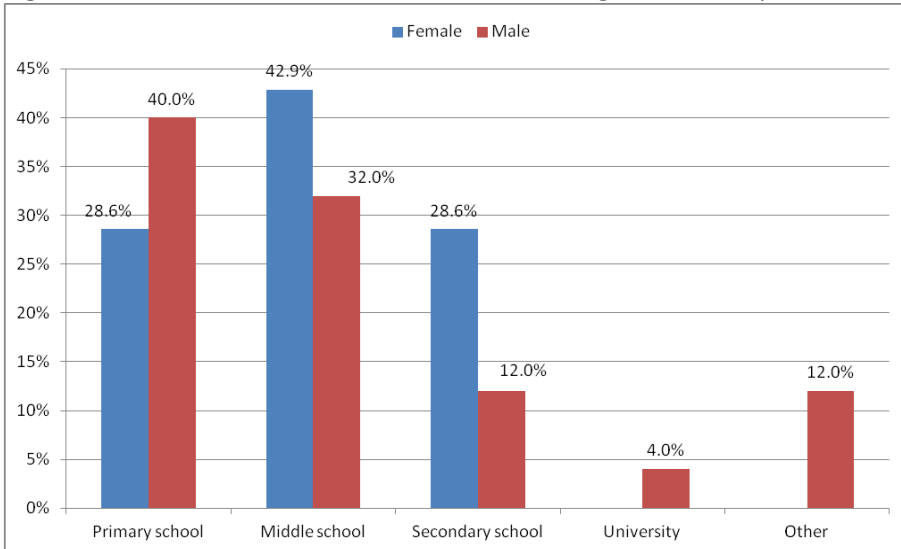


Higher proportions of primary school graduates were reported from low threshold services (46.5% vs 39.4% of TC patients), while higher rates of secondary school certificates were reported by therapeutic community patients (33.3% vs 28.1% of LTS patients). CT users are highest represented also among those who obtained other school diplomas (9.1%) while LTS reported considerable rates of those without any education level (3.5%).

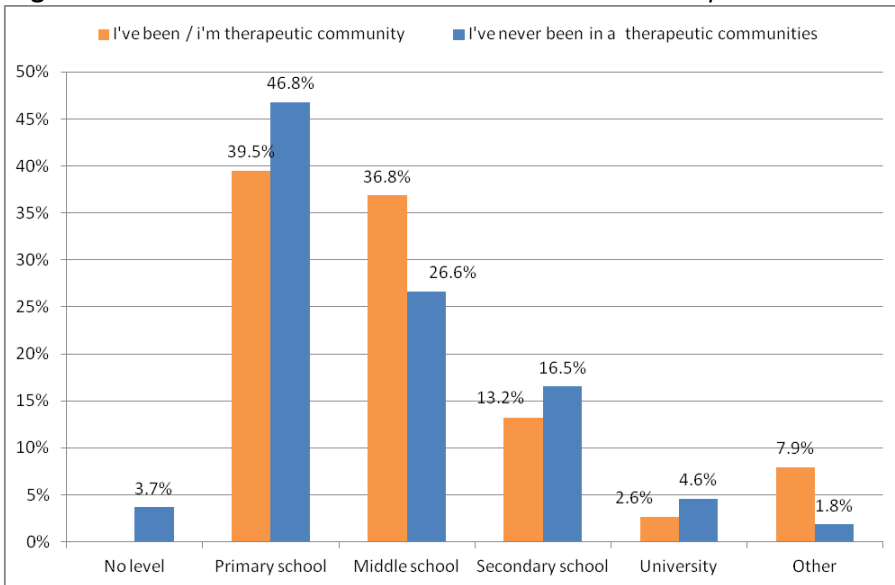
**Figure 2.2. education level of LTS users related to gender 144 respondents**



Among LTS patients, 47.2% of men vs 45.2% of women had only a primary school diploma. A middle school diploma was reported mostly by men, at 29.2%, in comparison with 26.2% for women. A slightly smaller percentage of men attended university, 2.8% versus the female rate of 7.1%. It is interesting to note how among those who don't have any educational qualification women are not represented at all, whereas men are represented at 5.6%.

**Figure 2.3. education level of TC users related to gender 32 respondents**

As in LTS, women in therapeutic communities (Figure 2.3) are more educated than men. Most of them reported a middle school diploma (42.9%) followed by those with a secondary school level (28.6%); the same level were obtained only by 32% and 12% of men. University, on the other hand, was reported only by men (4%) as well as for “other technical schools” (12%).

**Figure 2.4. education level of TC and non-TC users 147 respondents**

Generally those who have never been in TC have higher qualifications than TC patients (Figure 2.4): 16.5% reached secondary school level and 4.6% obtained a university degree. Note also the high percentage for other qualifications like technical school degrees (7.9%).

The relation between the educational level of users and their criminal history is described in tables 2.2, 2.2bis and 2.3.

Higher percentages of people who have never arrested are found among those with secondary school diplomas and university degrees. Those with a low education level reported higher percentages of arrest.

Only 1.4 % of users arrested for both kinds of crime have a university degree. Looking at the column concerning those arrested for crimes not related to drugs (Table 2.2), the great majority are composed of people with primary and middle school level as their highest qualification. Those with a primary school level education only are the most important group also for the other two kinds of arrest.

In conclusion, those who have never been arrested, have higher educational qualifications than those who have been arrested; those who have been arrested for crimes not related to drugs have higher educational qualifications than those arrested for trafficking or both dealing and other crimes.



**Table 2.2. education level related to arrest history (joint distribution) 142 respondents**

		Arrested				Total
		Never	Yes. for dealing	Yes. for others crimes	Yes. both for dealing and others crimes	
Educational Level.	No level	-	0.7%	-	1.4%	2.1%
	Primary school	13.4%	3.5%	25.4%	1.4%	43.7%
	Middle school	9.2%	-	21.1%	-	30.3%
	Secondary school	10.6%	0.7%	4.9%	-	16.2%
	University	2.8%	-	1.4%	-	4.2%
	Other (e.g technical school...)	2.1%	-	1.4%	-	3.5%
Total		38.0%	4.9%	54.2%	2.8%	100.0%

**Table 2.2 Bis. Education level related to arrest history (conditional distributions) 142 respondents**

		Arrested				Total
		Never	Yes, for dealing	Yes, for others crimes	Yes, both for dealing and others crimes	
Educational Level.	No level	-	33.3%	-	66.7%	100.0%
	Primary school	30.6%	8.1%	58.1%	3.2%	100.0%
	Middle school	30.2%	-	69.8%	-	100.0%
	Secondary school	65.2%	4.3%	30.4%	-	100.0%
	University	66.7%	-	33.3%	-	100.0%
	Other (e.g technical school...)	60.0%	-	40.0%	-	100.0%
Total		38.0%	4.9%	54.2%	2.8%	100.0%

Almost the same trend seen here can be found in Table 2.3: the education level is a strong indicator of lifestyle in particular in relation to the probability of encountering arrest without consequences or incarceration.

**Table 2.3. distribution of patients that served or did not serve alternative sentences to prison according to their educational level (conditional distributions) 141 respondents**

		Alternative sentences to prison		Total
		yes	no	
What is your educational level?	No level	4.9%	-	2.1%
	Primary school	49.2%	38.8%	43.3%
	Middle school	37.7%	25.0%	30.5%
	Secondary school	4.9%	25.0%	16.3%
	University	1.6%	6.3%	4.3%
	Other (e.g technical school...)	1.6%	5.0%	3.5%
Total		100.0%	100.0%	100.0%

A last but no less important analysis, can be conducted on the subject of those who have obtained an alternative to prison (like house arrest, house arrest in a therapeutic community or spending time in social services for drug addicts).

As shown in table 2.3 those who entered facilities as a substitute to prison tend to be less qualified. 6.3% of those who have served a prison sentence have a university degree vs 1.6% of those who have served an alternative; the greatest differences can be found in the case of a secondary school diploma (4.9 % vs 25 %).

## 2.2. Education Level of Users' Parents

Here we are going to analyze the relation between the educational qualification of respondents' parents in relation to some variables regarding the drug users themselves.

**Figures 2.5.** parents' educational level 139 (Mother) 137 (Father) respondents

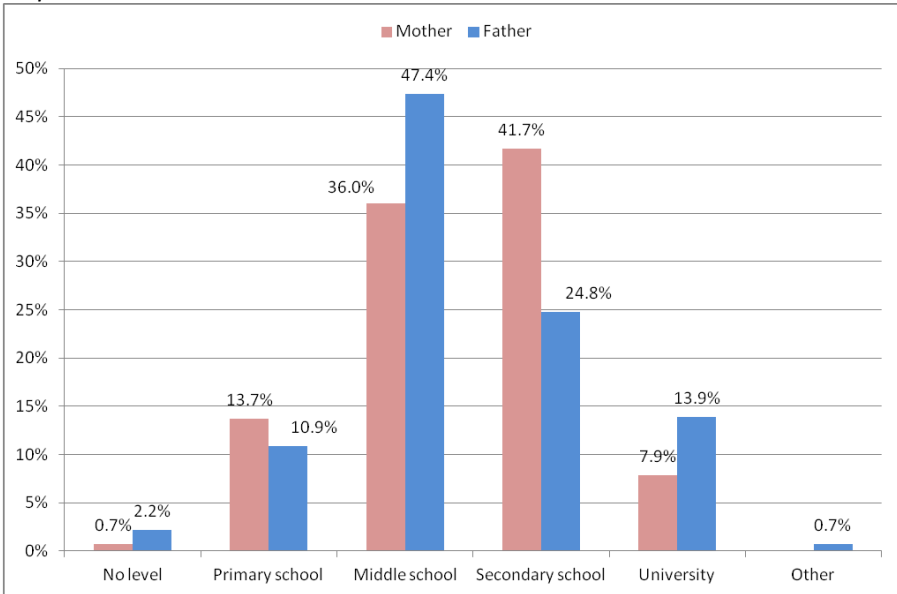


Figure 2.5 shows the distribution of the respondents' parents according to the education level reached

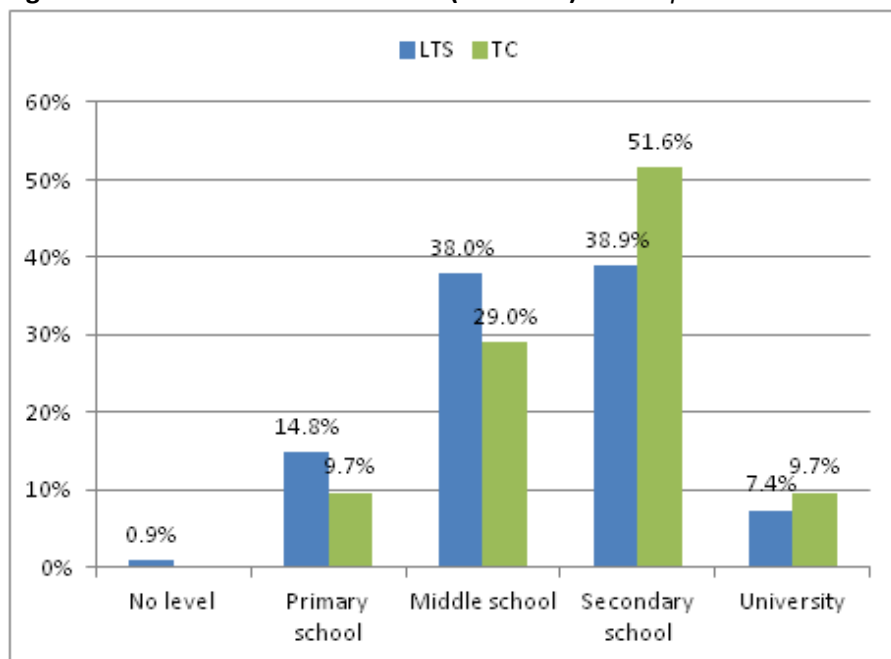
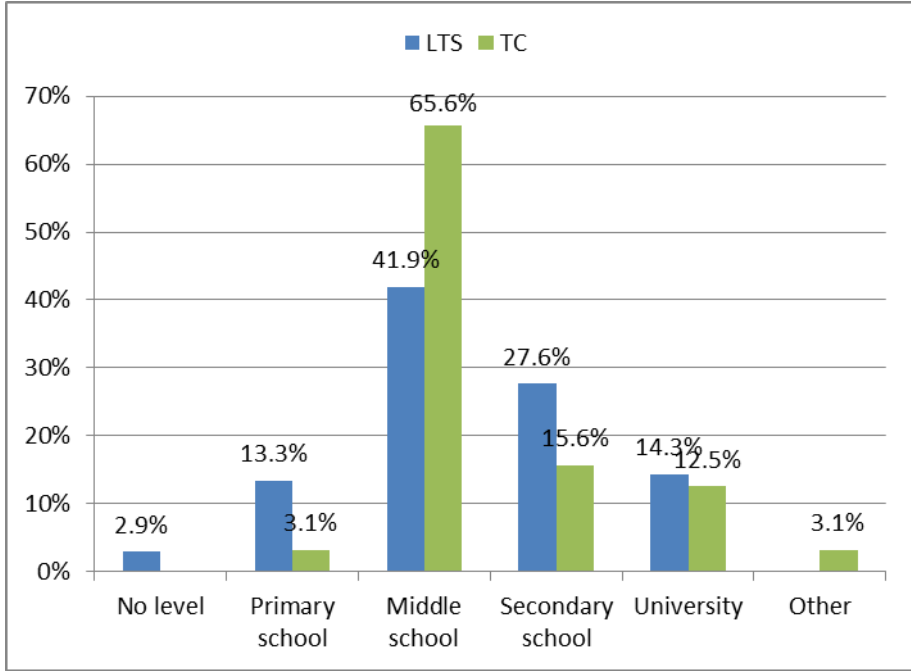
**Figure 2.6. mothers' education level (LTS or TC) 139 respondents**

Figure 2.6 is an individual examination of mothers' education level distribution, relative to whether their children are in LTS or TC.

**Figure 2.7. fathers' education level (LTS or TC) 137 respondents**

In conclusion, mothers of the patients of TC seem to be more qualified than mothers of those in LTS. The opposite happens for fathers.

**Table 2.4. education level of respondents related to education level of their mothers.**

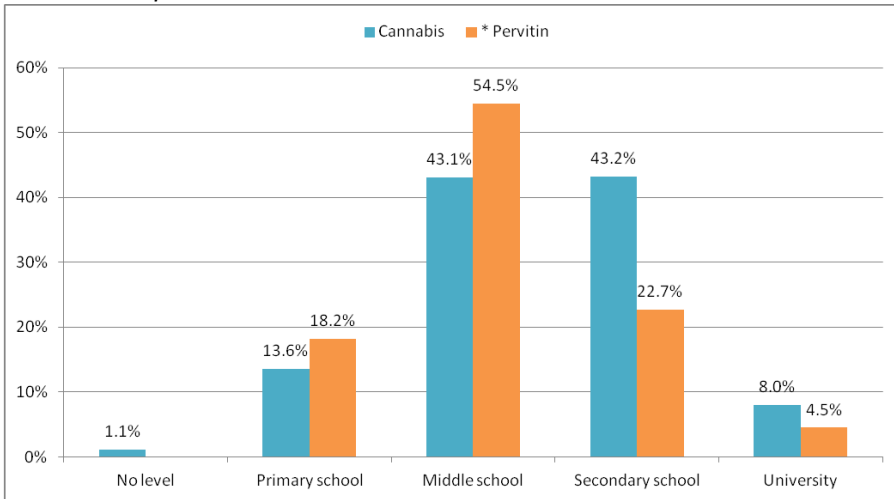
		Mother's educational level					Total
		No level	Primary school	Middle school	Secondary school	University	
Users educational level	No level	25.0%	50.0%	25.0%	-	-	100.0%
	Primary school	-	19.7%	45.9%	29.5%	4.9%	100.0%
	Middle school	-	7.3%	34.1%	48.8%	9.8%	100.0%
	Secondary school	-	4.3%	21.7%	65.2%	8.7%	100.0%
	University	-	-	-	66.7%	33.3%	100.0%
	Others (e.g technical school...)	-	25.0%	50.0%	25.0%	-	100.0%
Total		0.7%	13.7%	36.0%	41.7%	7.9%	100.0%

**Table 2.5. education level of respondents related to education level of their fathers (conditional distributions)**

		Father's educational level						Total
		No level	Primary school	Middle school	Secondary school	University	Others (e.g. technical school...)	
Users educational level	No level	66.7%	33.3%					100.0%
	Primary school	18.4%	52.6%	23.7%	2.6%		2.6%	100.0%
	Middle school	6.3%	39.4%	33.4%	14.9%	4.2%	1.8%	100.0%
	Secondary school	2.2%	24.1%	25.0%	31.6%	14.9%	2.2%	100.0%
	University		18.2%	27.3%	22.7%	31.8%		100.0%
	Others (e.g. technical school...)	5.8%	30.8%	19.2%	25.0%	11.5%	7.7%	100.0%
Total		5.6%	33.6%	28.6%	20.8%	9.0%	2.4%	100.0%



**Figure 2.8. first drug experimented with related to mother educational level 110 respondents**



**Figure 2.9. first drug experimented with related to fathers' educational level 110 respondents**

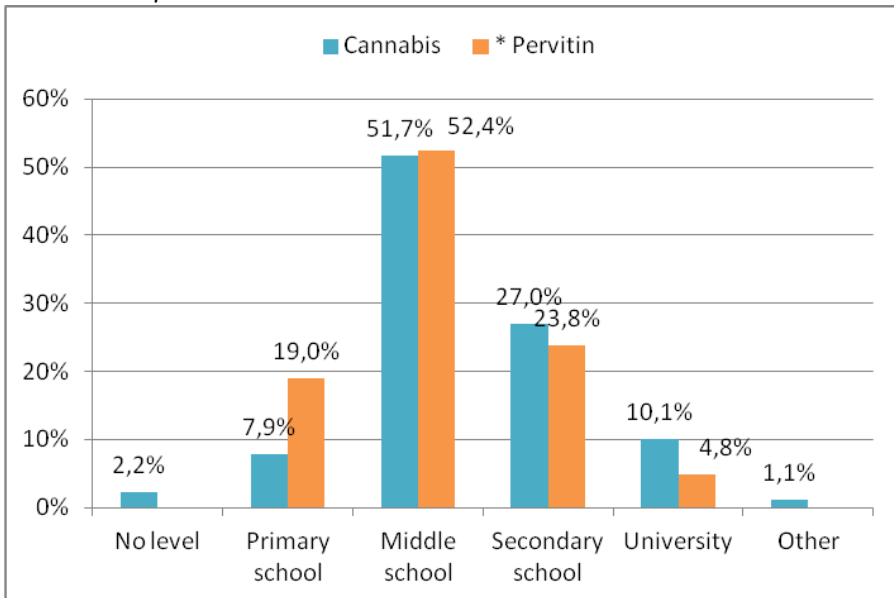


Figure 2.8 underlines the relation between first drug used and the education level of mothers.

We can see how the mother of a first time pervitin user will on average have a lower education level compared to the mothers of those who started by consuming cannabis. 8% of them have a university degree and 43.2% have a secondary school diploma. Almost the same happens with fathers.

Fathers of pervitin users are distinguished having lower educational levels than fathers of cannabis first-timers. They are for the most part in the educational group “middle school” ( 52.4%), then score significant percentages among those with a primary education (19%). Fathers of cannabis users scored higher percentages among secondary school and university graduates.

Generally parents of those who used cannabis as a gateway drug are more qualified than parents of those who started with pervitin.

### 2.3. Employment status

For the purpose of this survey it’s important to analyze the working conditions of respondents. It is an important factor in understanding lifestyles of users and especially their purchasing power.

**Table 2.6 last employment situation (LTS and TC) 143 respondents**

	Last work situation							Total
	Student	Long term contract	Short term contract	Self-employed or professional work	Occasional worker	Never employed	Student worker	
LTS	2.7%	9.9%	5.4%	4.5%	58.6%	16.2%	2.5%	100.0%
TC	-	18.8%	-	21.9%	50.0%	9.4%	-	100.0%
Total	2.1%	11.9%	4.2%	8.4%	56.6%	14.7%	2.1%	100.0%

The specific work categories (Table 2.6) with the largest number of respondents among LTS and TC users were occasional job (56.6%) and never employed (14.7%, but with a great difference between LTS and TC), followed by long term job (11.9%) and self employed or professional work (8.4%). 2.1% of users reported that they were students (2.7% of the LTS

patients). Among them 2.5% of LTS patients reported that they were student workers.

TC patients seem to have a better working situation than LTS users .

**Figure 2.10. last employment situation of LTS users by gender 111 respondents**

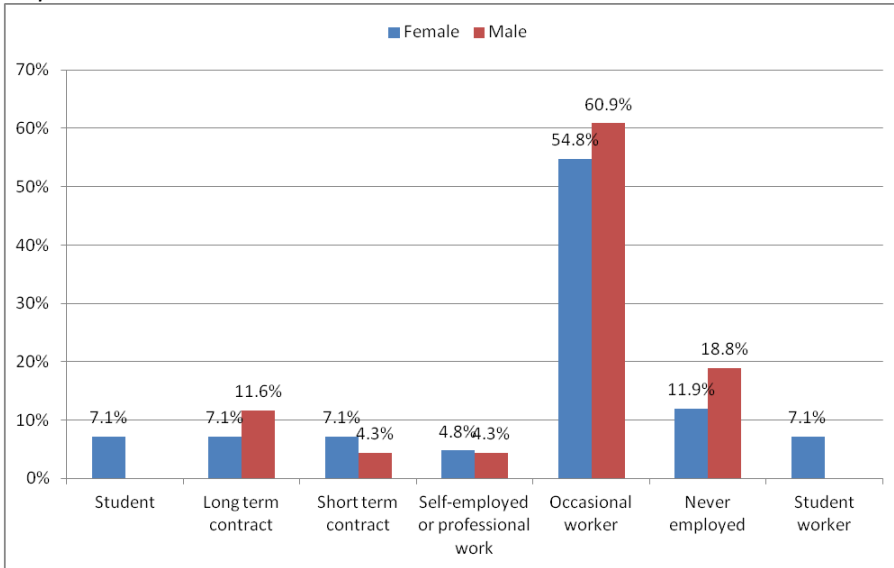


Figure 2.10 shows the distribution of the last employment situation for LTS users. Higher rates of occasional workers were reported from both the gender groups (60.9% male and 54.8% female). They represent more than half of the whole population. Considerable differences between men and women are found in the work categories "never employed", where men are more highly represented (18.8% vs 11.9% of women), "long term contract" (11.6% of men and 7.1% of women) and "student", where men are not represented at all. Thus we have more men attending stable jobs than women, yet also more men who have never worked.

**Figure 2.11. last employment situation of TC users by gender.<sup>31</sup>**  
*respondents*

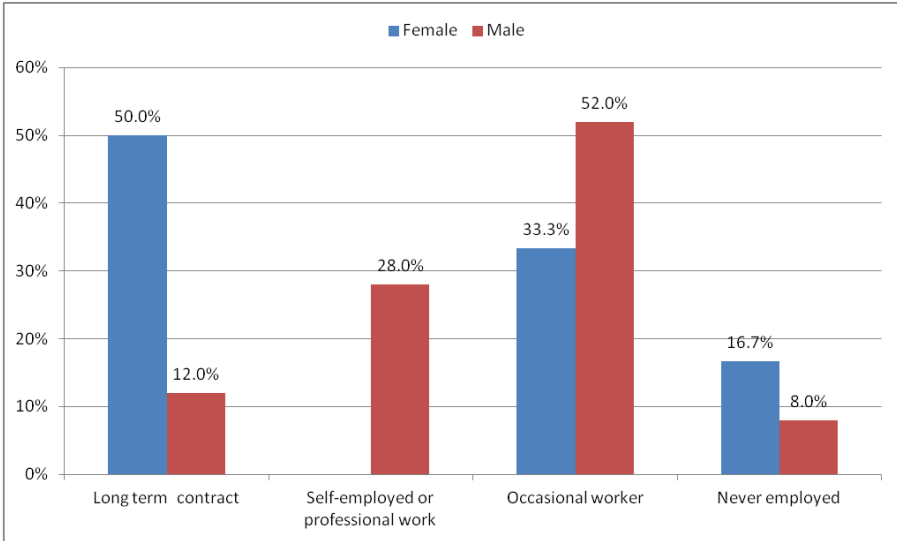


Figure 2.11 shows a situation completely different for TC. Here we have considerably more women working in stable jobs (50%) than men (12%) who are mostly occasional workers or self-employed. Of those who have never been employed women are the majority.

**Table 2.7. last employment situation of TC and non-TC users 143 respondents**

		Therapeutic community		Total
		I've been / I'm in a therapeutic community	I've never been in a therapeutic community	
Work	Student	-	2.8%	2.1%
	Long term contract	16.2%	10.4%	11.9%
	Short term contract	-	5.7%	4.2%
	Self-employed or professional work	18.9%	4.7%	8.4%
	Occasional worker	54.1%	57.5%	56.6%
	Never employed	10.8%	16.0%	14.7%
	Student worker	-	2.8%	2.1%
Total		100.0%	100.0%	100.0%

Table 2.7 shows the different employment situation of respondents in relation to their contact with therapeutic communities.

Users who have been in therapeutic communities report higher percentages of long-term employment. Conversely lower rates of occasional workers and never employed were reported from these respondents.

**Table 2.8. last employment situation of users related to their contact with prison (column conditional distributons) 138 respondents**

		Prison				Total
		Never	For dealing	For other crimes	Both for dealing and other crimes	
work	Student	3.4%	-	-	-	2.2%
	Long term contract	16.9%	16.7%	2.4%	-	12.3%
	Short term contract	6.7%	-	-	-	4.3%
	Self-employed or professional work	6.7%	-	14.3%	-	8.7%
	Occasional worker	49.4%	50.0%	73.8%	-	56.5%
	Never employed	13.5%	33.3%	9.5%	100.0%	13.8%
	Student worker	3.4%	-	-	-	2.2%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

**Table 2.8 bis. last employment situation of users related to their contact with prison (rpw conditional distributions) 138 respondents**

		Prison				Total
		Never	For dealing	For other crimes	Both for dealing and other crimes	
work	Student	100.0%	-	-	-	100.0%
	Long term contract	88.2%	5.9%	5.9%	-	100.0%
	Short term contract	100.0%	-	-	-	100.0%
	Self-employed or professional work	50.0%	-	50.0%	-	100.0%
	Occasional worker	56.4%	3.8%	39.7%	-	100.0%
	Never employed	63.2%	10.5%	21.1%	5.3%	100.0%
	Student worker	100.0%	-	-	-	100.0%
Total		64.5%	4.3%	30.4%	0.7%	100.0%

Those who had never been imprisoned, had the highest percentage for “long term contract” (16.9%). Also those who have been incarcerated for drug crimes have a high percentage of employment with a long-term contract (16.7%) but most of them are in the group “occasional workers” (50%).

Users who have been in prison for others crimes present important rates in the category of occasional workers (73.8%) while users who have been imprisoned for both types of crime have never been employed.

Data shows that those who have been incarcerated for drug crimes present lower rates of “never employed” (9.5%) compared to others. Among students and student workers nobody reported incarceration.

**Table 2.9. last employment situation related to the use of alternatives to prison 137 respondents**

		Alternative sentences to prison		Total
		No	yes	
work	Student	1.3%	3.4%	2.2%
	Long term contract	17.9%	5.1%	12.4%
	Short term contract	7.7%	-	4.4%
	Self-employed or professional work	10.3%	6.8%	8.8%
	Occasional worker	44.9%	71.2%	56.2%
	Never employed	14.1%	13.6%	13.9%
	Student worker	3.8%	-	2.2%
Total		100.0%	100.0%	100.0%

Table 2.9 reports the frequency of patients who received alternative sentences listing them according to their last working condition. Those who entered into facilities as an alternative to prison have higher rates of occasional workers (71.2%) while those who have never received an alternative sentence tend to have more stable job (17.9% of long term workers and 10.3% of self-employed).

#### **2.4. Contact with Prison**

This sample contains people who had been convicted. 35.2% have been incarcerated (Table 2.10) and the majority had been convicted for crimes not related to drugs (86 % in Figure 2.11).



Table 2.10. typology of crime committed 142 respondents

Prison				
No	For dealing	For other crimes	Both for dealing and other crimes	Total
64.8%	4.2%	30.3%	0.7%	100%

Figure 2.11. typology of crime committed

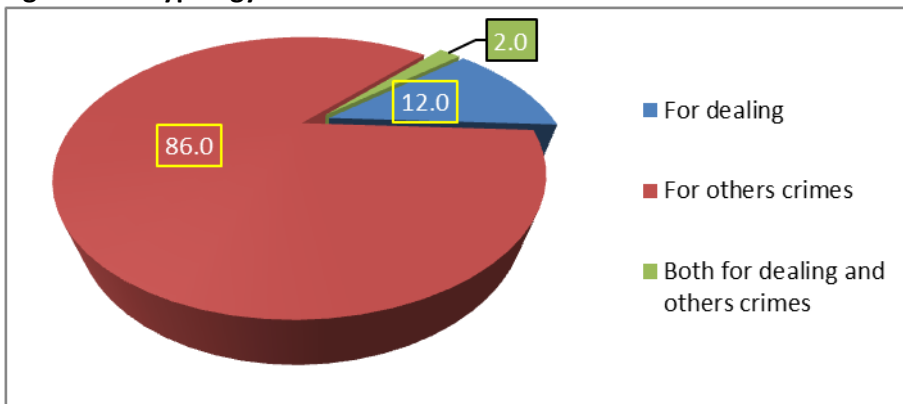


Figure 2.12. typology of crime committed (LTS or TC)

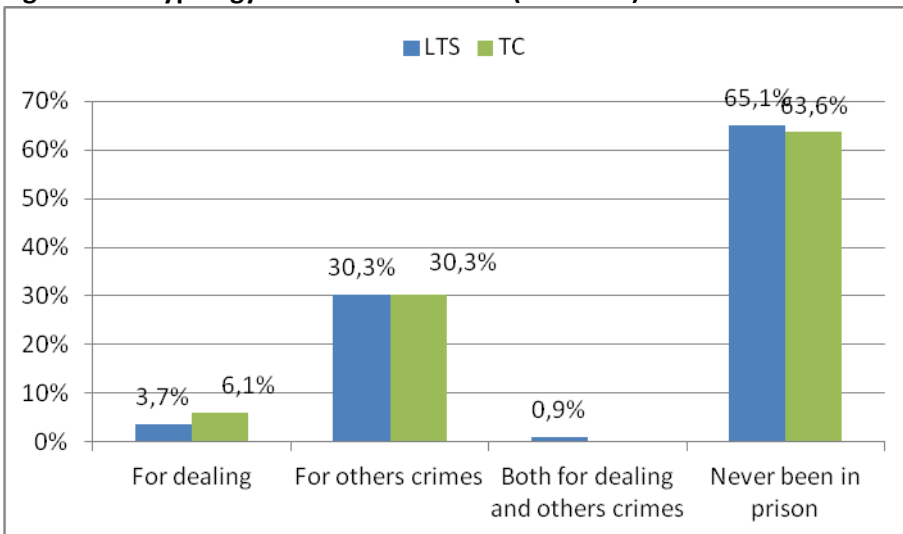
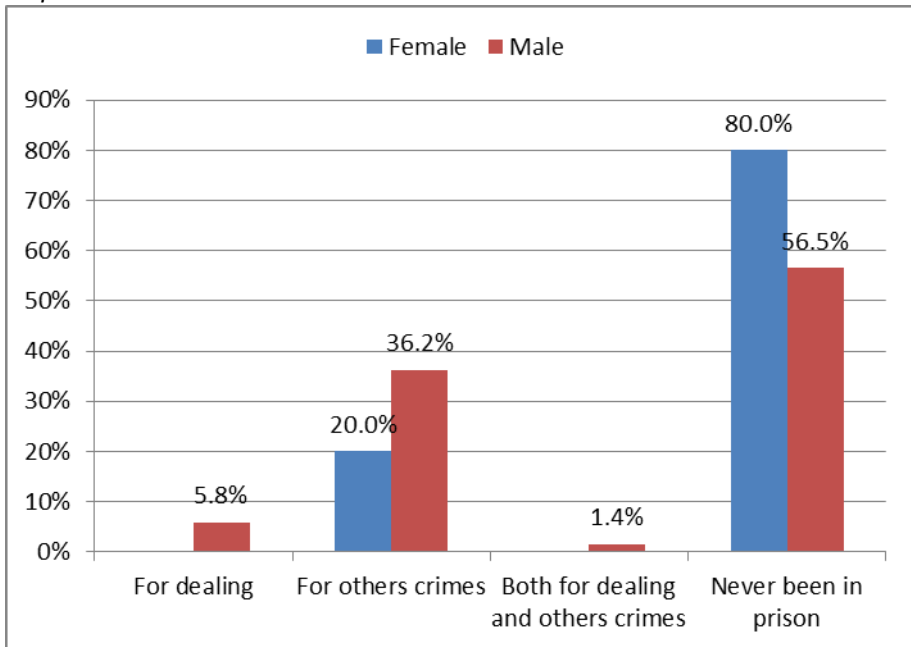


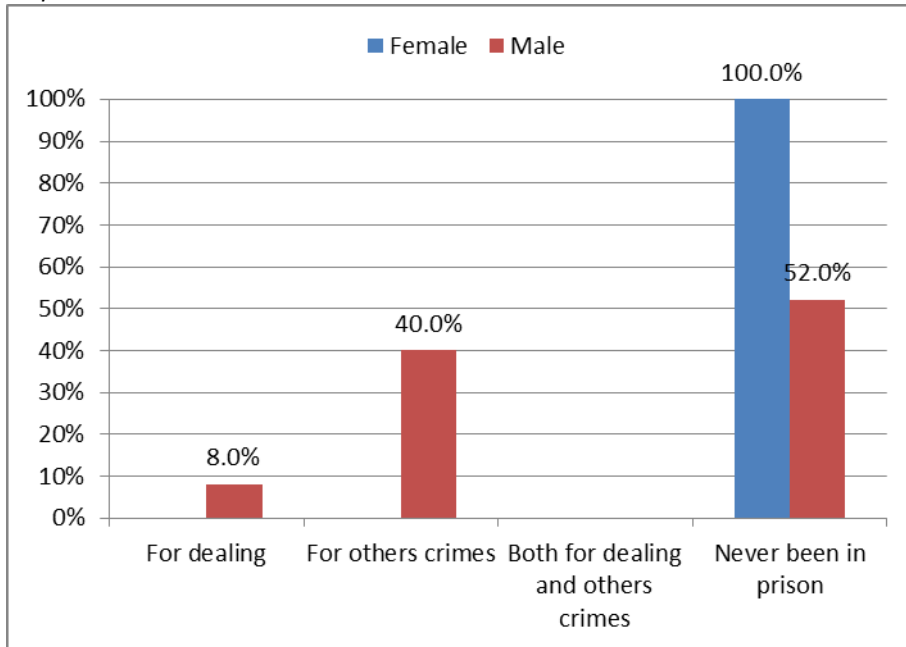
Figure 2.12 displays the prevalence rates for each specific typology of crime that was committed by LTS and TC respondents.

LTS and TC respondents report almost the same proportion of those who have “never been in prison” as those who have been imprisoned. Among imprisoned people TC respondents report a higher proportion “for drug crimes”, which reduces the frequency of “both for dealing and other crimes”, but the distributions of LTS and TC remain similar.

**Figure 2.13. typology of crime committed by gender (LTS) 109 respondents**



**Figure 2.14. typology of crime committed by gender (TC) 32 respondents**



When distinguishing by gender in each crime category we see that over the 80% women in LTS (Figure 2.13) have never been in prison, and just 56.5% men. The entire population of women who have been arrested have undergone arrest for crimes not related to drugs (20%).

Even among users in TC (Figure 2.14) the difference between men and women is quite significant. No women have been arrested, but 52% of men have undergone arrest.

Crimes not related to drugs are the most usual offense (40%) followed by dealing (8%). Nobody in TC was incarcerated for both crimes.

In conclusion, females are less frequently incarcerated than males.

**Table 2.11. typology of crime committed by age 136 respondents**

		Age						Total
		<18	18-24	25-34	35-44	45-54	>54	
Prison	For dealing	-	3.1%	3.9%	9.5%	-	-	4.4%
	For other crimes	-	18.8%	32.5%	42.9%	50.0%	100.0%	31.6%
	Both for dealing and other crimes	-	-	-	4.8%	-	-	.7%
	No	100.0%	78.1%	63.6%	42.9%	50.0%	-	63.2%
Total		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Looking at Table 2.11 a first analysis of the trend in each single row leads to the conclusion that the first crime category – in the case of prison - is “other crimes”; “dealing” is more important for the age group 35-44 the probability of having committed a crime increases year by year, but in this case the age group “45-54” reported less crime than other groups, maybe because of the low number in our sample.

## 2.5. Alternative Sentencing

After having analyzed the interviewed relations with prison it is interesting to proceed elaborating the characteristics of users who received an alternative sentence.

**Figure 2.15. patients who obtained alternative sentence or did, not related to the typology of alternative 141 respondents**

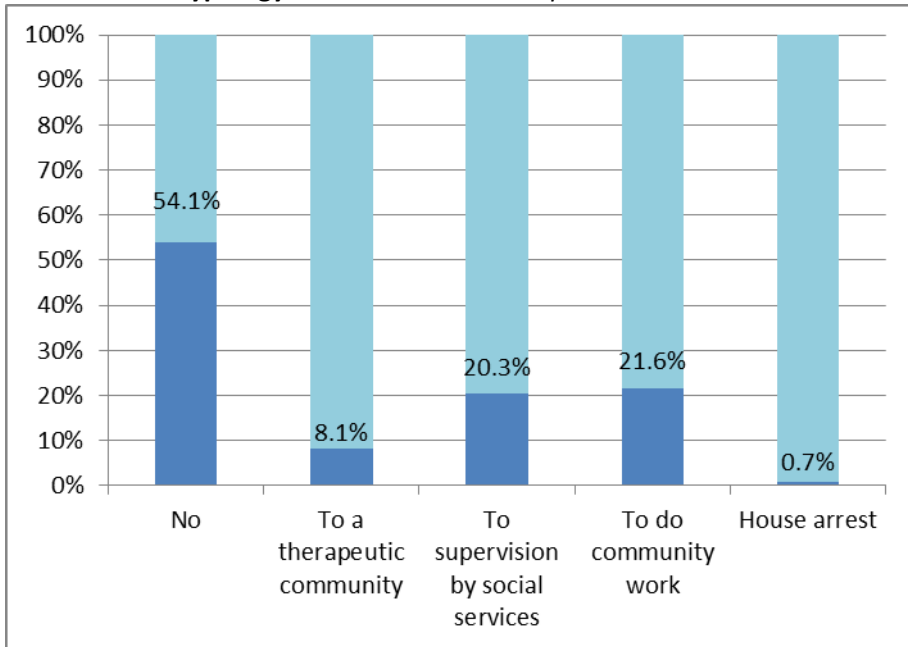
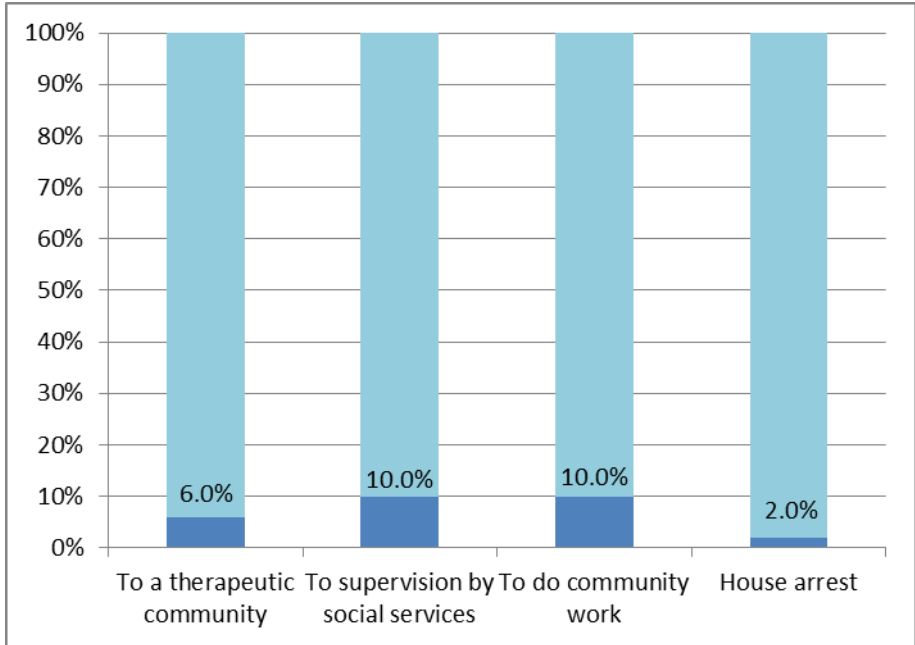


Figure 2.15 shows that more than half of the respondents (54.1%) couldn't obtain any sort of alternative to prison. The most popular alternative, received by 21.6% of those who could skip prison, consists of community work. Next we have supervision by social services with a rate of 20.3% respondents. Therapeutic community was reported by 8.1%. Those obtained house arrest are very few, just 0.7% of the total respondents who obtained an alternative.

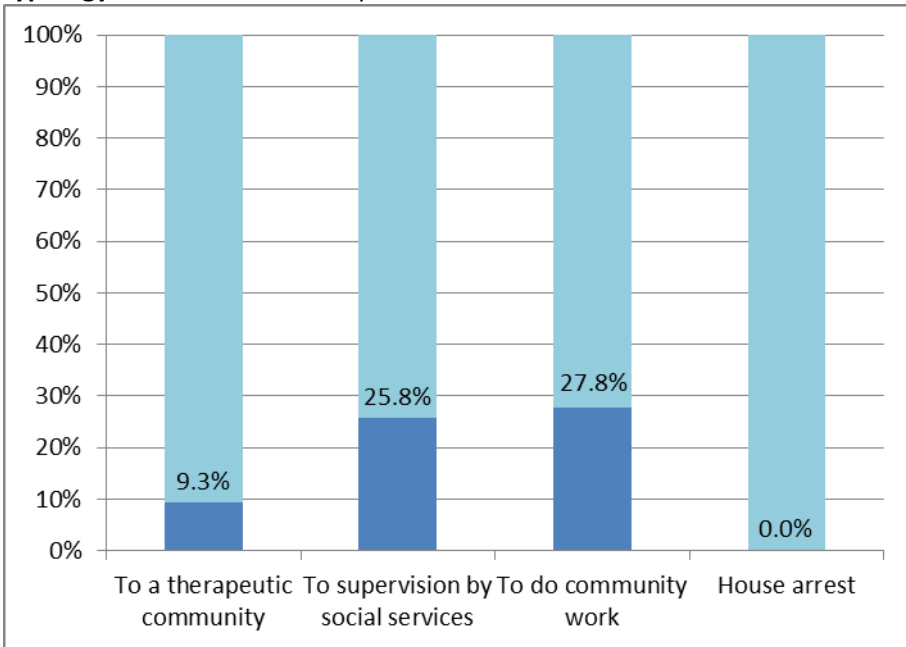
Around 9.2 % of respondents report to have received an alternative sentence more than once.

**Figure 2.16. female patients who obtained an alternative sentence related to the typology of alternative 50 respondents**



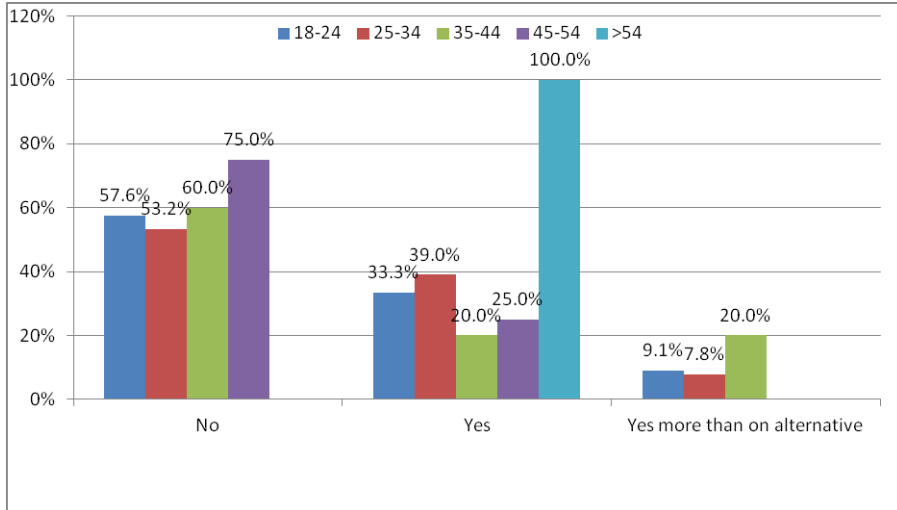
Figures 2.16 and 2.17 take into consideration only the users who benefited from alternative sentences distinguishing them by gender. In general men report a higher percentage among all the types of alternative classes than women with the exception of house arrest, which is never reported by men.

**Figure 2.17. male patients who got alternative sentence related to the typology of alternative 97 respondents**



The most frequent alternative choice for men and for women are community work (27.8% and 10%) and supervision by social services (25.8% and 10%). Following that, we have therapeutic community both for women and men. No men and just 2% of women reported to have received house arrest as a sentence.

**Figure 2.18. patients who got alternative sentences related to the number of reported alternatives. Distinguished by age. 136 respondents**



The data from figure 2.18 allow us to document how many alternative sentences users received in relation to their age.

This analysis must take in consideration the logical possibility that younger patients might have faced justice in fewer cases than older users.

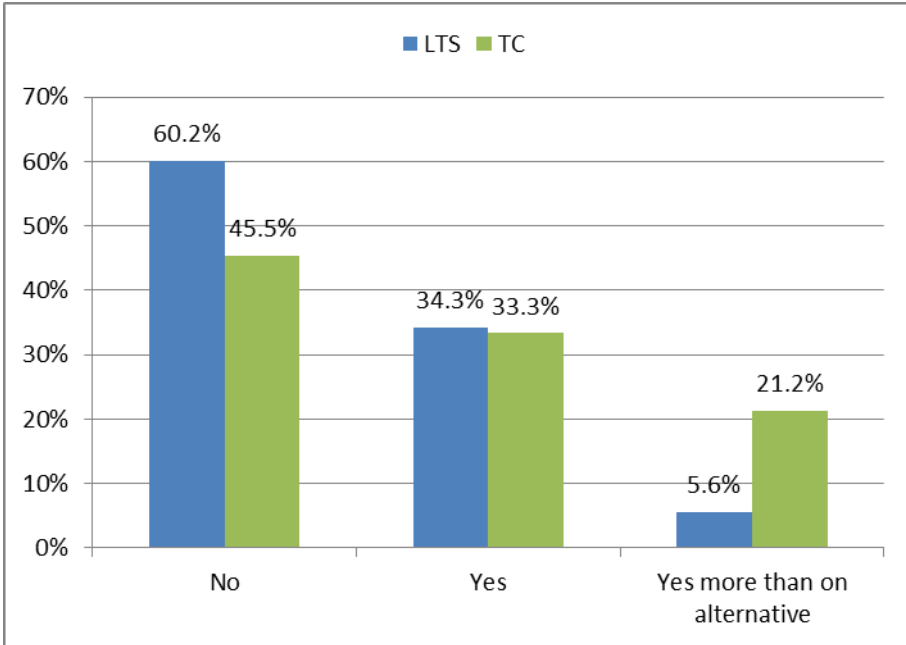
Looking at the 3 possibilities (“yes”, “yes, more than once” and “no”) we can see how those who benefited from more than one alternative are mostly aged 35-44. Nobody over 45 years old benefited from more than one alternative. Younger users aged 18-24 and 25-34 are the highest among those who benefited from just only one alternative and they are also well represented among those who benefited from alternatives more than once.

It is easy to infer from Figure 2.19, which shows the distribution of LTS and TC patients according to their use of alternative sentences, that TC patients benefited from alternatives more often than LTS patients. They mostly received more than one alternative (21.2% vs 5.6% of LTS).

Rates of those who received just one alternative are pretty much the same for TC and LTS (33.3% and 34.3% respectively).



**Figure 2.19. patients who got alternative sentences. Distinguished by services: LTS and TC.**





# CHAPTER 3

## Consumption, Doses, Prizes

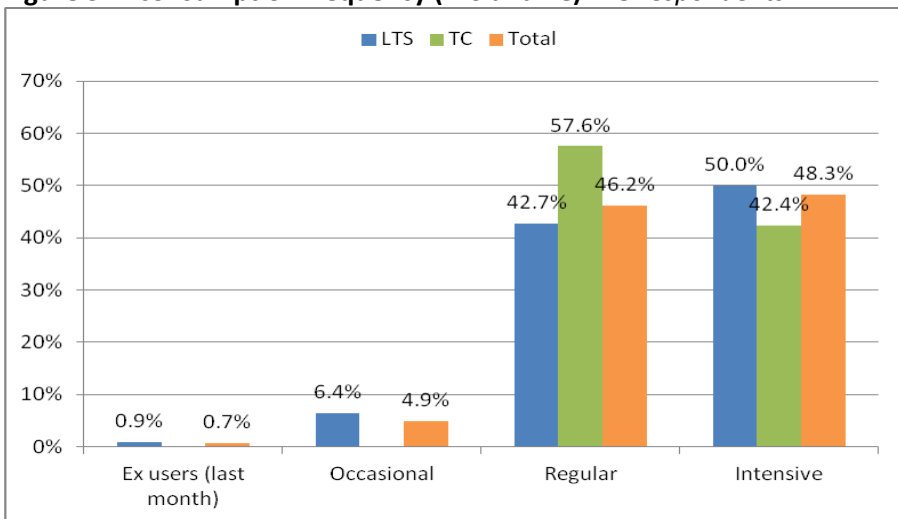
### 3.1. Drug Consumption

This chapter concerns the consumption analysis in the last 30 days for LTS patients, in the case of TC patients it refers to the last month before entering the current therapeutic community.

Therefore it is possible to have 4 different categories: ex users, occasional users (1-5 times in the last 30 days), regular (6 – 19 times) and intensive users (20 times and more).

The last month is not always a month of high consumption because the patients could already be in treatment (for detoxification) before starting a treatment period in a TC or they might be simply be reducing their normal consumption whilst keeping in touch with a health care structure.

**Figure 3.1. consumption frequency (LTS and TC) 143 respondents**



Ex-users or temporary “ex” users represent 0.7% of respondents. Among “regulars” LTS represent 42.7% and TC 57.6%. Conversely, looking at intensive consumers, LTS users are in the majority (50% vs 42.4% of TC patients). TC patients are not represented at all among occasional users. In Table 3.1 rates of consumers are reported distinguished by gender and service used.

Among LTS patients, a high rate of women responded that they were intensive consumers (46.3%) while in TC women are mostly regular users (57.1%).

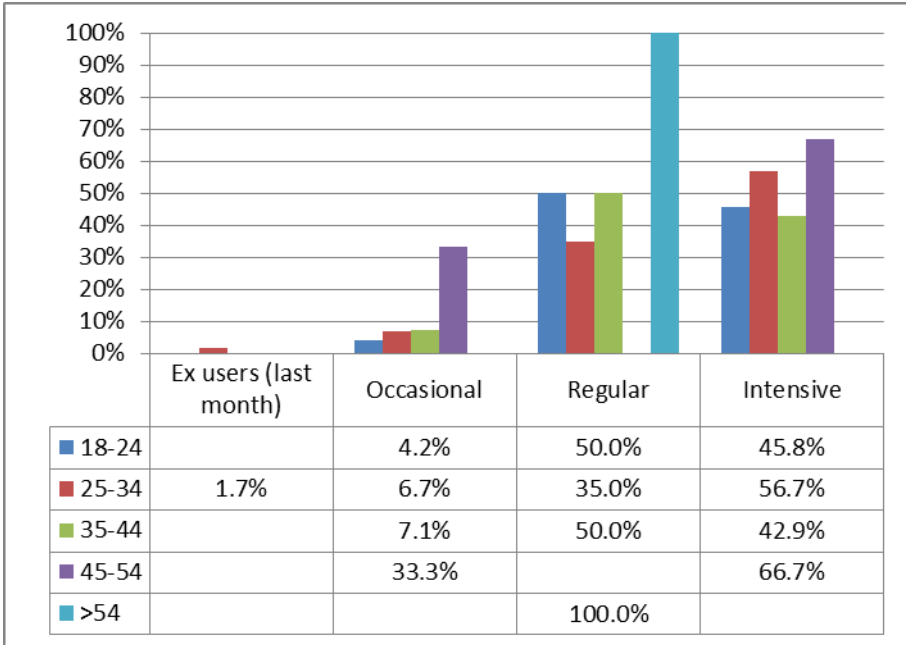
Data also shows that women had used drugs more frequently than men in the last month in TC, but not in LTS.

**Table 3.1. consumption frequency of LTS and TC users distinguished by gender 142 respondents**

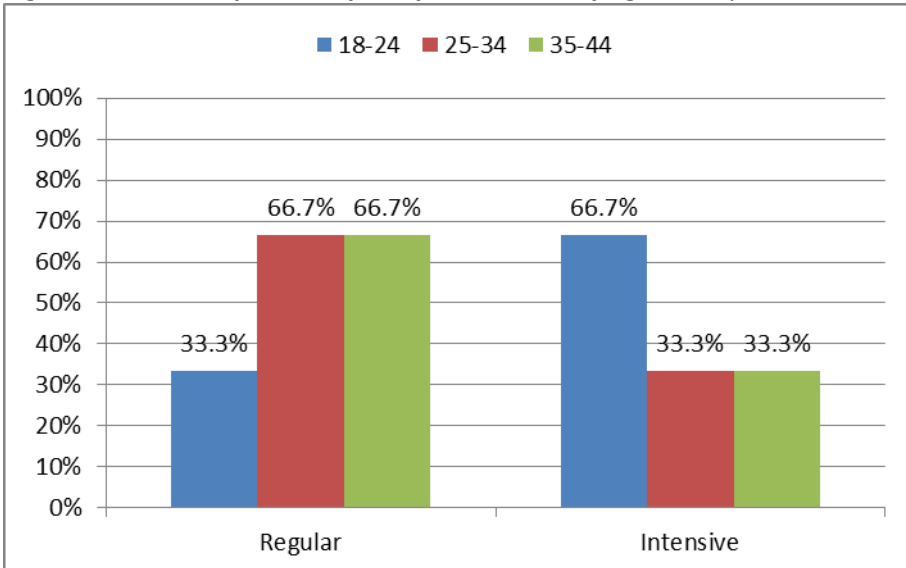
	LTS		TC	
	Female	Male	Female	Male
Ex users (last month)	-	1.4%	-	-
Occasional	12.2%	2.9%	-	-
Regular	41.5%	43.5%	57.1%	60.0%
Intensive	46.3%	52.2%	42.9%	40.0%
Total	100.0%	100.0%	100.0%	100.0%

Analyzing consumption frequency according to the age of users, in LTS younger respondents are mostly regular and intensive consumers; occasional consumers are mostly in the age group 45 – 54 (Figure 3.2).

**Figure 3.2. consumption frequency of LTS patients related to their age group 103 respondents**

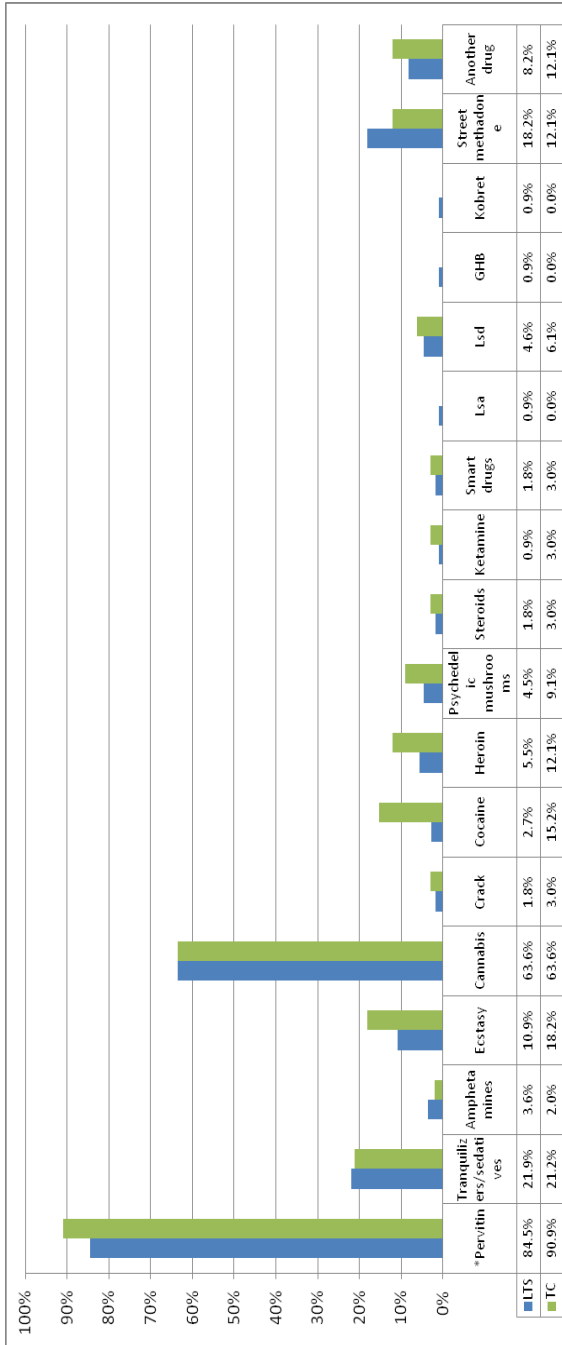


**Figure 3.3. consumption frequency of TC users by age 33 respondents**



Trends are dissimilar across the two services. As shown in figure 3.3 (which refers to TC patients) all the users are distributed between regular and intensive consumers. The distributions of those aged 25-34 and 35-44 are fairly evenly spread among the two consumption categories. Young adults (18-24) are mostly classified as intensive users (66.7%). In the following figures and tables we are going to analyze the consumption frequency of each kind of substance.

**Figure 3.4. last month's drug consumption (LTS and TC patients)**  
 143 respondents

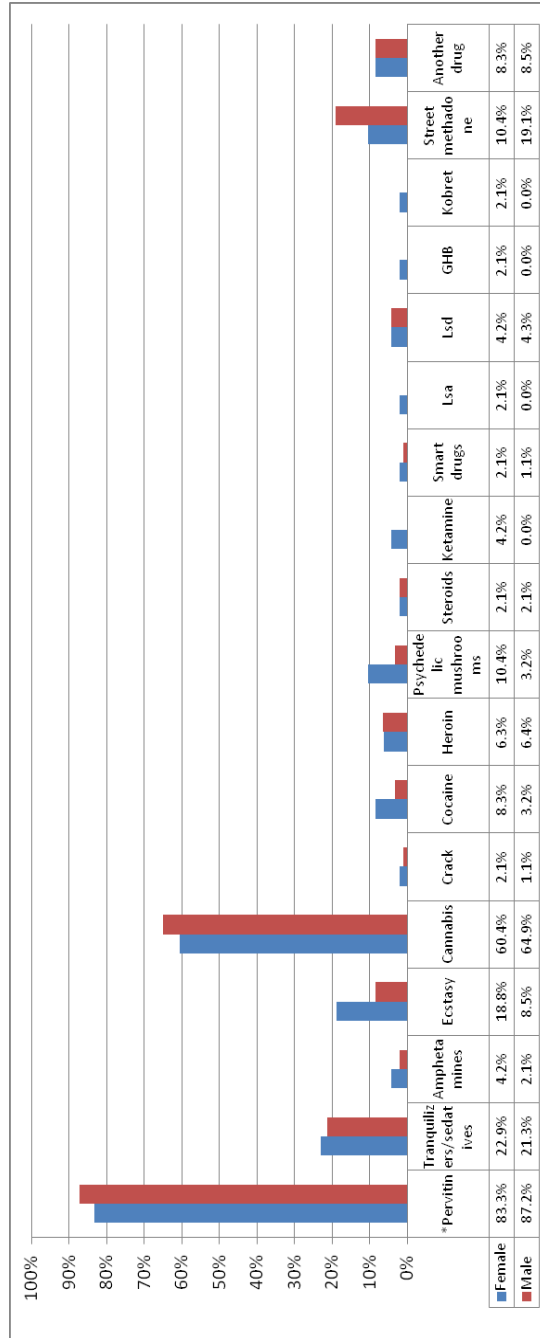


Cannabis and pervitin are the most popular drugs (Figure 3.4). Pervitin was more appreciated by TC patients (90.9% of TC users vs 84.5% of LTS users) while cannabis users have the same rates of consumption among TC and LTS users (63.6%).

To be considered in descending order are: Tranquillizer and sedatives, ecstasy, street methadone, cocaine and heroin. Regarding these types of drug there's a significant difference between LTS and TC patients when considering the consumption of cocaine and heroin (used more often by TC patients) and street methadone (used more by LTS patients).



**Figure 3.5. frequency distribution of the last month's drug consumption by gender 142 respondents**



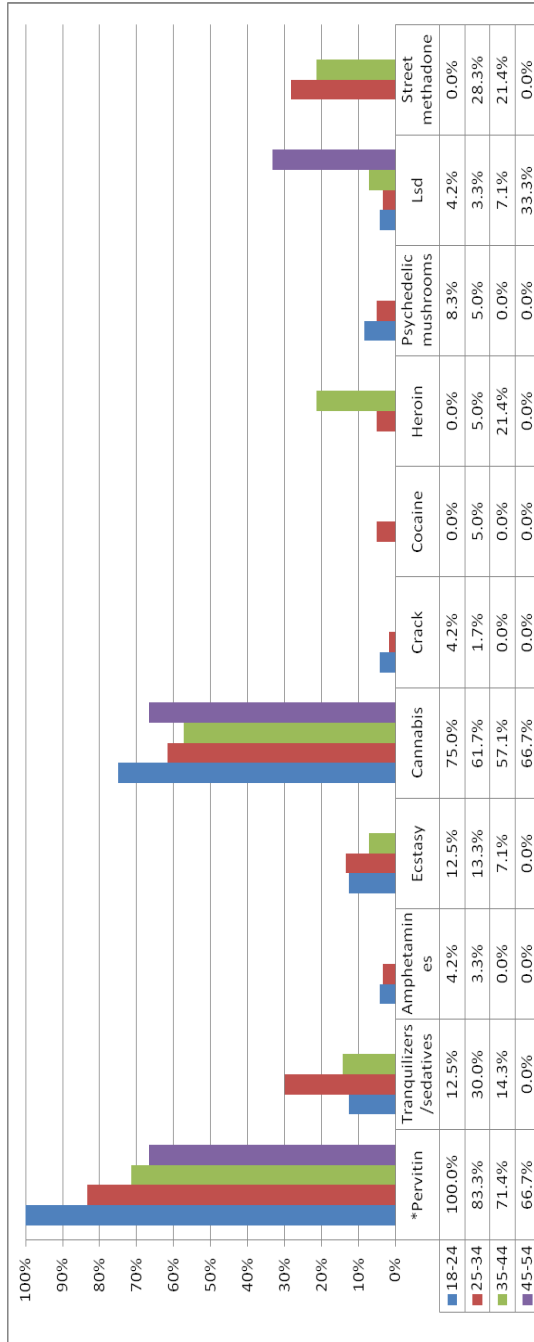
Distinguishing consumers by gender, Figure 3.5 reports little difference between men and women. Both pervitin and cannabis are the most used drug by men, while cocaine, ecstasy and tranquillizer are mostly used by women. Other differences between males and females are observed in the use of street methadone. For this substance men have higher consumption rates (19.1%) than women (10.4%). Regarding amphetamines, cocaine, psychedelic mushrooms, Lsa, ghb, kobret and ketamine consumption women are the main consumers. "Other drugs" (that often means alcohol) are used both by women and men in equal measure as well as heroin and LSD.

Another examination can be conducted distinguishing users by age. Figure 3.6 reports the rates of drug consumption among LTS patients.

Young patients are the most important consumers of pervitin, cannabis, psychedelic mushrooms and crack (100%, 75%, 8.3% and 4.2% respectively).

Pervitin distribution shows an inverse correlation between age and consumption frequency: as age increases, consumption rates decrease. This happens also for cannabis use with the exception of the oldest users. This latter category is the most significant consumer of LSD, while tranquillizers, sedatives and street methadone are consumed more by 25-34 years old users. Users aged 35-44 are the most significant consumers of heroin.

**Figure 3.6. frequency distribution of the most used drugs during the last month by age group - LTS 103 respondents**



Young users in TC reported higher percentages of consumption than those in LTS and this indicates that young adults in TC are more likely to be poly-drug users than those in LTS (Figure 3.7). They are the most significant consumers of cannabis, cocaine, crack, ecstasy, psychedelic mushrooms and LSD.

Pervitin and cannabis consumption frequency is almost the same among the 3 age groups. 35-44 year old users are the most important consumers of pervitin, tranquillizers and sedatives, heroin and street methadone.

**Figure 3.7. frequency distribution of the most used drugs during the last month by age group - TC 33 respondents**

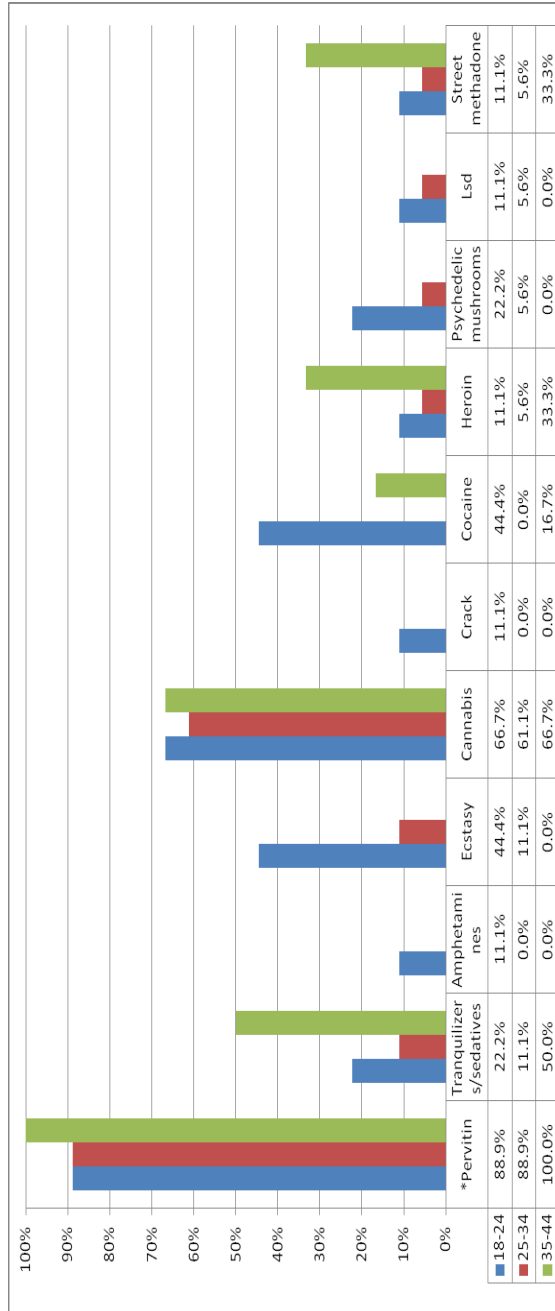
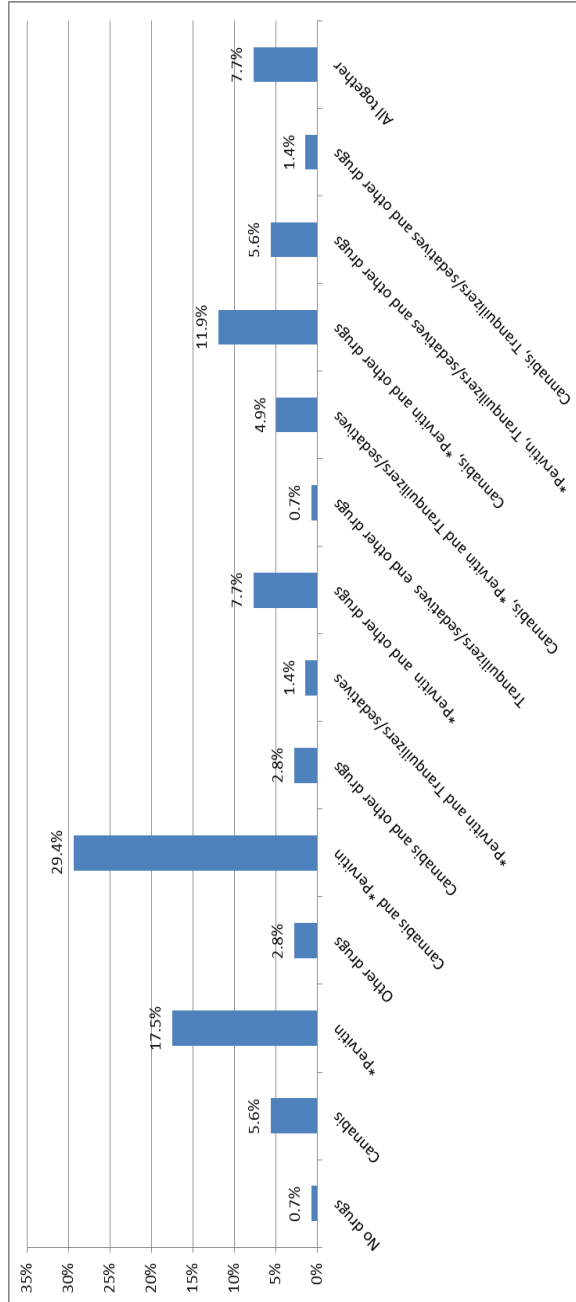


Figure 3.8 deals with poly use. Poly use is the most common mode of consumption for both LTS and TC patients. "One drug consumed" (or reported) was indicated by just 25.9% of respondents and among them only pervitin was used by 17.5%, only cannabis by 5.6% and only other drugs\* by just 2.8 %. Poly-drug users commonly take pervitin and cannabis sometimes together with other drugs.

The prevalence of hard drugs taken with soft drugs is quite important in this population, but it is evident that pervitin is the most important drug on the Czech market.

Pervitin and cannabis together were used by 29.4% respondents: cannabis and other drugs (\*) 2.8%; all together (\*\*) 7.7%.

Figure 3.8. poly-use as a percentage of the sample 143 respondents



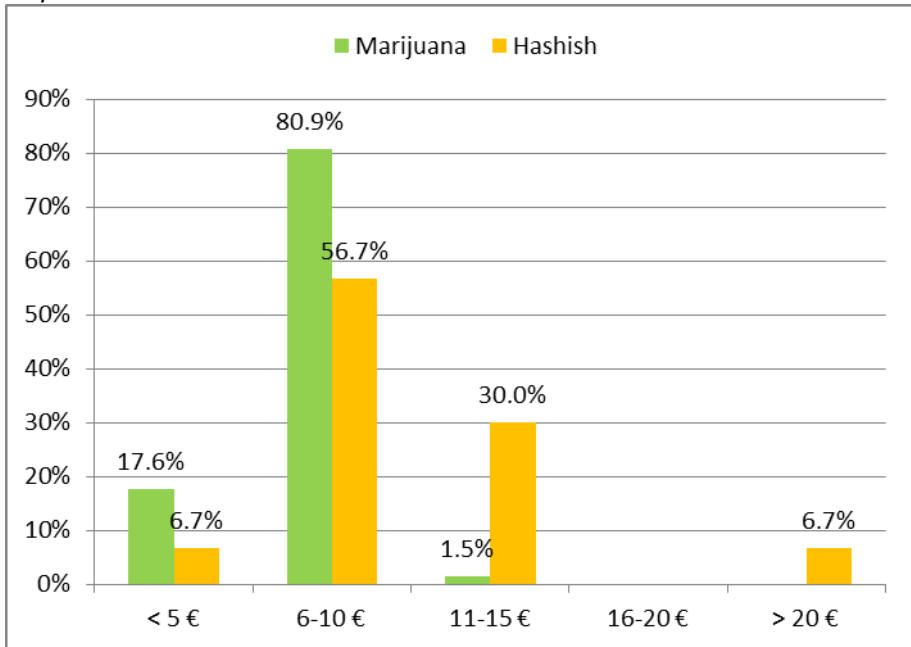
\*" Other drugs" means that at least one of the drugs listed other than the main two (cannabis, and pervetin) is consumed.

\*\* All together includes consumers of cannabis, pervetin and at least one of the "other drugs".

### 3.2. Prices and Substances

Information on drug prices comes from the answers to question number 23 of the questionnaire. Users were asked to indicate the latest known prices per dose, gram or pill of a list of 9 main drugs and pervetin. It is also asked to distinguish the prices of poor and top quality for cocaine and heroin.

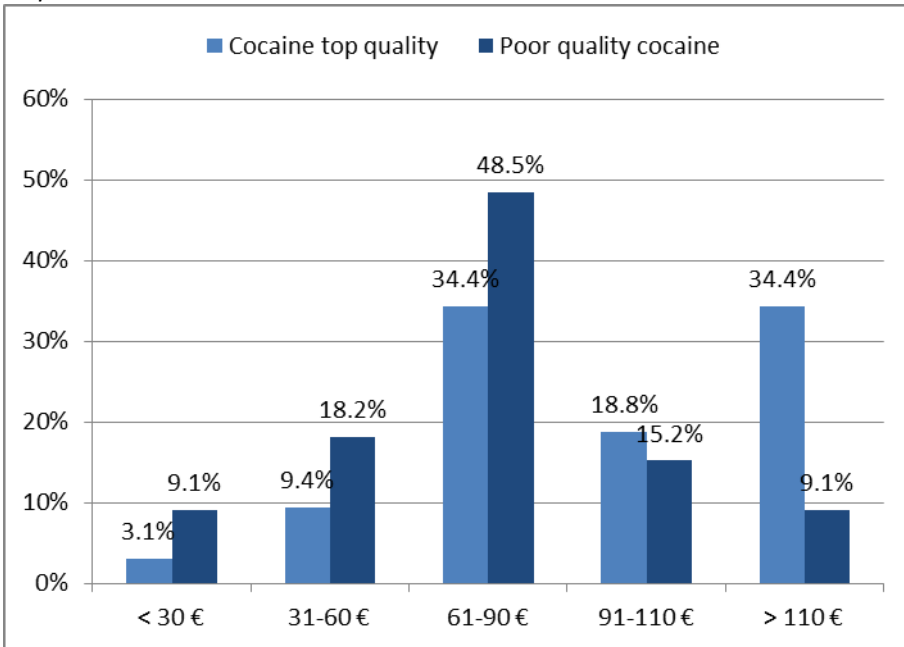
**Figure 3.9. Price for 1 gram of marijuana and 1 gram of hashish. 68 and 30 respondents**



Most respondents indicated the prices of marijuana and hashish at between 6-10 €. A small percentage of users (17.6% for marijuana and 6.7% for hashish) reported a price at less than 5€. Considerable percentages of consumers priced hashish within 11-15€. The price marijuana price is less than 10€ while hashish is commonly priced at between 6 and 15€.

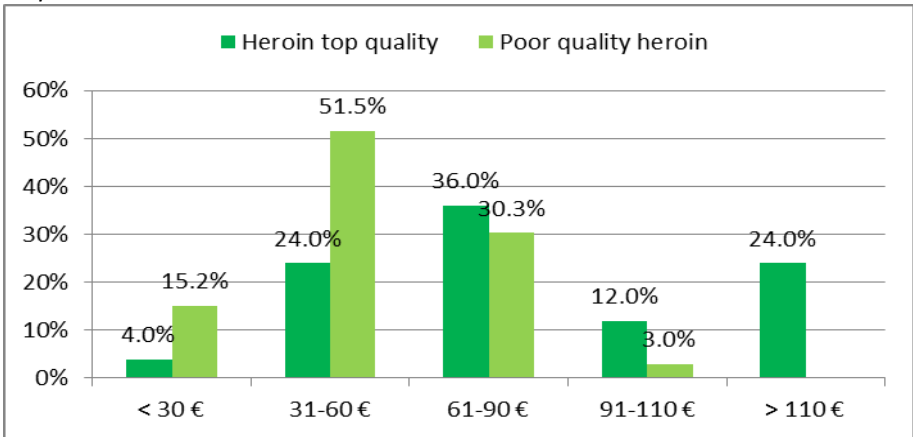


**Figure 3.10. price for 1 gram of top quality and poor cocaine 32 and 33 respondents**



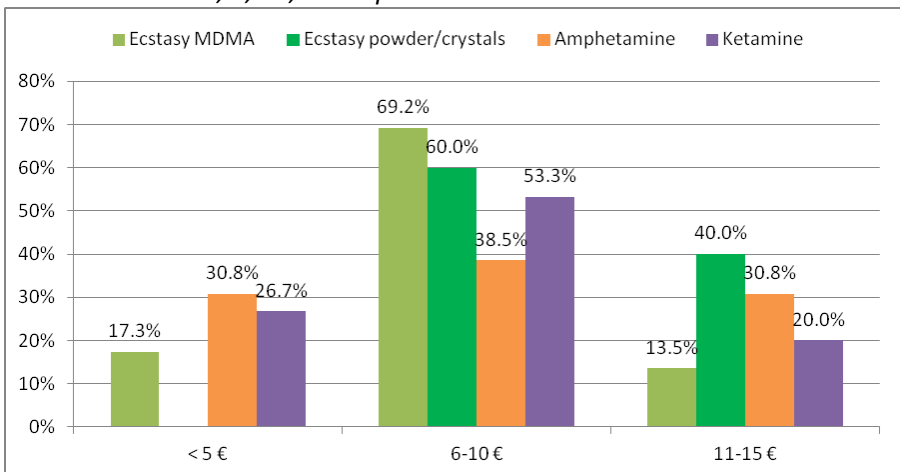
Low quality cocaine was priced by most respondents at between 61 - 90 €. Top quality cocaine distribution has two modal classes: "61-90 €" and ">110 €" with a percentage of 34.4%. 18.8% priced top quality cocaine between 91-110 € while 9.4% said the last price known was 31-60 €. Poor quality cocaine distribution is varied and it's difficult to estimate a price trend.

**Figure 3.11. price for 1 gram of top quality and poor heroin 25 and 33 respondents**



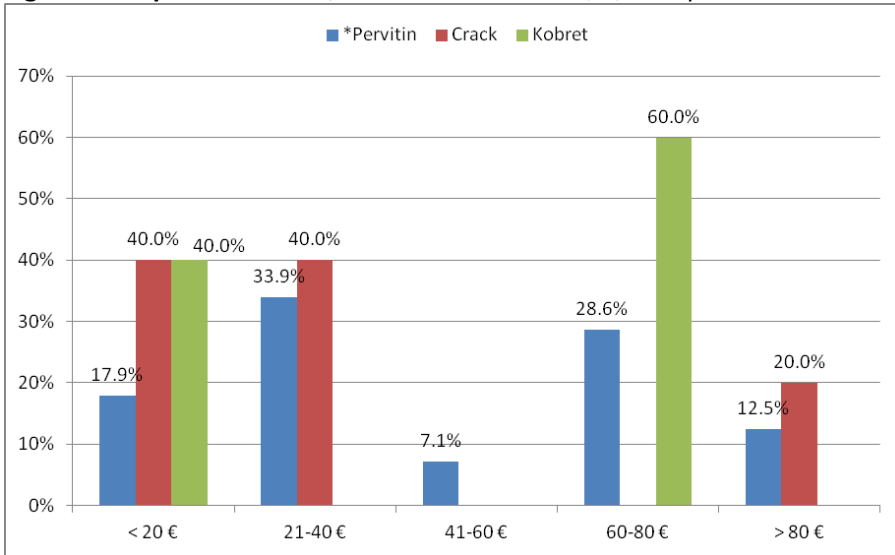
The modal value of poor quality heroin is “31-60 €” (51.5%) followed by “61-90 €” (30.3%) and by “<30 €” . Top quality heroin distribution is varied; 36% priced it within 61-90€, 24% said the last price known was 31-60 € and the same percentage said over 110 €, 12% reported a price between 91-110 € and the remaining 4% reported a price lower than 30 €.

**Figure 3.12. price Ecstasy MDMA, Ecstasy powder/crystals, Amphetamine and Ketamine. 52, 5, 13, 15 respondents**



The modal value for all the kinds of substances listed in figure 3.12 is “6-10 €”. The distribution shows a price for ecstasy powder surely between 6 and 15 € while the price of MDMA is probably lower than 11 €.

**Figure 3.13. price \*Pervitin, Crack and Kobret 56, 5, 5 respondents**



Most interviewers (60%) said the price of kobret was 60-80 € per pill whereas 40% of users estimated kobret prices at less than 20 €. The price of crack had its modal values in the classes of “< 10 €” and “21-40 €” (40%) and another large group indicated a price higher than 80 € (20%).

The price of pervitin seems to be the most variable: 33.9% of respondents indicated between 21 and 40 €; 28.6% 60-80 €, 17.9% <20 and 12.5% > 80 €. Just 7.1% reported a pervitin price between 41 and 60 €.

Further analysis can be done drawing from data surveyed separately for occasional, regular and intensive consumers. The aim is to obtain an estimate of prices from those who had more recent experience.

**Table 3.2. estimated price for 1 gram of marijuana expressed by cannabis**

		< 5 €	6-10 €	11-15€	16-20€	> 20 €	Total
<b>Cannabis consumers</b>	Regular	15.8%	78.9%	5.3%	-	-	100.0%
	Intensive	19.4%	80.6%	-	-	-	100.0%

Table 3.2 displays estimated prices the users gave for marijuana according to their consumption habit.

Most respondents, whether they are regular or intensive marijuana users, estimated marijuana prices at less than 10 €. Insignificant levels of regular users declared a price of between 11-15 € (5.3%).

Data about hashish shows that the whole population of regular hashish consumers reported a price within 6-10 €. The distribution of intensive consumers is spread among the five price classes; most of them reported a price between 6-15 € while other rates are fairly evenly spread among the other classes (11.8%).

**Table 3.3. estimated price for 1 gram of hashish expressed by cannabis consumers according to their consumption frequency.**

		< 5 €	6-10 €	11-15€	16-20€	> 20 €	Total
<b>Cannabis consumers</b>	Regular	-	100.0%	-	-	-	100.0%
	Intensive	11.8%	52.9%	23.5%	11.8%	11.8%	100.0%

**Table 3.4. estimated price for pervitin, expressed by consumers of these substances according to their consumption frequency**

		< 20 €	21-40 €	41-60 €	60-80 €	> 80 €	Total
<b>*Pervitin consumers</b>	Occasional	33.3%	33.3%	-	-	33.3%	100.0%
	Regular	21.1%	15.8%	10.5%	47.4%	5.3%	100.0%
	Intensive	17.2%	44.8%	6.9%	17.2%	13.8%	100.0%

Table 3.4 depicts the estimated price of pervitin expressed by those who were consumers of this drug. Analysis was undertaken distinguishing users according to their consumption frequency.

Levels of intensive consumers are concentrated in the price class between 21 and 40€ per gram (44.8%). Most regular consumers priced pervitin between 60-80€ (47.4%) but significant rates are found also in the price classes “<20€” and “21-40€” (21.1% and 15.8% respectively). Rates of occasional consumers are fairly evenly spread among 3 price classes “<20€”, “21-40€” and “>80€” (33.3%).

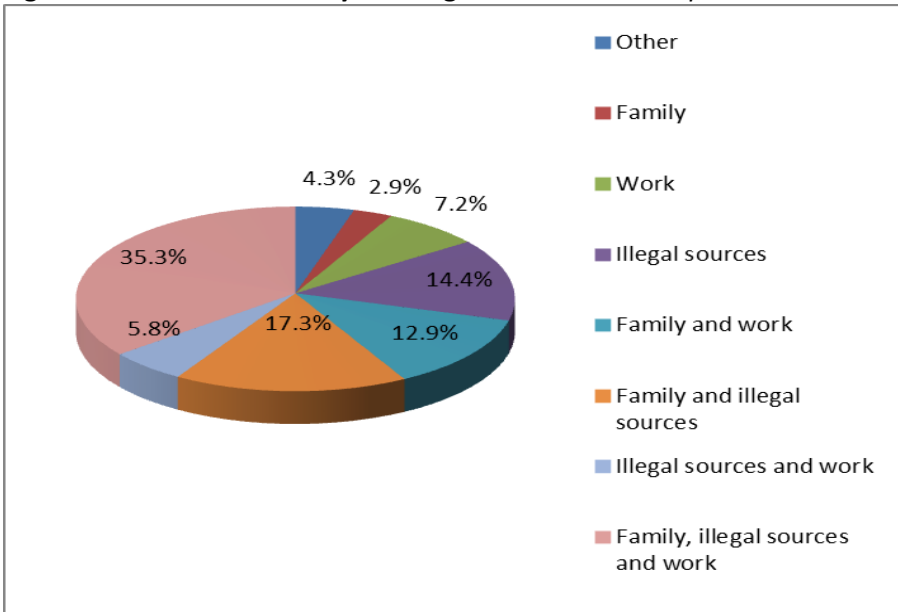


# CHAPTER 4

## Legal and illegal sources of revenue for drug addicts

This chapter aims to identify the sources of income (legal and illegal) through which users obtain the money to buy drugs. The issue of income sources is strongly correlated with the question of the funding of illicit drugs. There are three main sources of revenue that users invest in drugs purchases: money from family, work and illegal activities. The question “How did you usually get money to buy drug(s)?” could be answered choosing more than one answer. This has allowed the aggregation of the respondents into 8 categories in which all the three main sources identified are combined .

**Figure 4.1. sources of money for drug consumers 139 respondents**



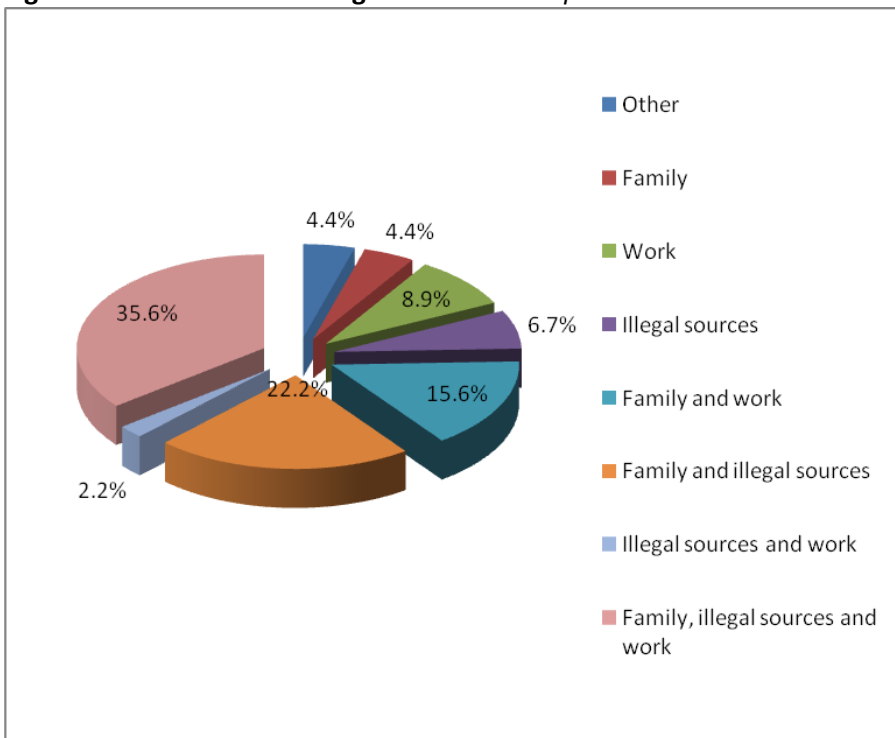
“Illegal activities” alone is the income source of 14.4% of users. 17.3% collected money from illegal activities and family resources while 5.8% got money from illicit activities and work. Illegal means have a powerful prevalence as income for drugs addicts. 72.8% of respondents draw from illegal activities, nearly always in conjunction with other sources.

Family is the only source of income for 2.9% of users.

It is important to highlight that the main source after “illegal activities” is “work”: 7.2% of respondents could rely just on their salary without drawing from other sources. Although over one-quarter of respondents (35.3%) use the three income sources all together to get money to spend on drugs.

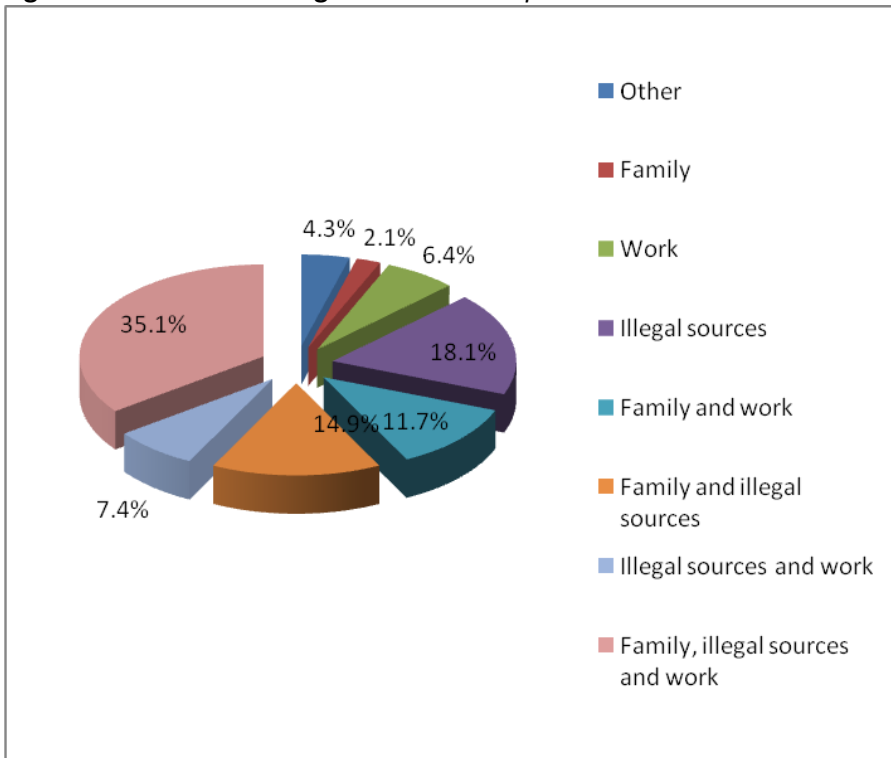
Distinguishing the income sources by gender, figures 4.2 and 4.3 display almost the same distribution with some differences. While 18.1% of men can count just on illegal activities to fill their need to buy drugs, women tend to use illegal activities as an income source always in conjunction with family resources (22.2%) and with work salary (2.2%). Family as the only income source is cited mostly by women (4.4% vs 2.1% of men) and the same can be seen with work salary.

**Figure 4.2. women’s income generation 45 respondents**





**Figure 4.3. men's income generation 94 respondents**

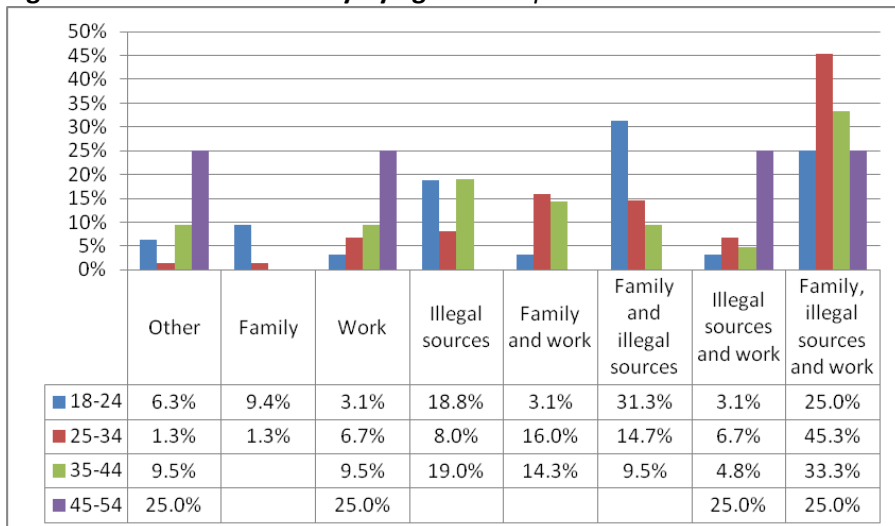


Other important features can be observed in relation to the age of the respondents.

31.3% of young adults aged 18-24 (Figure 4.4) received revenue from “family and illegal activities” and another 25% of them from all the three sources of income.

Looking at the 35-44 age group “family, illegal activities and work” was the modal value but was less important (33.3%) than for the 25-34 age group (45.3%). For these two groups “family and work” are very important but for users aged 35-44 illegal sources also play a fundamental role.

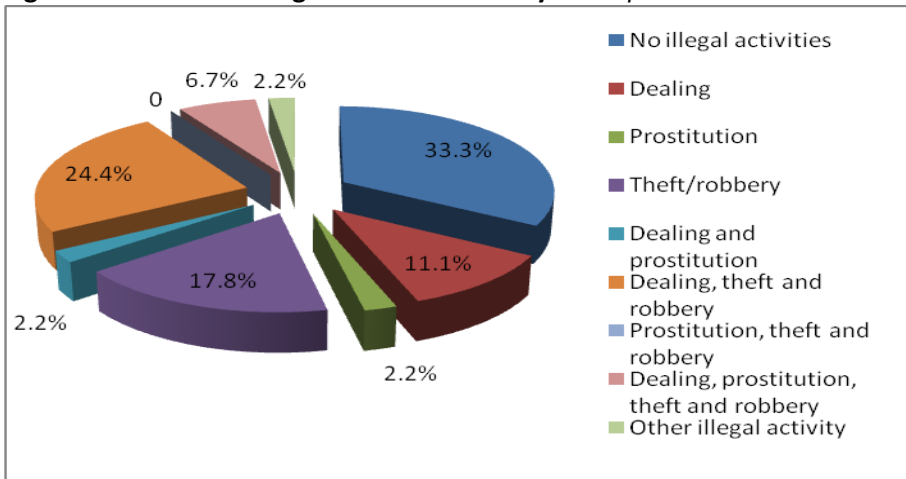
The frequency distribution of the older group aged 45-54 is fairly evenly spread among the 4 groups of sources: work, work and illegal activities, other sources and work, illegal activities and family (25%).

**Figure 4.4. sources of money by age 134 respondents**

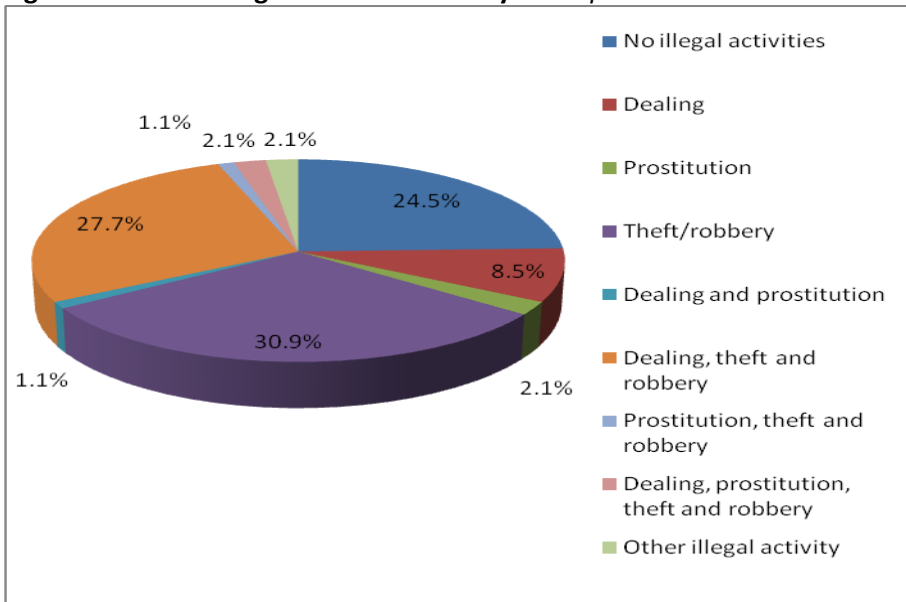
The survey also allows a deeper analysis concerning the main illegal activities: dealing, prostitution and theft/robbery. In order to better understand the phenomenon we built seven different clusters containing one or more of the above-mentioned activities in accordance with the multiple or single choices of respondents.

Figure 4.5 displays the illegal sources of funding for females. Their main illegal source of revenue is drug dealing combined with theft and robbery (24.4%), while 17.8% of them use just theft and robbery to collect money to buy drugs, 11.1% drug dealing and 6.7% performed all of these activities. Prostitution is the only illegal activity for 2.2% of women as well as dealing and prostitution (2.2%).

**Figure 4.5. women's illegal sources of money 45 respondents**



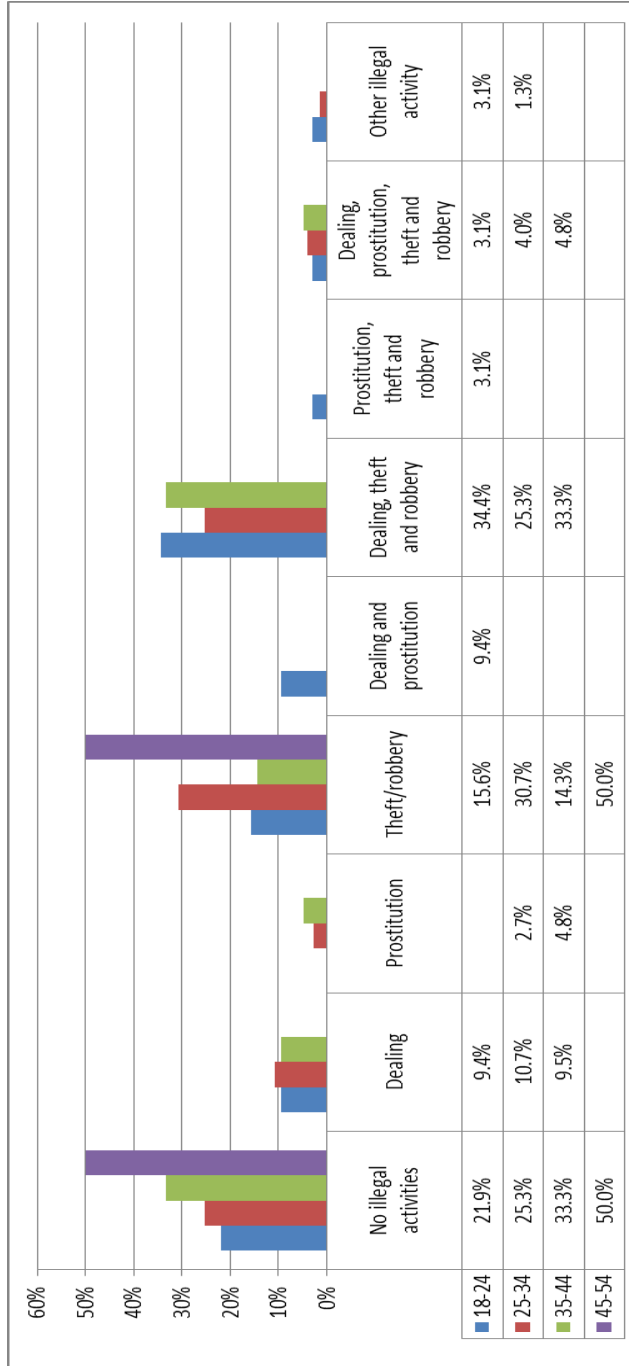
**Figure 4.6. men's illegal sources of money 94 respondents**



The illegal activities of men are more concentrated in two categories: “theft and robbery” (30.9%); “theft and robbery combined with dealing” (27.7%). Dealing itself is the main income source for 8.5% of men.

The other categories present very low percentages among men. Significant data: prostitution was declared by 3.2% men (summing up “prostitution and dealing” and “prostitution” alone).

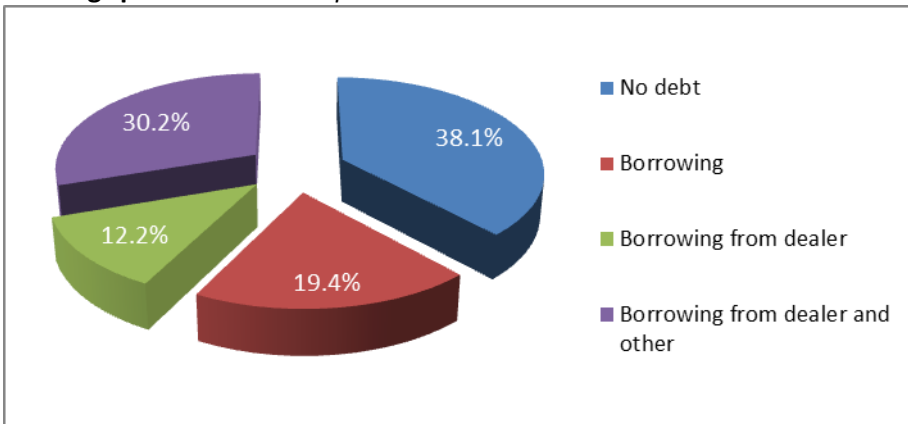
Figure 4.7. illegal source of money by age 134 respondents



Theft and robbery, alone and combined with dealing are among the main activities used as an illegal income source to purchase drugs. That applies to all of the age groups except for the oldest group (45-54 years old) that are all concentrated in the first category.

Prostitution is more widespread among the younger generation, especially in combination with theft and robbery.

**Figure 4.8. distribution of respondents who contracted a debt or did not for drugs purchases 139 respondents**



Among those who borrowed money to buy drugs, 30.2% had borrowed both from dealers directly and from other subjects, 19.4% reported to have borrowed money just from people other than a dealer and 12.2% only from a dealer. The majority of respondents (38.1%) have never received a loan to buy drugs.

**Figure 4.9. distribution of respondents who contracted a debt or not for drugs purchase by gender 139 respondents**

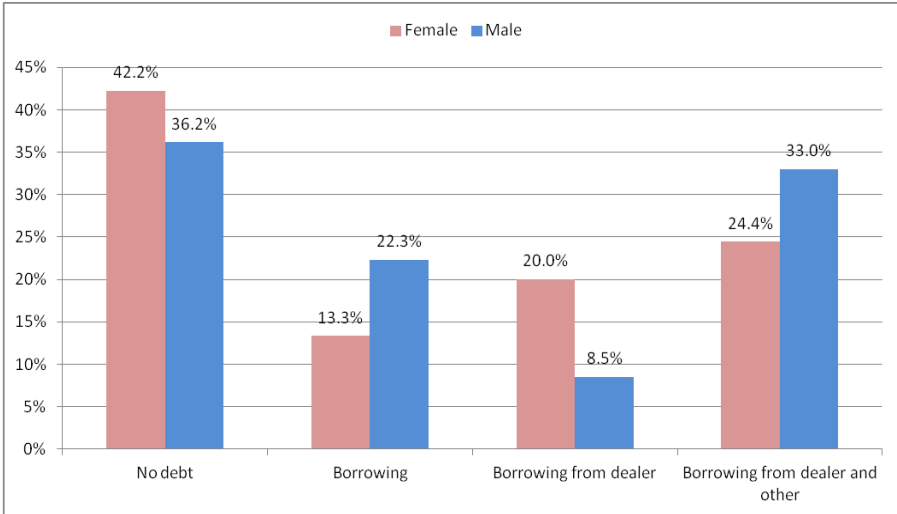
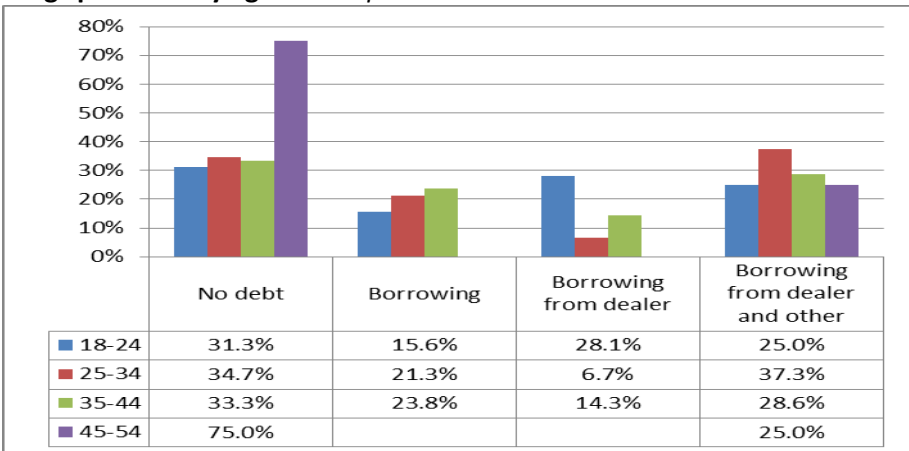


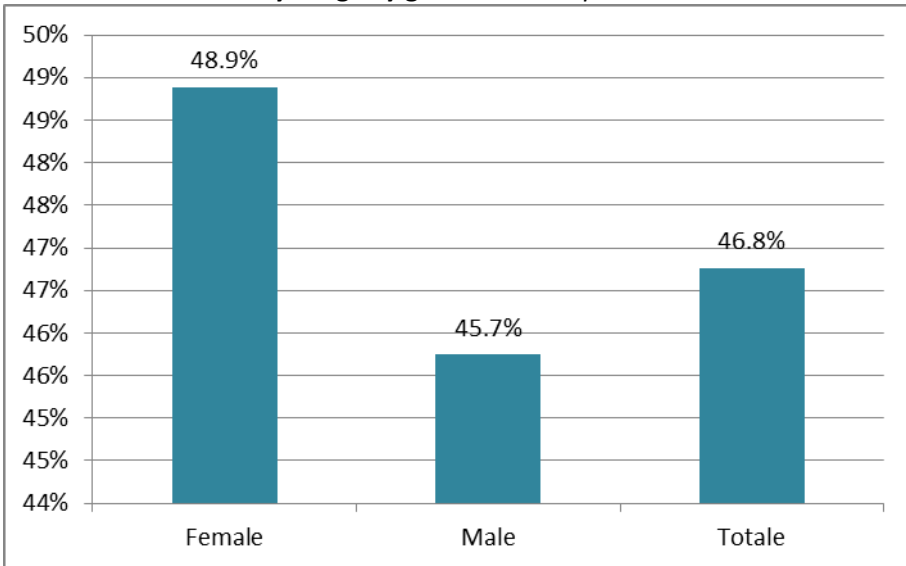
Figure 4.9 displays users distribution by gender and the way to purchase drugs by means of borrowing money. The data shows the significant difference between men and women in the category of those who used to borrow from a dealer: here women are the majority (20% against 8.5% of men). Men are most common in the categories of those who used to borrow from other subjects and of those who used to borrow both from a dealer and from other people. Men incurred more debt than women.

**Figure 4.10. distribution of respondents who contracted a debt or not for drugs purchase by age 134 respondents**



The younger the users are the more they asked for a loan to finance their addiction (Figure 4.10). The younger generation prefer to borrow from dealers directly while the older the user is, the more likely they are to ask for a loan from a third party.

**Figure 4.11. distribution of respondents who used contributions from social assistance to buy drugs by gender 139 respondents**



A last analysis can be conducted of those who used contributions from social assistance to spend on the illicit drug market. They amount to 46.8% of the whole sample and they are mostly women (48.9% of the whole female sample). Men comprise 45.7% of the whole male sample.







# CHAPTER 5

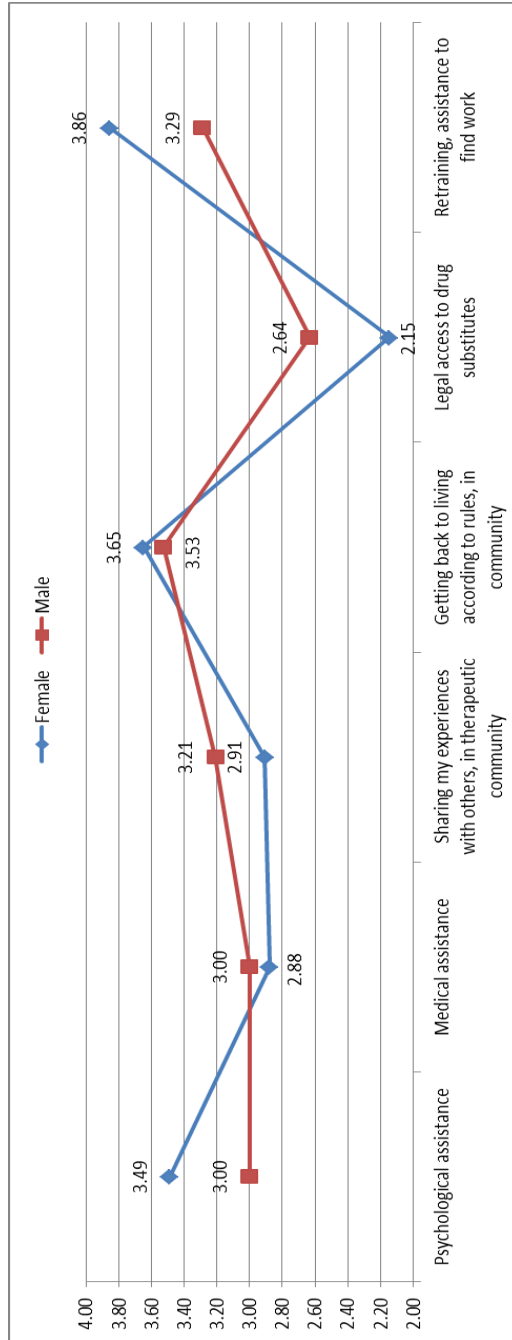
## Evaluation of Services

Patient satisfaction is the major indicator of the quality of services provided by a health facility. In this chapter the aim is to assess the level of satisfaction of patients within the various aspects of health care.

### **5.1. Satisfaction with Services**

Respondents were asked about the usefulness of assistance received during their treatment program in care facilities. The usefulness of services has been expressed through a utility score ranging from 1 to 5, where 1 represents the minimum benefit and 5 the maximum one. Services under assessment are: psychological assistance, medical assistance, the chance of sharing experiences with others, going back to living by communal rules, access to drug substitutes and assistance in job hunting.

**Figure 5.1. average rate of patient satisfaction for health care services**  
 123, 120, 119, 116, 115, 119 respondents



**Table 5.1. evaluation of a services usefulness [1= lowest rating \_ 5 = highest rating] 124. 121. 120. 117. 116. 120 respondents**

	<i>Psychological assistance</i>	<i>Medical assistance</i>	<i>Sharing my experiences with others. in therapeutic community</i>	<i>Getting back to living according to rules. in community</i>	<i>Legal access to drug substitutes</i>	<i>Retraining. assistance to find work</i>
Values						
1	21.0%	20.7%	21.7%	14.5%	44.8%	11.7%
2	12.1%	16.5%	12.5%	12.8%	10.3%	10.8%
3	21.0%	27.3%	20.8%	16.2%	18.1%	27.5%
4	20.2%	15.7%	24.2%	15.4%	8.6%	18.3%
5	25.8%	19.8%	20.8%	41.0%	18.1%	31.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Figure 5.1 shows the average satisfaction expressed by female and male respondents and there are no relevant differences.

Table 5.1 gives more details about the distribution of these evaluations: social and work reinstatement assistance (50%), getting back to living according to rules (56.4%) and psychological assistance (46%) receive the best evaluation with a high percentage of users giving them a utility score between 4 and 5. On average women evaluated these services better than men.

The worst evaluated service is legal access to drug substitutes. 44.8% of users gave it the lowest utility score. Medical assistance is preferred by men but it received bad utility scores among both genders (37.2% gave it no more than 2 points);

Further analysis can be undertaken distinguishing users between those who have never entered a therapeutic community and those who have been a patient in these structures at least once in the life.

**Table 5.2. evaluation of service usefulness by TC patients, at least in the past [1= lowest rating \_ 5= highest rating] 33, 29, 32, 29, 25, 32 respondents**

	<i>Psychological assistance</i>	<i>Medical assistance</i>	<i>Sharing my experiences with others. in therapeutic community</i>	<i>Getting back to living according to rules. in community</i>	<i>Legal access to drug substitutes</i>	<i>Retraining. assistance to find work</i>
Values						
1	18.2%	20.7%	3.1%	6.9%	76.0%	9.4%
2	18.2%	24.1%	9.4%	20.7%	4.0%	15.6%
3	12.1%	31.0%	18.8%	17.2%	8.0%	31.3%
4	15.2%	10.3%	15.6%	3.4%	4.0%	12.5%
5	36.4%	13.8%	53.1%	51.7%	8.0%	31.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**Table 5.3. evaluation of services by never in TC [1= lowest rating \_ 5= highest rating] 91. 92. 88. 88. 91. 88 respondents**

	<i>Psychological assistance</i>	<i>Medical assistance</i>	<i>Sharing my experiences with others. in therapeutic community</i>	<i>Getting back to living according to rules. in community</i>	<i>Legal access to drug substitutes</i>	<i>Retraining. assistance to find work</i>
Values						
1	22.0%	20.7%	28.4%	17.0%	36.3%	12.5%
2	9.9%	14.1%	13.6%	10.2%	12.1%	9.1%
3	24.2%	26.1%	21.6%	15.9%	20.9%	26.1%
4	22.0%	17.4%	27.3%	19.3%	9.9%	20.5%
5	22.0%	21.7%	9.1%	37.5%	20.9%	31.8%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The service considered to be the most useful by both TC residents and non-TC residents is "getting back to following the rules". Around 50% of TC users and 37.5% of non-TC users gave the maximum utility score to this service. The other service proper to the therapeutic community (sharing experiences with others) received a very positive evaluation from TC

patients (5 points 53.1%) but a pretty negative judgment from non-TC patients.

Psychological assistance is more appreciated by those who have been in therapeutic communities (51.6% of users assigned a score between 4 and 5). On the contrary the never-been- in-TC assigned low or neutral satisfaction rates to psychological services.

Negative evaluations were given to legal access to drug substitutes but some of those who have never been in TC gave it the maximum utility score (20.9%) while the majority of TC users evaluated it with the minimum utility score (76%).

The never-been-in-TC gave more importance to medical assistance (4-5 points 39.1%) while “retraining” received the same judgments by both kinds of user. The mean utility score given by non-TC users is 3.5 against 3.41 given by TC patients.

Tables 5.2 and 5.3 and the figure below (5.2) show that TC and non-TC patients evaluated psycho-social services (Sharing experiences...) in a very different way. Margins between the average scoring are considerable: 4.06 vs. 2.75 non-TC users.

Figure 5.2. average evaluations according to enrollment in TC [1= lowest rating\_ 5 = highest rating]

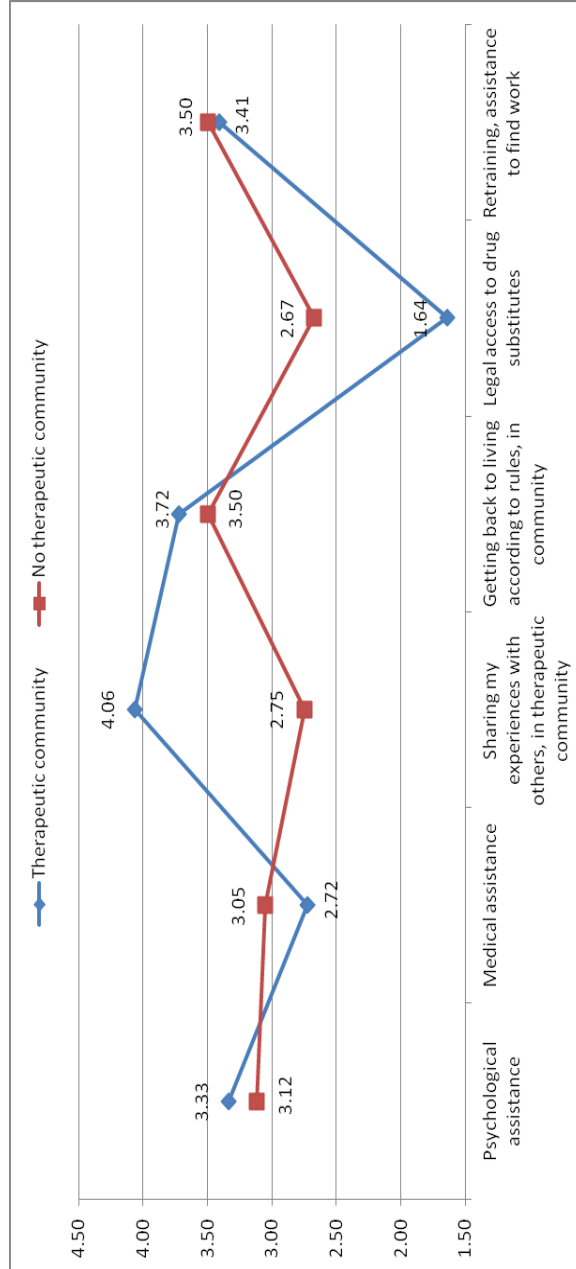
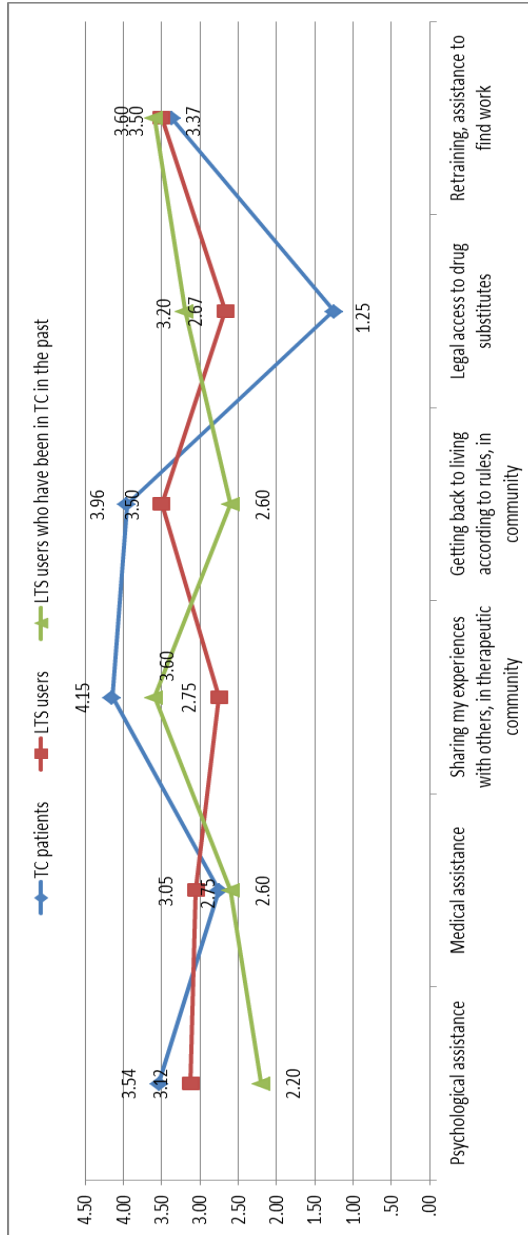


Figure 5.3. comparison of the evaluations by TC patients, LTS users and LTS users been in TC, regarding the utility of services [1= lowest rating \_ 5= highest rating]



Comparing differences in patient characteristics and average utility scoring among the three patient groups reported in figure 5.3, we can suppose that the low evaluation for the psycho-social treatments (“getting back...”, “psychological assistance” and “sharing experiences...” ) is given by LTS patients who have been in TC in the past. TC patients, who should have more experience with these kinds of treatments, have a more positive opinion of psychological assistance and related treatments. For “sharing experiences with others in TC” LTS users gave the worst evaluation followed by those who had been both in LTS and TC.

The three groups of users are nearly equivalent in their strong appreciation for retraining services.

Users who have been in TC gave a lower rating to legal access to drug substitutes than those who have experienced only LTS.

In the evaluation of the first six services, men and women do not show particular differences (Figure 5.4). On average women evaluated services (especially for “methadone programs” ) higher than males except for “sheltered accommodation and protected work” and “diagnostical institutions”. This latter service is the lowest rated: 50% of users (table 5.6) gave to diagnostical institutions the lowest utility score.

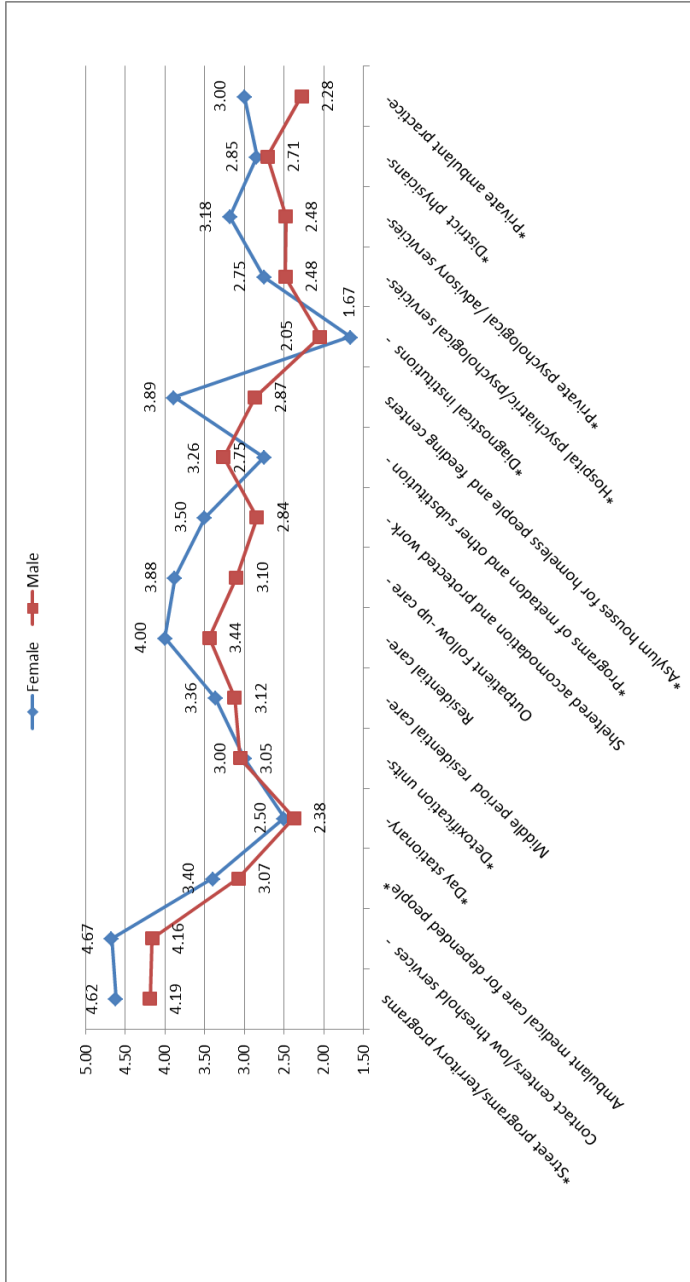
Street programs and contact centers are considered to be good services by both genders: more than 6 out of 10 users gave to these two services the maximum quality score. Generally other services received a neutral evaluation.

Tables 5.7 and 5.8 make a comparison between quality evaluation expressed by users who have tried therapeutic community services and by those never made use of such facilities. Those who have never been in a therapeutic community gave a very negative evaluation of methadone programs, private psychological services and private ambulant practice; more than half of the non-TC population gave a utility score between 1 and 2. TC patients have a better opinion of these two services.



## 5.2. Satisfaction with Institutes

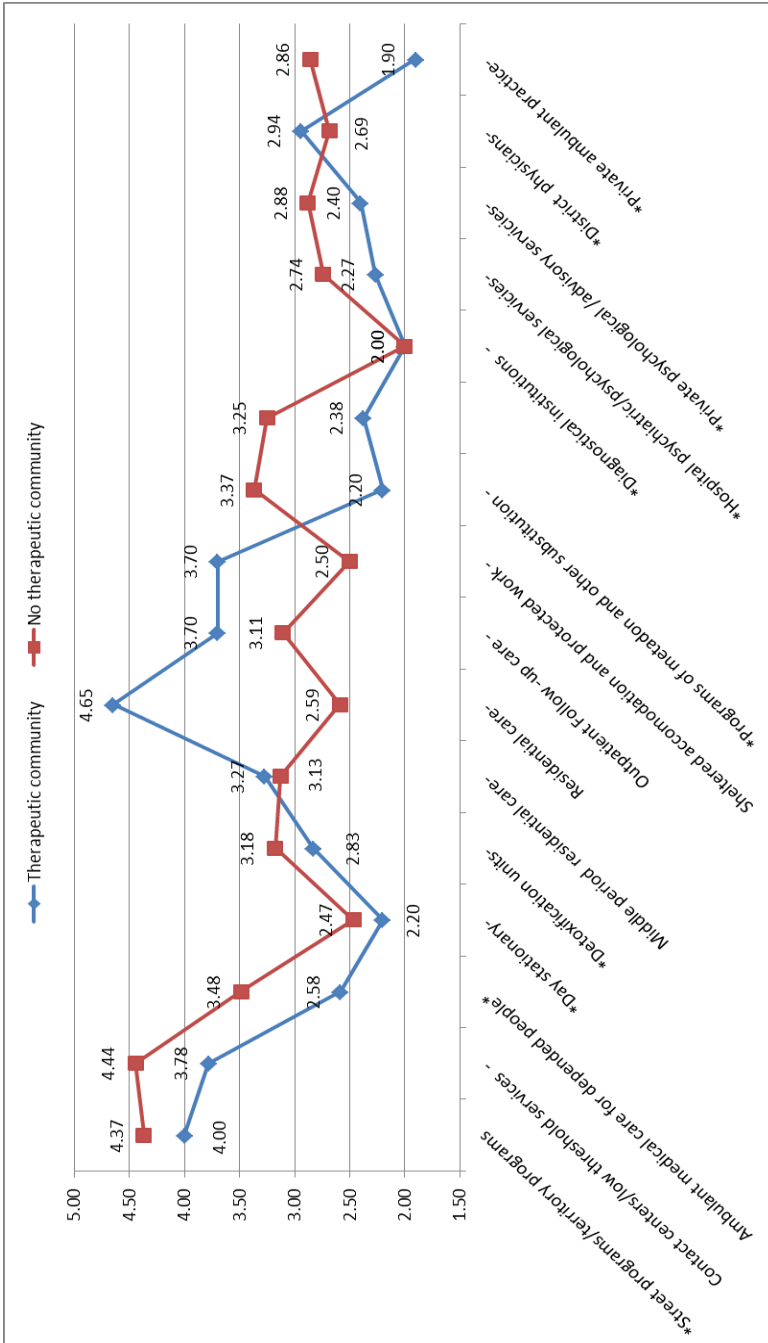
**Figure 5.4. average rate of patient satisfaction for typology of institute**  
 Female min. 3, max 40 respondents; male min. 16, max 79 respondents



**Table 5.6. Evaluation of service quality by whole sample [1= lowest rating  
\_ 5 = highest rating]**

	Values					Total
	1	2	3	4	5	
*Street programs/territory programs	6.1%	2.0%	9.2%	20.4%	62.2%	100%
Contact centers/low threshold services -	5.0%	5.0%	9.2%	15.0%	65.8%	100%
Ambulant medical care for depended people*	16.3%	18.6%	20.9%	14.0%	30.2%	100%
*Day stationary-	40.0%	15.0%	20.0%	15.0%	10.0%	100%
*Detoxification units-	23.1%	15.4%	21.2%	17.3%	23.1%	100%
Middle period residential care-	17.8%	11.1%	31.1%	13.3%	26.7%	100%
Residential care-	20.6%	2.9%	17.6%	11.8%	47.1%	100%
Outpatient Follow -up care -	27.6%	6.9%	10.3%	17.2%	37.9%	100%
Sheltered accomodation and protected work -	26.9%	19.2%	11.5%	15.4%	26.9%	100%
*Programs of metadon and other substitution -	20.8%	20.8%	16.7%	8.3%	33.3%	100%
*Asylum houses for homeless people and feeding centers	17.5%	12.5%	32.5%	20.0%	17.5%	100%
*Diagnostical institutions -	50.0%	15.4%	23.1%	7.7%	3.8%	100%
*Hospital psychiatric/psychological servicies-	26.1%	26.1%	23.9%	10.9%	13.0%	100%
*Private psychological /advisory servicies-	28.6%	20.0%	14.3%	22.9%	14.3%	100%
*District physicians-	29.4%	20.6%	14.7%	16.2%	19.1%	100%
*Private ambulant practice-	35.5%	19.4%	16.1%	12.9%	16.1%	100%

**Figure 5.5. Difference between TC and non-TC users evaluation of services [1 = poor 5 = excellent].**



**Table 5.7. evaluation of institute by TC patients [1= lowest rating \_ 5= highest rating]**

	Values					Total
	1	2	3	4	5	
*Street programs/territory programs	17.6%	5.9%	-	11.8%	64.7%	100%
Contact centers/low threshold services -	13.0%	13.0%	8.7%	13.0%	52.2%	100%
Ambulant medical care for depended people*	33.3%	16.7%	25.0%	8.3%	16.7%	100%
*Day stationary-	40.0%	40.0%	-	-	20.0%	100%
*Detoxification units-	29.2%	16.7%	20.8%	8.3%	25.0%	100%
Middle period residential care-	13.6%	18.2%	22.7%	18.2%	27.3%	100%
Residential care-	-	-	11.8%	11.8%	76.5%	100%
Outpatient Follow -up care -	10.0%	20.0%	10.0%	10.0%	50.0%	100%
Sheltered accomodation and protected work -	10.0%	20.0%	10.0%	10.0%	50.0%	100%
*Programs of metadon and other substitution -	40.0%	40.0%	-	-	20.0%	100%
*Asylum houses for homeless people and feeding centers	25.0%	37.5%	25.0%	-	12.5%	100%
*Diagnostical institutions -	33.3%	33.3%	33.3%	-	-	100%
*Hospital psychiatric/psychological servicies-	33.3%	26.7%	26.7%	6.7%	6.7%	100%
*Private psychological /advisory servicies-	40.0%	20.0%	-	-	40.0%	100%
*District physicians-	23.5%	23.5%	11.8%	17.6%	23.5%	100%
*Private ambulant practice-	50.0%	30.0%	10.0%	-	10.0%	100%

On average the evaluation concerning programs with short term permanence or drop in centers such as street programs, ambulant services, short permanence structures and so on follows the same trend for both TC and non-TC patients.

For those who have never been in TC the best quality services are provided by street programs and contact centers (LTS): 6 users out of 10 gave the maximum quality score to these two facilities. For the patients of therapeutic communities the best quality structures are the residential care structures (76.5% 5 points), street programs (64.7% 5 points), outpatient follow-up and sheltered accommodation and protection work. The satisfaction regarding “programs of methadone” and “asylum houses” (figure 5.6) is very negative for TC users (about 1.5 point averages) but is better for LTS users (up to 3 points). The above mentioned services had a positive evaluation by LTS users who have been also in TC, on average.

Speaking about psychiatric hospital and private psychological services, TC and LTS users follow the same trend in evaluation (around 2 points averages). Whereas LTS users who have been also in TC gave a worse evaluation of these two services (1 point average).

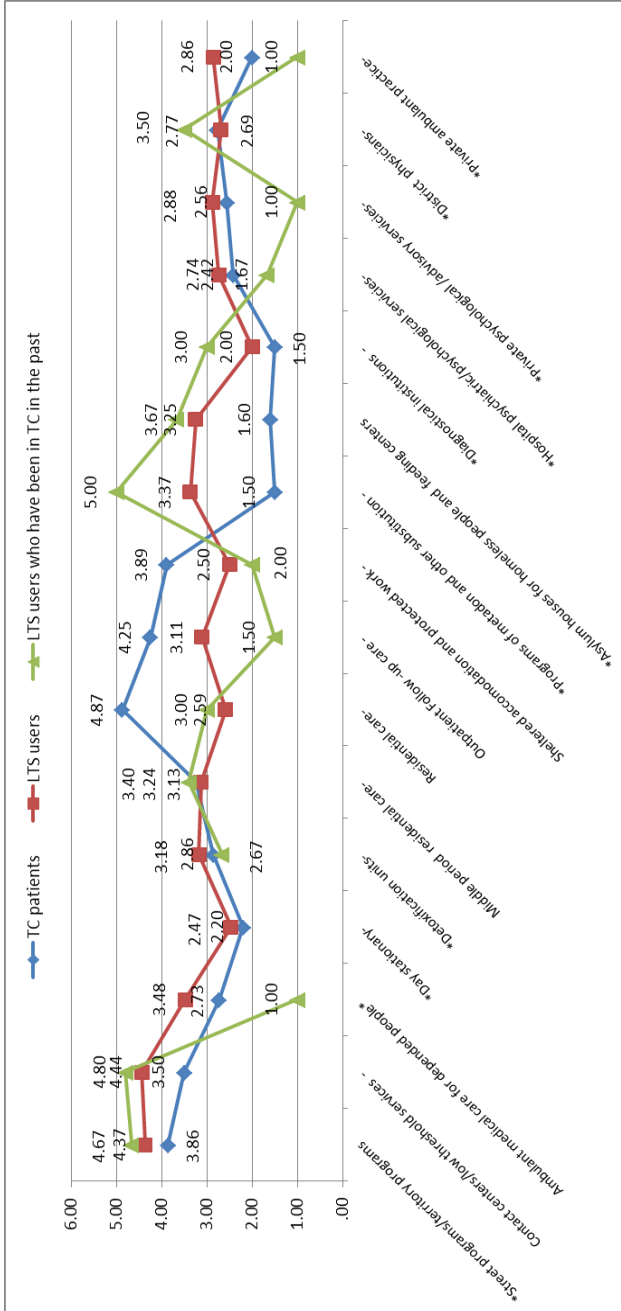
Ambulant services, outpatient follow-up care, private ambulant practices and private psychological centers are evaluated as bad by most LTS users who have been also in TC.

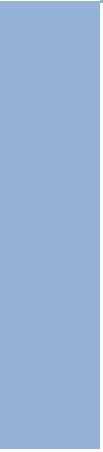
In conclusion, among those patients who have attended both LTS and TC structures, LTS services have been perceived in a more positive way compared to the feedback provided by attendees of solely TC services. On the contrary, the opinion of TC services by patients of both LTS and TC structures was more negative than by those who attended only TC services.

**Table 5.8. Evaluation of Institutes by non-TC patients [1= lowest rating \_ 5= highest rating]**

	Values					Total
	1	2	3	4	5	
*Street programs/territory programs	3.7%	1.2%	11.1%	22.2%	61.7%	100%
Contact centers/low threshold services -	3.1%	3.1%	9.3%	15.5%	69.1%	100%
Ambulant medical care for depended people*	9.7%	19.4%	19.4%	16.1%	35.5%	100%
*Day stationary-	40.0%	6.7%	26.7%	20.0%	6.7%	100%
*Detoxification units-	17.9%	14.3%	21.4%	25.0%	21.4%	100%
Middle period residential care-	21.7%	4.3%	39.1%	8.7%	26.1%	100%
Residential care-	41.2%	5.9%	23.5%	11.8%	17.6%	100%
Outpatient Follow -up care -	36.8%	10.5%	21.1%	-	31.6%	100%
Sheltered accomodation and protected work -	37.5%	18.8%	12.5%	18.8%	12.5%	100%
*Programs of metadon and other substitution -	15.8%	15.8%	21.1%	10.5%	36.8%	100%
*Asylum houses for homeless people and feeding centers	15.6%	6.3%	34.4%	25.0%	18.8%	100%
*Diagnostical institutions -	52.2%	13.0%	21.7%	8.7%	4.3%	100%
*Hospital psychiatric/psychological servicies-	22.6%	25.8%	22.6%	12.9%	16.1%	100%
*Private psychological /advisory servicies-	24.0%	20.0%	20.0%	16.0%	20.0%	100%
*District physicians-	31.4%	19.6%	15.7%	15.7%	17.6%	100%
*Private ambulant practice-	28.6%	14.3%	19.0%	19.0%	19.0%	100%

**Figure 5.6. mean average of the evaluations by TC patients, LT users and LT users been also in TC, regarding the quality of services [1= lowest rating \_ 5= highest rating]**







## APPENDIX 1 – Question 8: drugs used along three periods

During the first year of use - After three years of use - Last time  
Question 8 is the first multiple question of the questionnaire. It was asked which drugs have been used in three different periods and how much in each period.

The question aimed to investigate doses taken and tolerance.

*The descriptive analysis.*

Almost every respondent answered this question, but just around 2/3 of the respondents declared the daily doses for each period and for some drugs. The maximum number of respondents had been reached with the answer to the last time of use in the case of pervetin (70%).

The case of cannabis is quite interesting because the number of respondents decreases along the three periods (from 68% to 49%) and this confirms that cannabis is a drug for beginners and is less appreciated among intensive users of hard drugs. Pervetin increases 4 percentage points along the three periods.

- *A better description of tolerance.*

To give a better description of tolerance three new variables can be introduced.

Given X= doses used in the first year; Y= doses used in the third year; Z= most recent doses:

$(A1) = (Y-X)/X * 100$  measures if the consumption is increased or decreased between the first and the third year;

$(A2) = (Z-Y)/Y * 100$  measures if the consumption is increased or decreased between the third year and most recent use;

$(A3) = (Z-X)/X * 100$  measures if the consumption is increased or decreased between the first and most recent use.

The comparison between A1, A2, A3 is an attempt to gain a possible idea of the tolerance level induced by the use of each drug.

Cannabis seems to generate a low degree of tolerance or a greater possibility of being substituted; Pervetin and Heroin on the contrary, seem to generate a high degree of tolerance.



## APPENDIX 2 – Question 26: How many doses weekly sold?

Just 56 respondents reported to have sold drugs (38% on the sample) and it is assumed (but just for a statistical convenience) that non – respondents have never sold drugs; this assumption can be considered a good proxy of the real situation, therefore - in keeping with the methodology adopted for other countries - the “never-sold-drugs” comprise 62% of the sample.

The most common drugs sold by the respondents are: Pervetin (by 84% of the dealers); Heroin (by 12.5%); Cannabis (by 62.5%).

The other drugs are less available to our respondents: Ecstasy (by 5%); Cocaine and Crack (by 1.7%); LSD (by 9%).

In the following Table A2.1 doses and respective percentages of dealers of the main drugs are listed.

In the table A2.1, a very simple classification for dealers is proposed, in order to highlight how important the single dealer is within the market. The great majority of the respondents are small dealers.

**Table A2.1. Weekly doses sold by dealer respondents. 493 respondents**

		Pervetin		Cannabis		Heroin	
dealers	% on dealers population		84%		63%		12%
	% on sample population		32%		24%		5%
small dealers		doses	% dealers	doses	% dealers	doses	% dealers
		1	4%	1	3%	1	14%
		2	9%	2	9%	5	14%
		3	2%	5	6%	10	14%
		4	6%	8	3%	18	29%
		5	9%	9	3%	30	14%
		6	2%	10	11%		
		7	2%	15	11%		
		8	2%	17	3%		
		9	2%	20	9%		
		10	11%	30	6%		
		12	4%	40	6%		
		15	4%	45	3%		
		16	2%	50	3%		
		20	11%	95	9%		
		25	6%	100	6%		
		35	2%	105	3%		
		40	6%				
	<b>Sub-total</b>		<b>85%</b>		<b>71%</b>		<b>86%</b>
Street dealers		50	4%	50	8.6%	65	14%
		70	6%	95	2.9%		
		150	4%	100	5.7%		
				105	2.9%		
				150	2.9%		
	<b>Sub-total</b>		<b>15%</b>		<b>23%</b>		<b>14%</b>

		Pervetin		Cannabis		Heroin	
expert dealers				400	3%		
				10000	3%		
	<i>Subtotal</i>		<b>0%</b>		<b>6%</b>		<b>0%</b>

Specialization in the market is also another factor and poly dealing is described in Table A2.2.

**Table A2.2. Composition of the dealer market by number of substances sold. Frequencies of the respondents.**

Sold substances	Percentage
Never sold	62.16%
Only cannabis	2.70%
Only pervetin	10.14%
Only heroin	1.35%
Only other substances	0.68%
Cannabis and pervetin	10.81%
Cannabis and heroin	0.00%
Cannabis and other substances	0.68%
Pervetin and Heroin	0.68%
Pervetin and other substances	1.35%
Heroin and other substances	0%
Three or more substances	9.46%
Total	100.00%

### APPENDIX 3 – Question 38: The characteristics of users older than 25 years of age

This multiple question was the most complex, it was successful considering its position at the bottom of the questionnaire

At least 1 out of 3 of the respondents for this question (> 25 years old) answered all the details of this complex question.

Also for this question it was necessary to generate new variables for a simple description of the data.

<b>1 Civil status - parameters</b>	
Single 1	
Married /living together with a partner 2	
Divorced/widow 3	
NO ANSWER 5	
First position	Age of first use
Second	25 years old
Third	35
Fourth	Now

93% of the respondents are single at the age of first use; at the age of 25, 73% respondents are still single, while the married respondents reach the higher percentage of 24%; in the current status married respondents comprise only 13%, while 14% are divorced and 73% are still single.

#### 1 How do you live? And where?

The great majority of the respondents reported several changes during the four periods: just 15% of respondents in the first period were living alone, 56% were at a parents or relatives home; of the respondents around 25 years old only 11% were still living at parents or relatives home, though they didn't generally live alone (just 17%) but with a wife or partner (27%), friends (17%) or in other situations. Currently, 25% reported to be homeless, 19 % to be in a squat or in an hostel, 10% reported to live alone at home and 6% with parents; finally only 19 % with their wife or partner.

#### 2 Employment

Just 11% had always a full time job in every period. On the other hand 10.7 % had never worked across the four periods.

In the last period unemployed respondents were at 50%, at the beginning of drug use 32% and at around 25 years old only 23%.



## APPENDIX 4 – Main parameters of the sample

Age by gender	Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
Males	30.47	7.75	29	26	34	19	67
Females	27.21	6.36	25	23	32	13	49

First use by gender		Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
First use drugs	Males	14.88	2.61	14.5	13	17	10	21
	Females	14.58	1.77	15	13	16	12	18
First use hard drugs	Males	17.29	3.73	16	14.75	19.25	12	28
	Females	16.79	5.36	15	14	18	13	37
First time selling drugs	Males	18.94	4.40	18	15	21.25	13	30
	Females	19.16	5.18	19	15	21	14	37
Latency	Males	2.41	3.11	1	0	3.25	0	12
	Females	2.21	4.55	1	0	2	0	20

Prices	Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
Marijuana	7.2856	2.4976	8	4	10	4	10
Hashish	10.2856	1.7996	10	8	12	8	12
Cocaine	87.5712	32.1656	100	50	110	33	110
Eroine	78.2856	41.0312	90	50	92	23	150
Amphetamine	8.2856	3.3524	8	4	12	4	12
Pervetin	38	15.9584	40	40	40	6	60

Age at services first contact	Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
Street centers	22.47	12.69	19	17	23	12	45
Low threshold services	22.97	12.58	19	17	24.5	14	65
Therapeutic communities	22.18	6.33	20	18	26	14	37
Private detoxification centers	21.60	4.28	20	19	25	18	29







## PART 4

# Portuguese Survey

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Montenegro

Sampling design, data collection, data entry and analysis have been conducted by the Easy and Faster s.r.l. working group coordinated by Roberto Ricci and composed of: Francesco Fabi, Umberto Iallicco, Claudia Musella and Claudia Restelli.



# INTRODUCTION

## 1. Methodology of Sampling

The methodology of this research is based on a surveying unit composed by those who approached the socio-sanitary structures to confront their drug addiction. Essentially these structures are Low Threshold Services, Treatment Centers and Therapeutic Communities.

These patients can be divided into three groups:

*1. Users who entered the socio-sanitary system autonomously.* These individuals have usually gained an adequate consciousness of their condition. Drug addicts who were apparently stable and agreed to fill in questionnaires were selected by the Technical Teams. They include addicts without treatment, those starting treatment, those at a stable stage (taking methadone) and those undergoing a process of work and social reintegration.

These kind of users seem to be at the final stage of their addiction, but even if they have completed a therapeutic cycle, often they fall again into use and it is easy to meet people who come back several times to a "final" stage.

*2. The patients of LTS might only have the intention of avoiding a worsening of their situation and may not be truly determined to quit substance abuse.* They get in touch with these services only in order to "reduce the harm" inflicted by their addiction and/or to gain access to a drug substitute (methadone), or to get assistance and information. In any case, this is the first step towards a possible way out from the vicious cycle of dependence.

*3. Users who enter the health care structures as an alternative sentence to prison.* In the last case they do not have the same motivation that brings users into the rehabilitation process (conscious choice and willingness to be relieved from the pain of the critical phase). They are certainly addicts,

but the decision to look for help is determined by the intention of getting out of prison rather than the desire to start a rehabilitation process.

## 2. Typology of services

LTS are important as a first contact and as support for the drug addict. They are structures for people who don't want to enter in a residential therapeutic center and you can meet young beginners and old users. Most of time the patients of these facilities are still using. LTS are services aiming to provide material for reducing the risks associated with consumption and seeking to meet basic needs, as well as to motivate addicts for treatment in health and social services, including treatment units. They also provide basic health care and snacks, provision of basic hygiene and needle exchange, access to low-threshold programs through methadone, infectious diseases screening and psychosocial support that allows an effective approach to treatment facilities.

The main structures who provide these services are the “risk and harm reduction teams” and the “mobile units” (Article 42º, Dec-lei nº183/2001 de 21 de Junho).

The main goals of these structures are:

- the reduction of heroin use through methadone to be dispensed through outreach programs, without demanding immediate withdrawal and in adequate facilities for this purpose;
- the increase and regularity of consumer contacts with professionals from a social-health team which may contribute towards future abstinence.

If the LTS seem to be specialized in a first phase of treatment, the therapeutic communities seem to be specialized in the final phase, but it is so common that a patient falls again into use that sometimes, also in the case of a residential patient of a TC, the final rehab is never completely reached.

*Therapeutic communities* (TC) are drug-free environments distinguished by a residential long-term approach and they are designed to ensure a response to addicts requiring prolonged inpatient care, with psychotherapeutic support under psychiatric supervision concerning, namely, the creation of conditions for social reintegration.

*Treatment services (TrC)* are non-residential structures designed to ensure comprehensive and global care to drug users, individually or in a social group, namely family, following the most appropriate therapy for each situation through ambulatory care.

Between TrC and Tc there are *Drug Detoxification Units* usually residential for no more than 9 days.

The Drug detoxification units are intended to ensure the treatment of deprivation syndromes in addicts, under medical responsibility through inpatient care.

### 3. Care phases

The treatment plan offered by the three types of services can be articulated into four main steps:

1. First contact
2. Detoxification
3. Psychological treatment
4. Social reintegration

These steps can be processed either in residential and non-residential programs. 'First contact' is more usual in LTS.

Usually the first step consists in drug treatment (detoxification) which is considered to be the beginning of the treatment path. During detoxification, substitutive drugs dispensation is applied, with a consequent diminution in discomfort. In Portugal there are specific units to carry on this phase (Taipas Unit)

Psychological treatment aims to give solid instruments to avoid using drugs again. This last step consists of social reintegration, which could be provided by therapeutic communities or by other specific structures. Here patients are supported through work and social rehabilitation.

### 4. Sample structure.

The geographical area in which the survey was carried out is limited to the Region of Lisbon-Lisboa e Vale do Tejo. The targeted number of actual interviews was 381. Users were contacted through the private and public-social organizations that provide services for drug addicts. Eight organizations were contacted.

They can be divided into five different typologies of structures (all related to the three categories of services: LTS, TC and TrC):

1. Therapeutic communities with the highest number of residents

2. Public Treatment Units of the Institute for Drugs and Drug Addiction
3. Specific Drug detoxification centers - Public Service (Taipas Unit)
4. Street work – Private Risk and Harm reduction units (LTS)
5. Structures to support addicts (Risk and Harm Reduction) – addicts in drug treatment and in labor and social reintegration

**Users Distribution inside the three types of structures**

<b>Users distribution in each kind of structure (Portugal)</b>			
<b>LTS</b>	<b>TC</b>	<b>TrC</b>	<b>Total</b>
<b>83</b>	<b>124</b>	<b>174</b>	<b>381</b>

# CHAPTER 1

## Characteristics of User

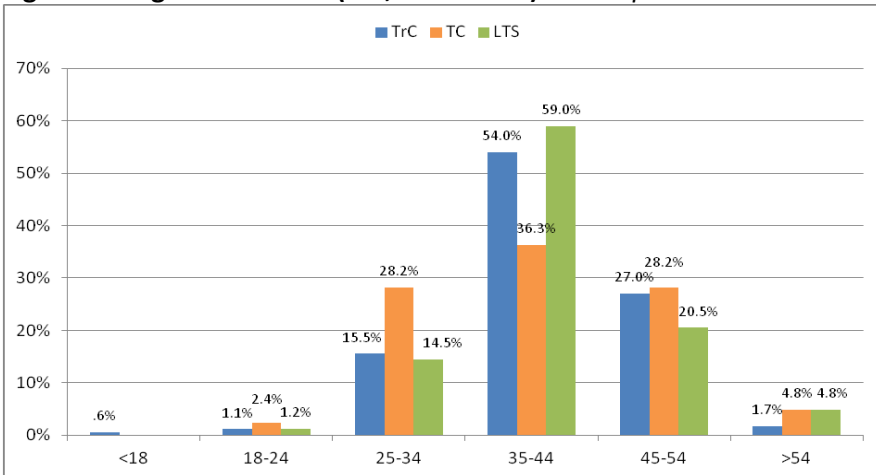
### 1.1. Age, gender and first use

Table 1.1. shows the proportion of male and female respondents in the sample. The majority are male (80.8%). Females are less represented among LTSs (12.2 %) and more represented (23.6%) among TrCs.

**Table 1.1. gender distribution (TrC, LTS and TC) 380 respondents**

	Low Threshold	Therapeutic Communities	Treatment center	Total
Female	12.2%	17.7%	23.6%	19.2%
Male	87.8%	82.3%	76.4%	80.8%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

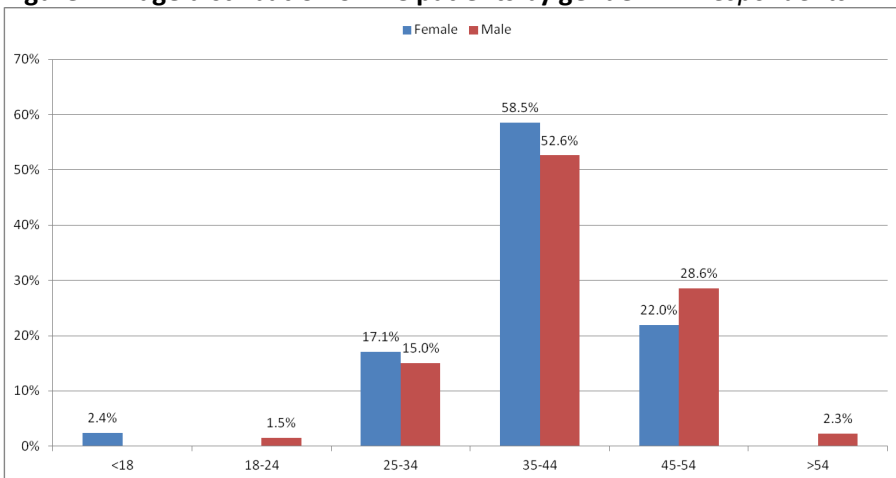
**Figure 1.1. age distribution (TrC, TC and LTS) 381 respondents.**



The age of patients in this sample is around 40 years old (Appendix 4); LTS and TC are frequented by older users than the TrC (Figure 1.1). The respondents aged 35 - 44 are the main users of all of the three kinds of services. They comprise 59% out of the whole population of low threshold service users, 54% out of the whole population of Treatment Centers users, and 36.3% of TC service users.

Looking at the general distribution, patients of therapeutic community services are a little bit younger than patients of LTS and TrC.

**Figure 1.2. age distribution of TrC patients by gender 174 respondents**

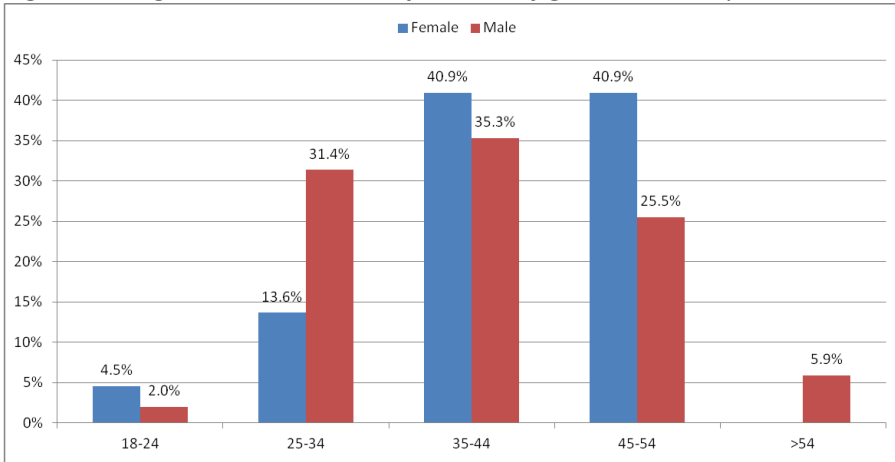


The age distribution is almost the same for men and women ( Figure 1.2). Most men approaching TrC are between 35 and 44 years old (52.6%). This class is followed by the age class 45 - 54 (28.6 %) and the age class 25 – 34 (15%).

The modal value is always in the class between 35 and 44 (58.5% for women, followed by 22% of subjects aged between 45 and 54 and by 17.1% of younger women aged 25-34. There is a notable presence (2.4%) in TrC of women younger than 18. On the opposite curve women older than 54 in TrC services are not present, whereas for men this age cohort comprises 2.3% of the total.

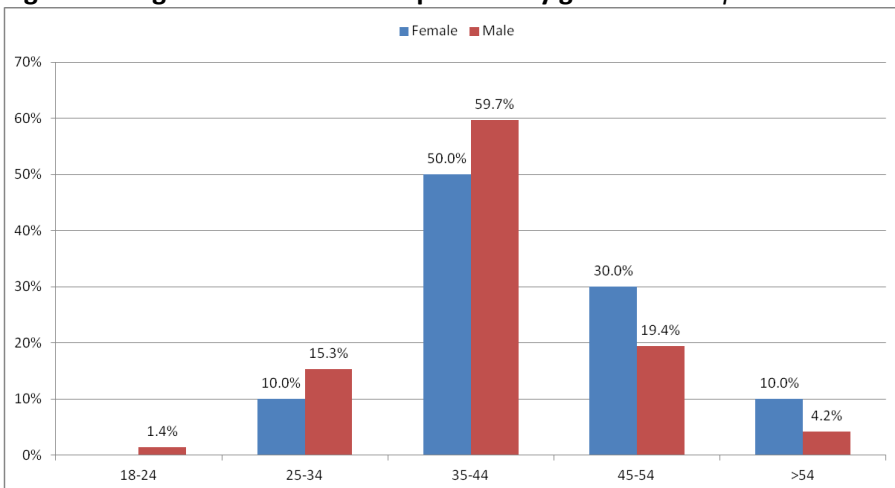


**Figure 1.3. age distribution of TC patients by gender 124 respondents**



Regarding the distribution of therapeutic community users ( Figure 1.3), women are older than men: the modal value coincides at the age group 35-44 and 45-54 years old (40.9% in each age group) while for men the modal value is lower only in the age group 35-44 (35.3%).

**Figure 1.4. age distribution of LTS patients by gender 82 respondents**

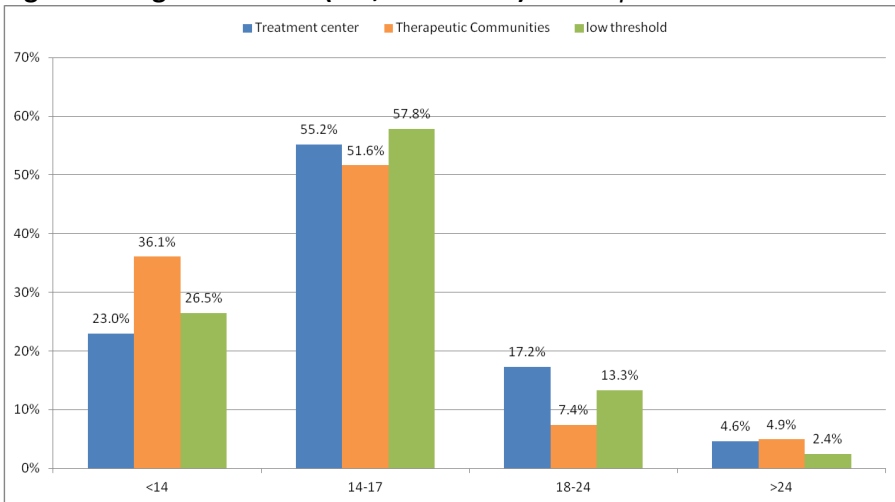


Concerning the distribution of LTS users (Figure 1.4) the modal value is the age group 35-44 years old for both genders and the two distributions don't show great dissimilarities, but women older than 45 years old have a higher rate (40%) than the corresponding male cohort (23.6%).

First use (Figure 1.5) is widespread in the age group 14 - 17 for all the users: TrC (55.2 %), TC (51.6%) and LTS users (57.8 %).

The second biggest age group concerns users less than 14 years old. TrC and LTS are almost at the same level (23 % and 26.5 %) while for TC 36.1% of users started at this age; moreover (Figure 1.5) the older beginners (>17) seem to prefer TrC to LTS and TC.

**Figure 1.5. age at first use (TrC, LTS and TC) 379 respondents**



**Table 1.2. first drug experimented with (TrC, TC and LTS) 379 respondents.**

	Treatment center	Therapeutic Communities	Low Threshold	Total
Tranquilizers/sedatives (without medical prescription)	4.6%	4.8%	2.4%	4.2%
Amphetamines	2.9%	3.2%	-	2.4%
Ecstasy (MDMA. XTC. etc...)	4.0%	2.4%	-	2.6%
Cannabis (marijuana. hash. ganja)	78.2%	75.8%	77.1%	77.2%
Crack	0.6%	0.8%	-	0.5%
Cocaine	2.9%	2.4%	4.8%	3.1%
Heroin	4.6%	4.8%	12.0%	6.3%
Another drug	2.3%	5.6%	3.6%	3.7%
Total	100.0%	100.0%	100.0%	100.0%

For all groups of users (Table 1.2.) cannabis was the most usual choice at first contact with illicit drugs. Almost 8 out of 10 users (77.2%) started with this type of illicit drug (78.2% in TrC, 75.8 in TC and 77.1% in LTS).

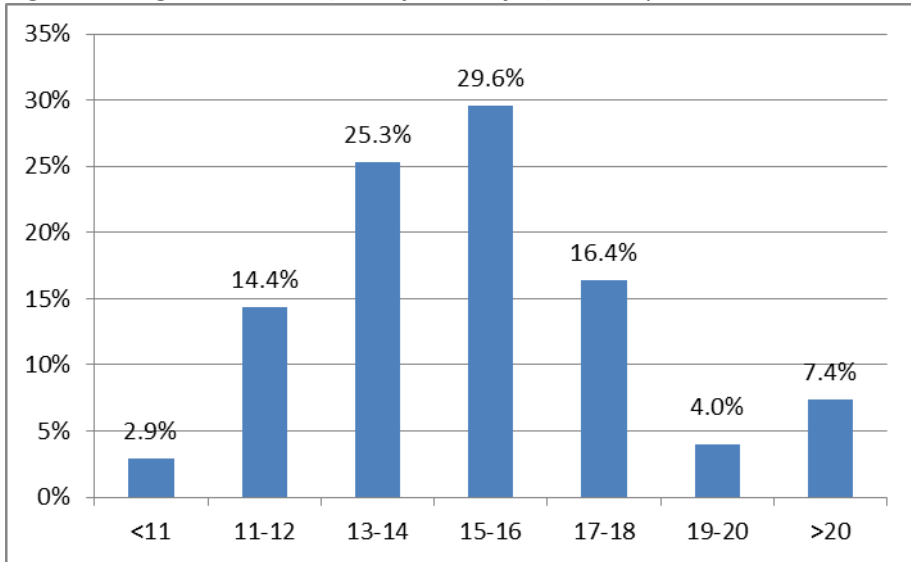
The second most popular drug is Heroin (6.3% average value between TrC, LTS and TC patients) especially by LTS users (12%), followed by tranquillizers and sedatives taken without medical prescription. Cocaine use was reported by 4.8% of LTS patients, and only by 2.9% and 2.4% of patients in TrC and TC.

Negligible rates regarding other drugs on the list: ecstasy is noteworthy, specifically 4% of TrC users and 2.4% of TC residents have used this type of substance when they first used an illicit drug.

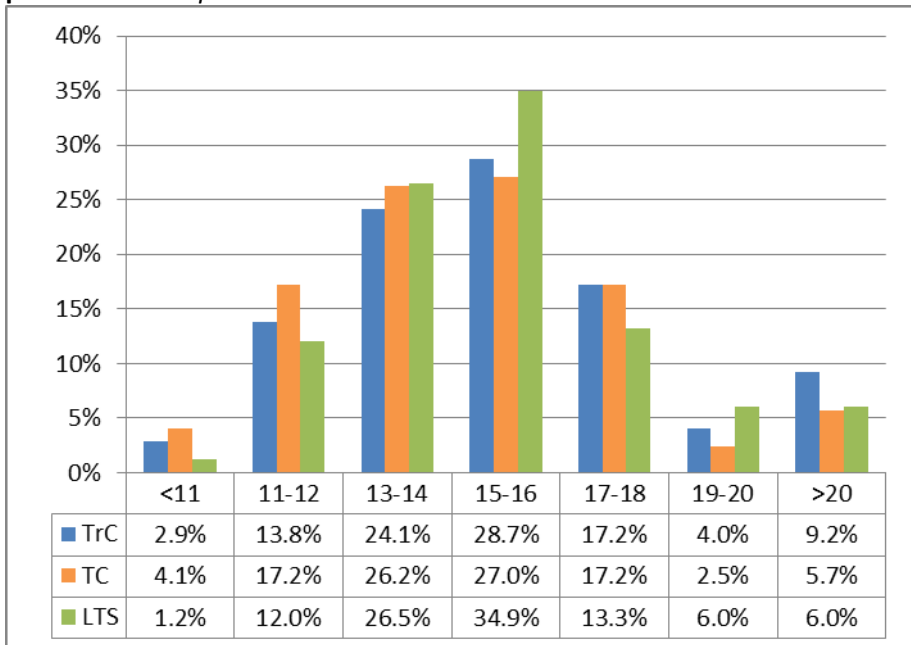
## 1.2. First contact with the drug

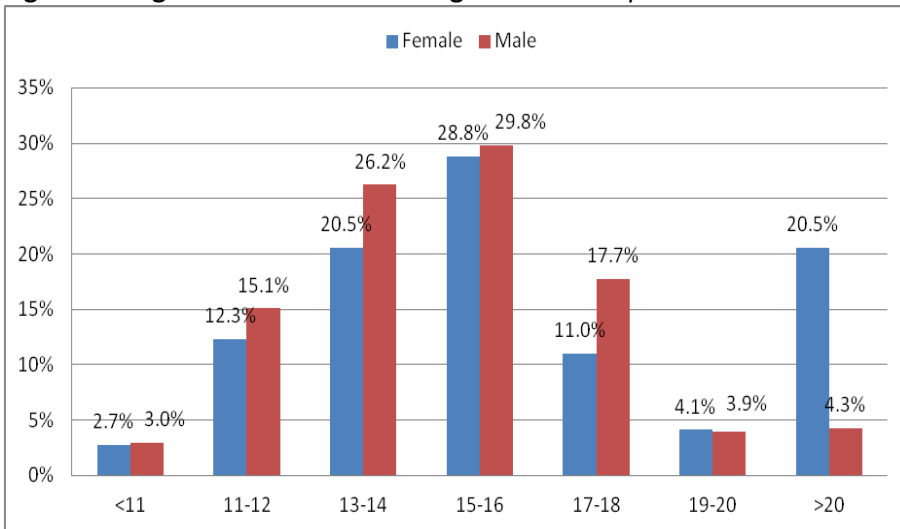
This section will attempt to provide some further information on the question of age of drug use initiation, and we start with a more detailed distribution of age (Figure 1.6, 1.7, 1.8).

**Figure 1.6. age at first use (a deeper analysis) 379 respondents**



**Figure 1.7. age at first use among TrC patient, LTS patients and TC patients 379 respondents**



**Figure 1.8. age at first use related to gender 378 respondents**

An absolute exception to the common rule can be seen where females are prevalent over male users (20.5% and 4.3% respectively) among beginners over 20 years of age.

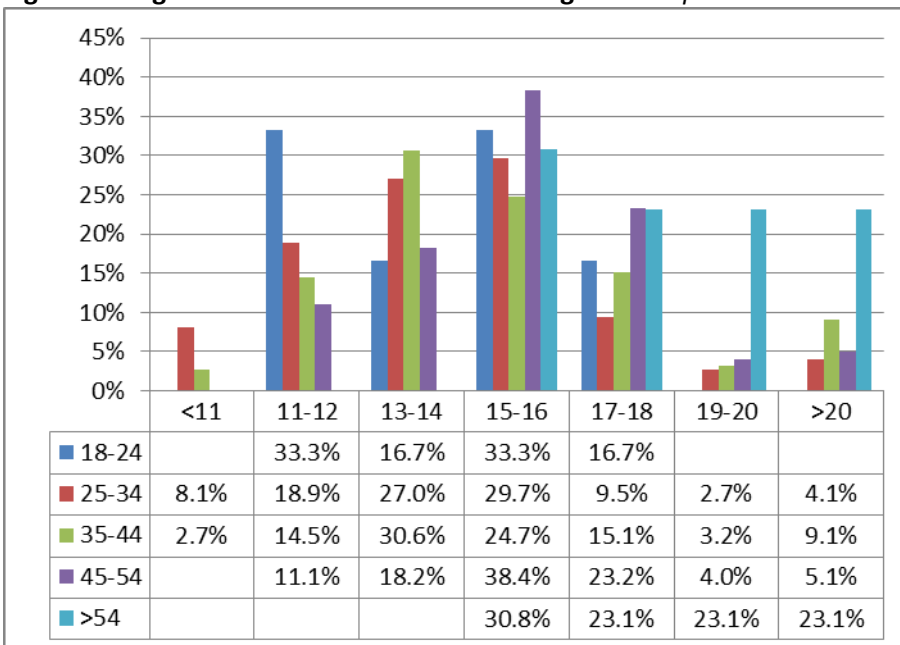
**Figure 1.9. age at first use related to current age 379 respondents**

Figure 1.9 confirms that no particular differences can be found among patients of different ages, but an increasing percentage of earlier first users is evident in the distribution of the age group 18 – 24 years old in comparison with the distributions for other groups. Around 33.3% in the age group 18 – 24 started at age 11 – 12 years old and a bit less than 17% in the age group 13 – 14 years old.

Relevant percentages of earlier first users are found also in the distribution of the age group 25-34; around 8% in the age group 25-34 started before 10 years old, around 19% in the period 11-12 years old and 27% started with drug at the age of 13-14.

**Figure 1.10. latency period of the changeover from soft drug to hard drug use (cocaine, heroin, LSD, ecstasy ...) 349 respondents**

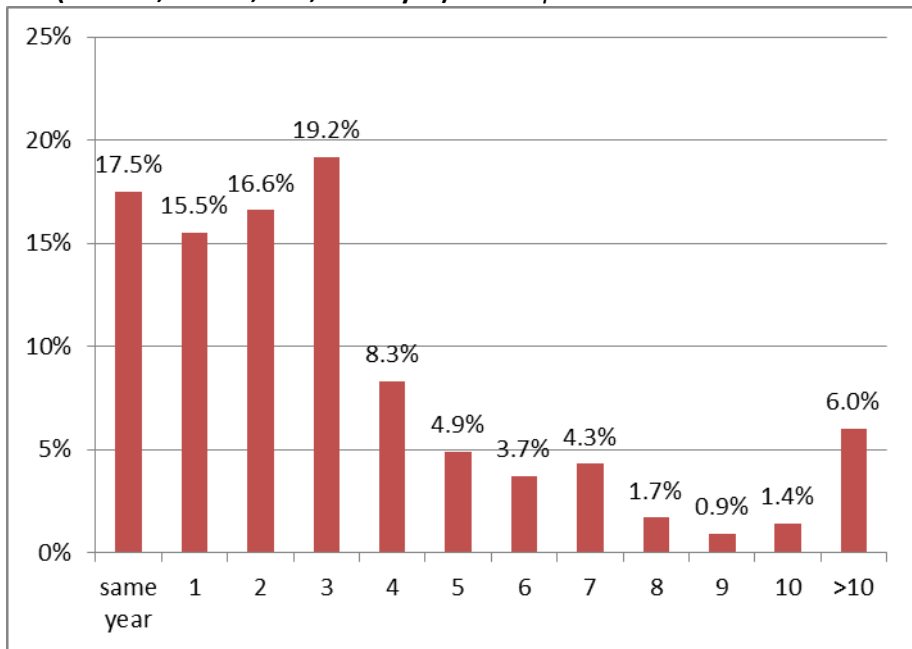


Figure 1.10 shows the latent period elapsed between the first use of soft drugs and the first use of hard drugs. Most patients tried hard drugs when 3 years had passed since their first use of an illicit drug: the modal value corresponds to “3” with 19.2 % of respondents conforming to this figure. Right after this type of user there are patients who tried heavy drugs the same year as they first tried an illicit drug (17.5%). From between 1 and 2 years from the first use of an illicit drug around 32 % of respondents have switched to hard drugs.

The latency of the switchover to hard drugs is influenced by the age in which users have experimented with these drugs. Most patients who tried drugs later (19-25) tended to change to heavy drugs in the same year that they first tried an illicit drug (Table 1.3.). 68% of users who tried drugs after the age of 20 and 22.5% who tried drugs when they were 19-20 years old, tend to changeover to hard drugs during the year of their first consumption of illegal drugs. This last category of users presents the same rate (22.5%) also among those who changed to hard drug use after 4 years. Again from Table 1.3. those who take their first illicit drug at about 11-14 years old pass to hard drugs after between 1 and 4 years.

As the age in which users first experimented with drug increases, latency rates decrease. The only one nonconforming case is those starting with drugs around 13-14 years old. In fact a considerable percentage of these users (14.5%) change over to hard drugs in the same years of first use.

To be noted, in Table 1.3., we see a small number of people starting drug use before they are 10 years old. They make up 2.9% of the whole sample, so an analysis of these respondents has no relevant weight.

**Table 1.3. age at Initiation of Drug use related to latency period of the changeover to heavy drug 349 respondents**

		Age of the first drug consumption							Total
		<11	11-12	13-14	15-16	17-18	19-20	>20	
Latency	same year	0.6%	1.4%	3.7%	2.9%	3.2%	0.9%	4.9%	17.5%
	after 1 year		1.7%	4.6%	5.2%	2.9%		1.1%	15.5%
	after 2 years		3.4%	5.4%	6.0%	0.6%	0.6%	0.6%	16.6%
	after 3 years	0.6%	4.0%	5.7%	5.7%	2.9%	0.3%		19.2%
	after 4 years	0.3%	1.7%	2.0%	1.4%	2.0%	0.9%		8.3%
	after 5 years	0.3%	0.3%	0.3%	1.4%	2.0%	0.6%		4.9%
	after 6 years	0.6%	1.1%	0.9%	0.9%	0.3%			3.7%

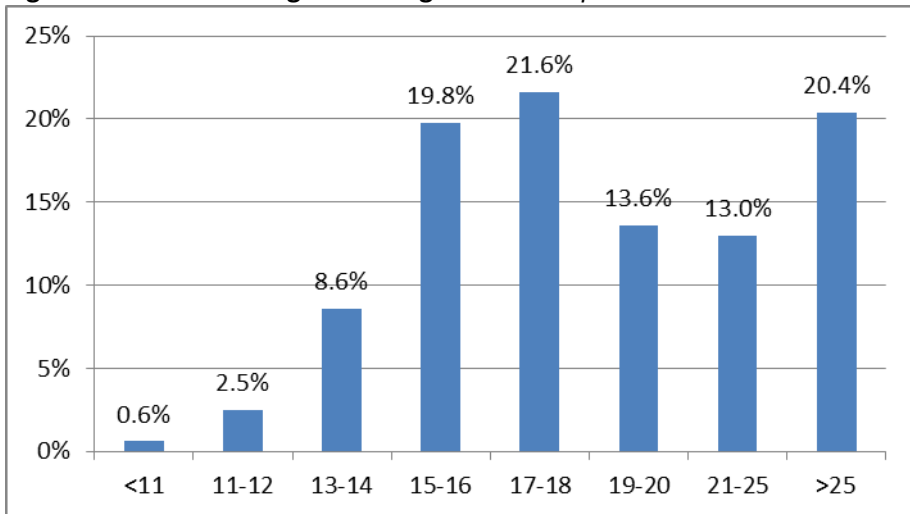
		Age of the first drug consumption							Total
		<11	11-12	13-14	15-16	17-18	19-20	>20	
	after 7 years		1.4%	0.6%	1.1%	0.6%	0.6%		4.3%
	after 8 years			0.9%	0.6%		0.3%		1.7%
	after 9 years	0.3%			0.3%	0.3%			0.9%
	after 10 years and over			1.4%	3.4%	2.0%		0.6%	7.4%
Total		2.6%	15.2%	25.5%	28.9%	16.6%	4.0%	7.2%	100.0%

### 1.3. age of first drug sale

The age of the first illegal drug sale is another important characteristic to be analyzed (Figure 1.11), the modal value is at the age 17-18 (21.6%) followed by those above 25 (20.4%) and the age group 15-16.

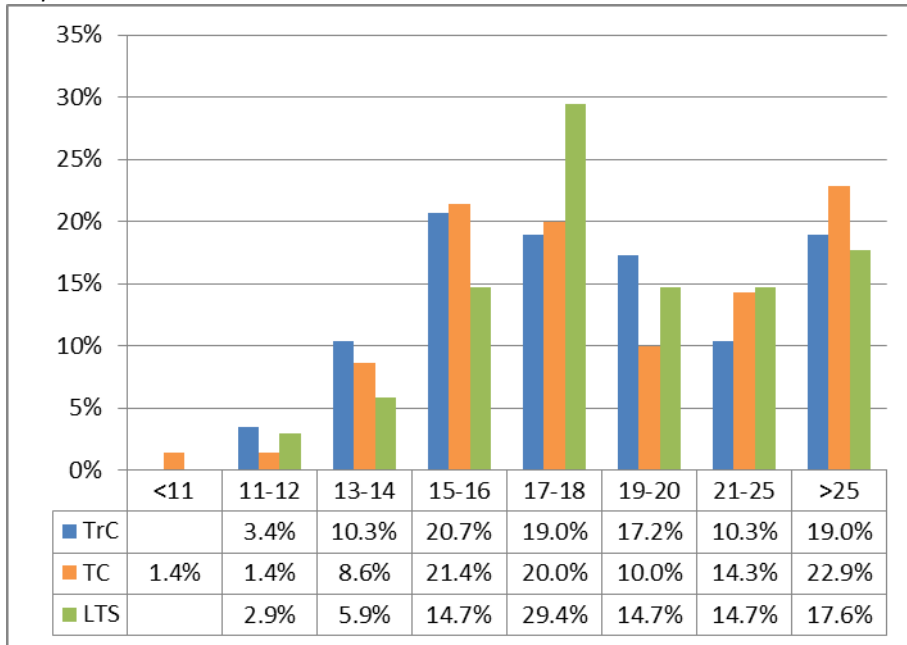
47% of respondents started to sell after 19 years old and 11.7% before they were 14 years old.

**Figure 1.11. initiation age into drug sale 162 respondents**





**Figure 1.12. initiation age into drug sale (TrC, LTS and TC). 162 respondents**



Patients of Treatment Centers started selling drugs at a younger age than patients of low threshold services and Therapeutic Communities. The higher rate is in the age group 15 – 16. Patients of TC started selling drugs older than patients of LTS: higher rates are recorded in the age group >25 and the 17-18 years groups respectively. Regarding gender the modal value is in the class of those older than 25 for female respondents and in the 17-18 years group for male respondents.

Women seem to start selling drugs at a very early age while men have a tendency to start selling drugs around 15-18 years old.

**Figure 1.13. initiation age into drug sale by gender 162 respondents**

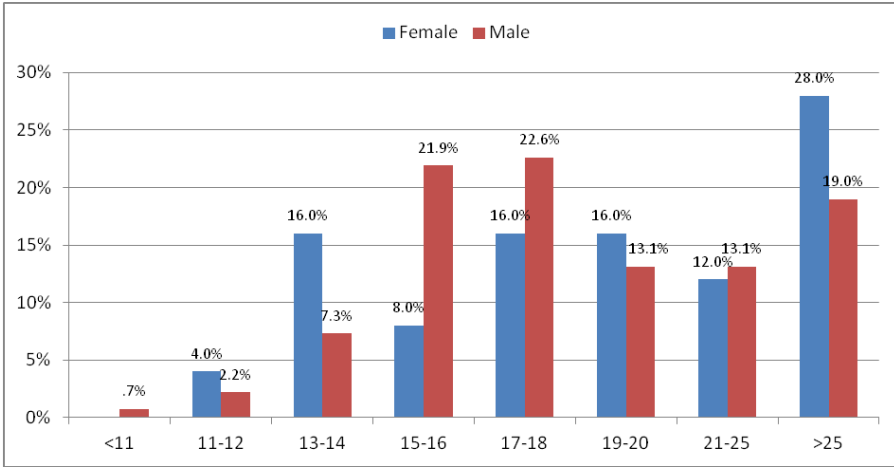
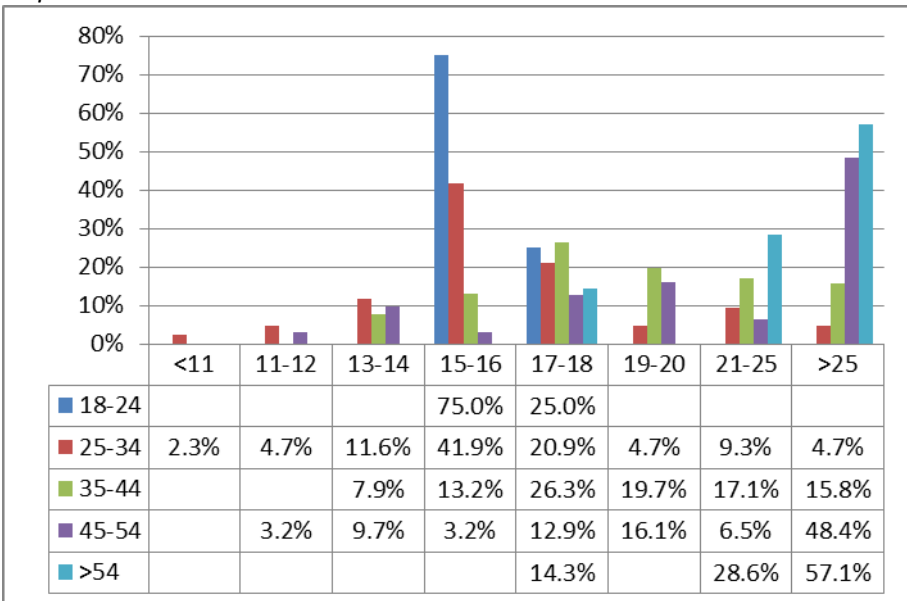


Figure 1.14 shows that patients aged 18 – 24 and 25-34 years old had started selling drugs at a younger age. On the contrary almost all the patients over 54 started dealing after 21 years old.

**Figure 1.14. initiation age into drug dealing related to current age 162 respondents**



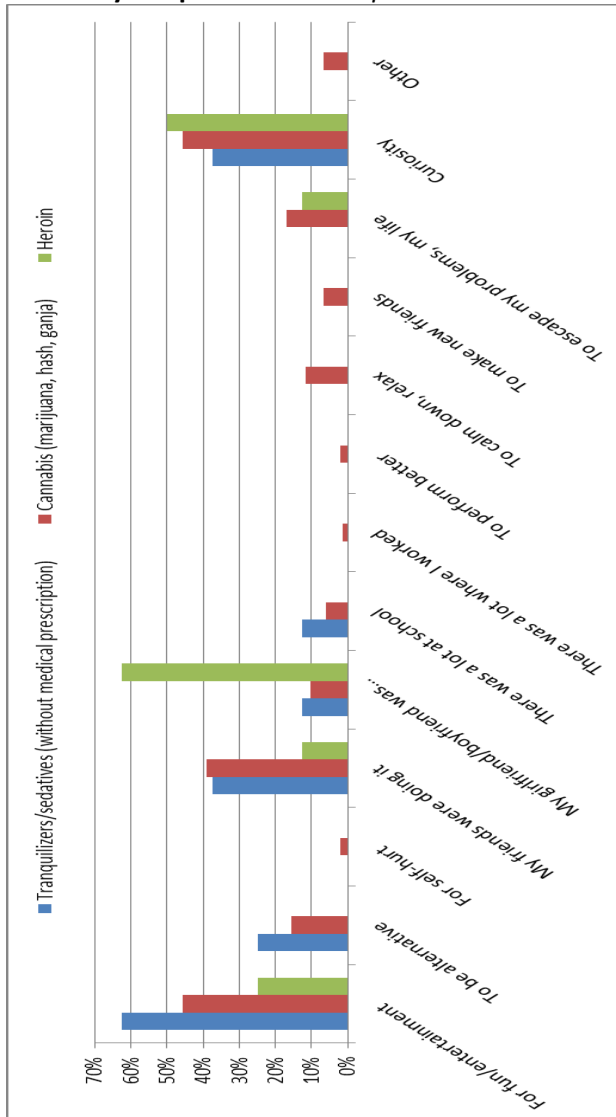
**Table 1.4. initiation age into drug sale related to latency period of the changeover to heavy drug (joint distribution) 158 respondents.**

		Age of first drug sale								Total
		<11	11-12	13-14	15-16	17-18	19-20	21-25	>25	
Latency	same year	0.6%	0.6%	3.2%		1.3%	1.3%	0.6%	4.4%	12.0%
	after 1 year		0.6%	0.6%	3.2%	5.1%	0.6%	3.2%	3.2%	16.5%
	after 2 years			3.2%	7.0%	10.1%	2.5%	0.6%	1.3%	24.7%
	after 3 years		0.6%	1.3%	5.7%	3.8%	4.4%	2.5%	1.9%	20.3%
	after 4 years			0.6%		0.6%	1.3%	1.9%	0.6%	5.1%
	after 5 years				1.3%	0.6%	0.6%	0.6%	2.5%	5.7%
	after 6 years				0.6%		1.9%	1.9%	0.6%	5.1%
	after 7 years				1.3%			0.6%	0.6%	2.5%
	after 8 years							0.6%		0.6%
	after 9 years		0.6%				0.6%			1.3%
	after 10 years and over						0.6%	0.6%	5.1%	6.3%
Total		0.6%	2.5%	8.9%	19.0%	21.5%	13.9%	13.3%	20.3%	100.0%

## 1.4. Motivation for First Drug Use

Respondents of this survey have been asked to choose 3 among 13 proposed motivations. The results are directly reported in relation to the main drugs used for the first time (Figure 1.16, 1.17 and 1.18).

**Figure 1.16. motivations for starting drug use related to drug experimented with by TrC patients 174 respondents**



Figures 1.16 1.17 and 1.18 show respectively the motivations of TrC, TC and of LTS patients. Everybody cited “positive” or recreational motivations: fun, curiosity and so on. But some differences emerge in the case of tranquillizers and sedatives.

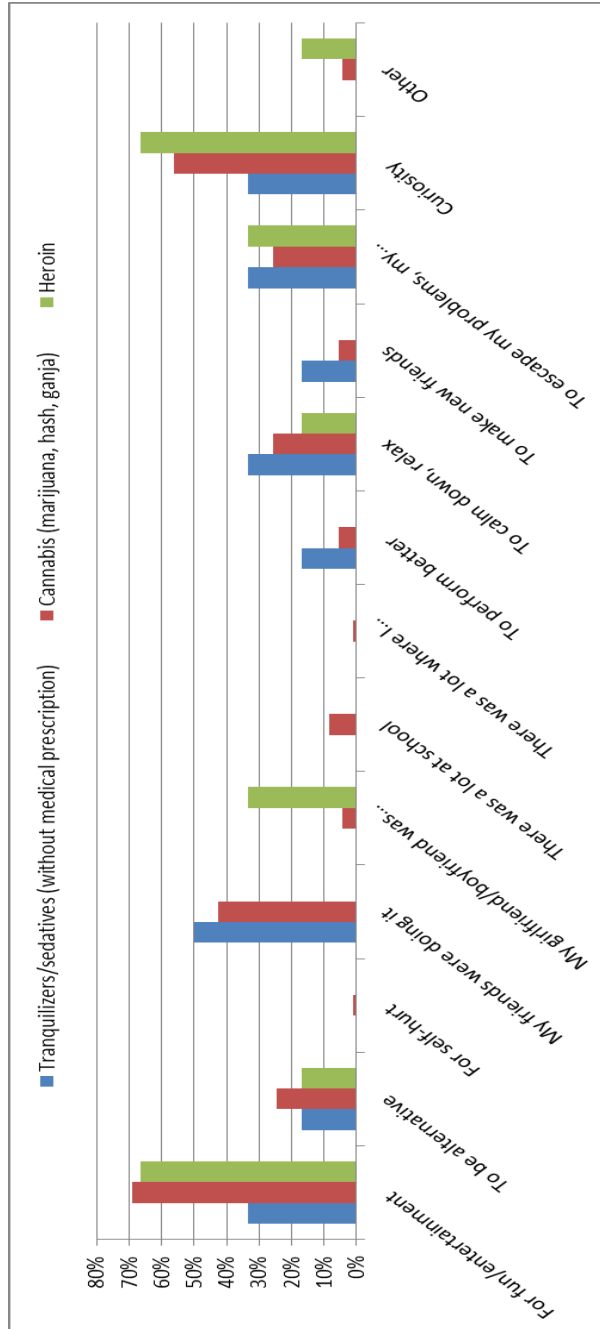
Consumers who started with cannabis have reported as the three main motivations fun, curiosity and emulation of friends across all of the three services.

Escaping life’s problem as a reason for first using cannabis was reported by 16.9% of TrC, 25,5% of TC and 12.5 of LTS users. The intent to calm down and relax as a motivation for first use is also noteworthy. 11.8% of TrC residents, 25.5% of TC patients and 18.8% of LTS users admitted this was a crucial influence.

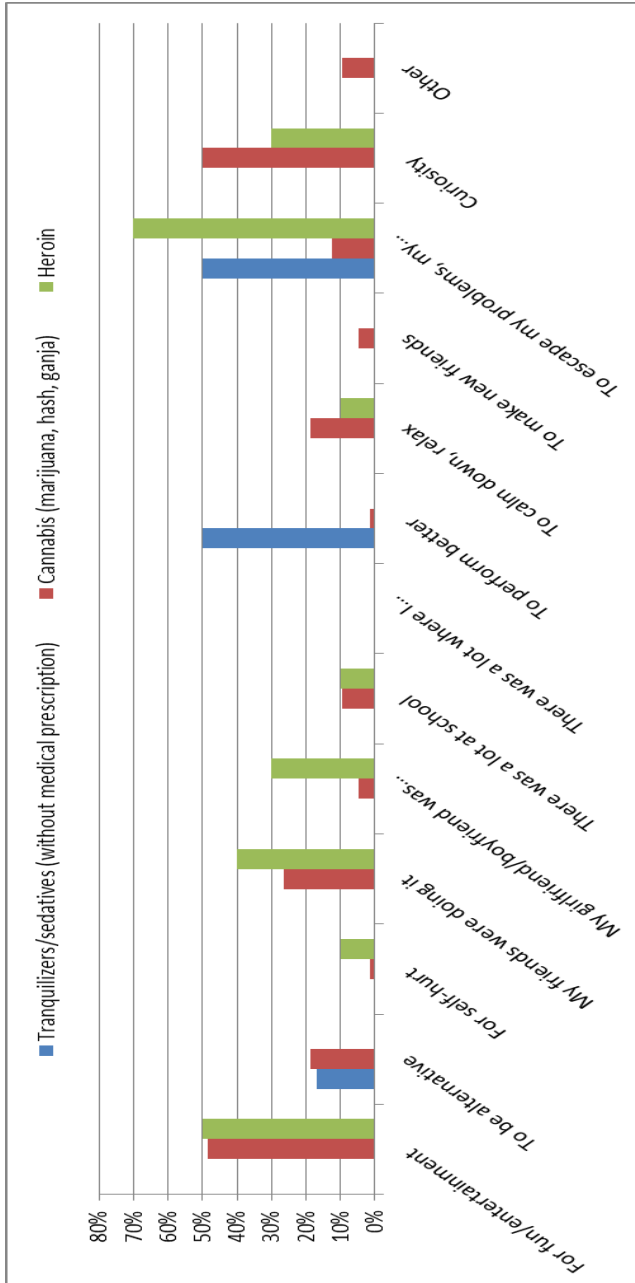
Regarding the distribution of heroin consumers, the three main reasons given by TrC users for first use are emulation of a partner (62.2%), curiosity (50%) and entertainment (25%).

66.7% of TC users said they started using heroin for entertainment purposes and out of curiosity while the desire to emulate their partner ranks second among TC users (33.3%), equal to the desire to escape life’s problems (33.3%). Consumers from LTS who started with heroin tried it mainly to escape life’s problems (70%), with entertainment purposes at 50% and ‘because their friends were already doing it’ at 40%. Emulation of a partner and curiosity (30%) are also notable motivations for users of LTS.

**Figure 1.17. motivations for starting Drug use related to the kind of drug experimented with by TC patients 124 respondents**



**Figure 1.18. motivations orf starting drug use related to the kind of drug experimented with by LTS patients 83 respondents**



The distribution of tranquillizer and sedative users diverges from TrC and TC to LTS users.

In TrC and TC, the majority of respondents assign relevance to entertainment purposes (62.5% TrC and 33.3% TC), curiosity (37.5% TrC and 33.3% TC) and emulation of friends (37.5% TrC and 50% TC). 25% of tranquillizer users in TrC tried drugs with the purpose of 'being alternative' while 29.2% of TC tranquillizers and sedatives consumers took it to calm down and relax.

In the case of LTS, the distribution of tranquillizer and sedatives users is spread among 3 classes of motivation: Escape life problems (50%), perform better (50%) and the purpose of being alternative (16.75%).



# CHAPTER 2

## Lifestyle:

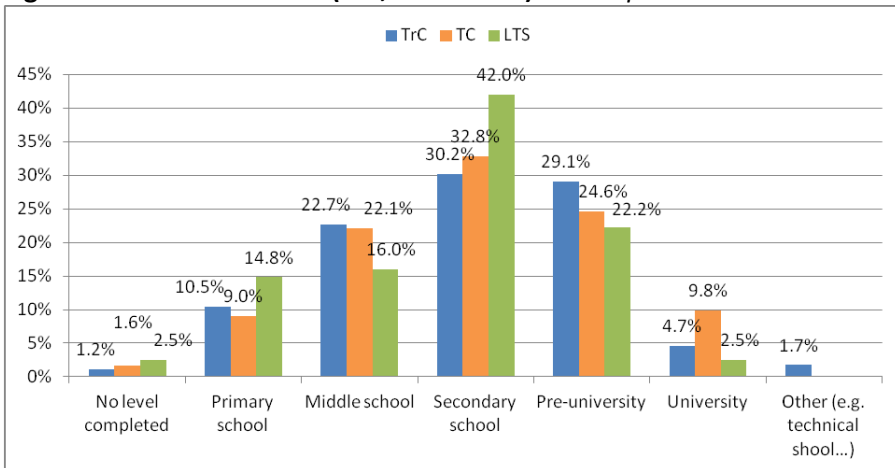
### Education, Work and Contacts with Prison

#### 2.1. Education Level of Users

**Table 2.1. educational level 375 respondents**

Education level							Total
No level	Primary school (1 <sup>o</sup> - 4 <sup>o</sup> )	Middle school (5 <sup>o</sup> - 6 <sup>o</sup> )	First Secondary (7 <sup>o</sup> - 9 <sup>o</sup> )	Second Secondary Pre - Univesity (10 <sup>o</sup> - 12 <sup>o</sup> )	University	Other	
1.6%	10.9%	21.1%	33.6%	26.1%	5.9%	0.8%	100.0%

**Figure 2.1. education level (TrC, LTS and TC) 375 respondents**



Higher proportions of secondary school graduates were reported from across all the three services (42% in LTS, 32.8 in TC and 30.2% in TrC). In fact “secondary school” is the modal value for LTS, TrC and TC users.

The second biggest education level group is pre-university, reached mostly by TrC users (29.1%), followed by TC (24.6%) and LTS (22.2%).

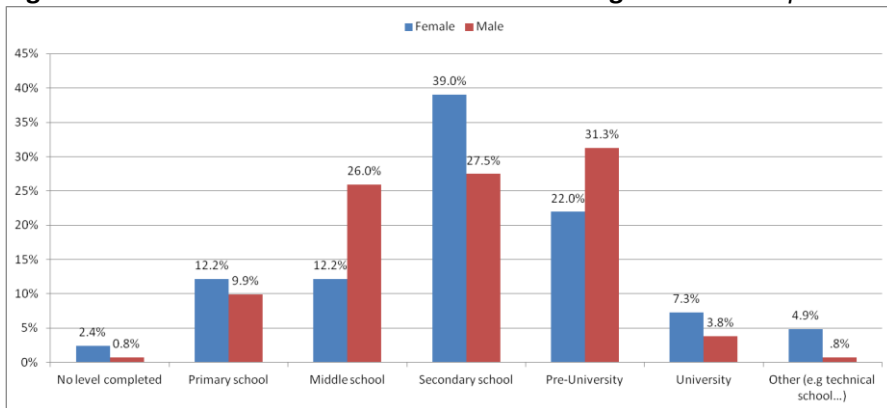
The most qualified users are those patients of TC: 67.2% of them have a certificate higher than secondary school and they are the most likely to have obtained a university degree (9.8% vs 4.7% in TrC and 2.5% in LTS). On the contrary LTS users are the least qualified with a higher percentage among those with no level obtained and those who have a primary school diploma as their highest level of education achieved.

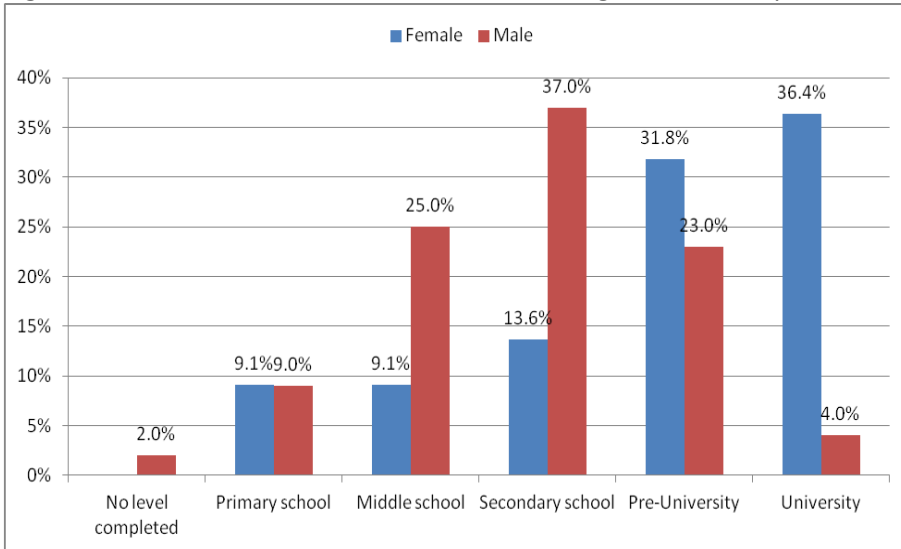
Among TrC patients, 39% of female vs 27.5% of male patients have a secondary school diploma. Men are prevalent among those with a pre-university level education (31.3%) and those with a middle school diploma (26%).

A primary school diploma was reported mostly by women (12.2%) and less by men (9.9%). A smaller percentage of men attended university, 3.8% versus the female rate of 7.3%.

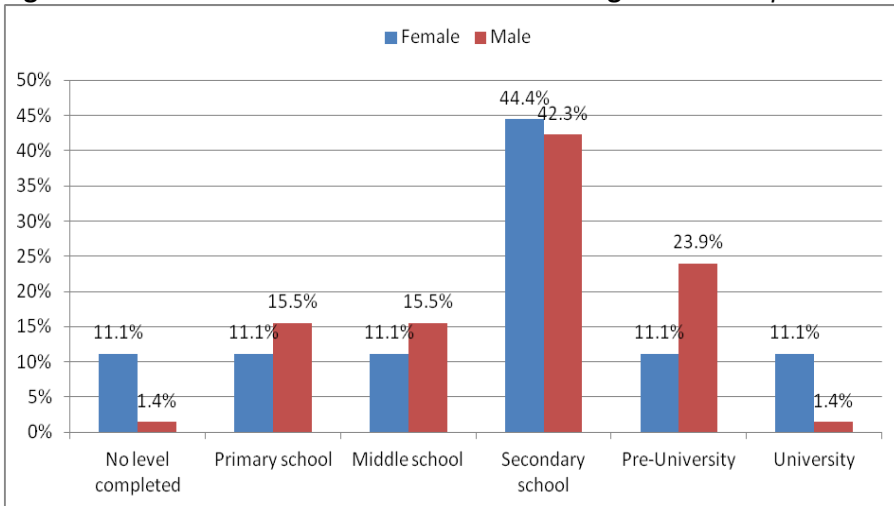
It is interesting to notice how among those who don't have any educational qualification women number 0.8%, whereas men number 2.4%.

**Figure 2.2. education level of TrC users related to gender 172 respondents**



**Figure 2.3. education level of TC users related to gender 122 respondents**

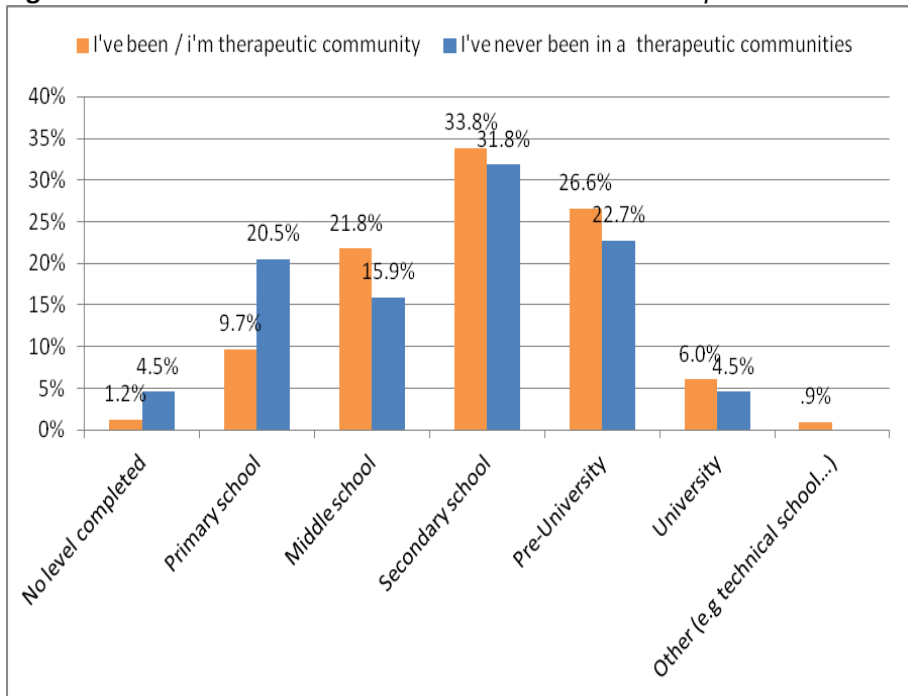
In TC females seem to be more educated than men with higher rates in the educational groups “university” (36.4%) and “pre-university” (31.8%). Men are prevalent among those who obtained a middle school and a secondary school diploma. Women are not represented at all in the educational group “no level” whereas men are, at 2%.

**Figure 2.4. education level of LTS users related to gender 80 respondents**

Women In LTS have their most frequent value (44.4%) in the education level “secondary school”. Other rates are fairly evenly spread among the other 5 educational categories (11.1%). Men are mostly secondary school educated (42.3%). 23.9% of them reached the pre-university level while 15.5% reported a primary school diploma and a middle school education. Men with a university degree and with no level are few with respect to women (1.4%).

In conclusion women in TC seem more qualified than men. In contrast men in LTS and TrC seem more qualified than women.

**Figure 2.5. education level of TC and non-TC users 375 respondents**



Generally those who have been in a TC have higher qualifications than “never been in TC” (Figure 2.5): 33.8% reached secondary school level, whilst 26.6% obtained a pre-university diploma and 6% had graduated.

**Table 2.2. education level related to arrest history (joint distribution) 373 respondents**

		Arrested				Total
		Never	Yes. for dealing	Yes. for others crimes	Yes. both for dealing and others crimes	
Educational Level.	No level	1.1%	-	0.5%	-	1.6%
	Primary school	4.6%	3.2%	2.7%	0.5%	11.0%
	Middle school	7.0%	5.6%	8.0%	0.5%	21.2%
	Secondary school	11.5%	6.7%	12.9%	2.4%	33.5%
	Pre-university	12.3%	1.6%	10.5%	1.6%	26.0%
	University	3.8%	0.3%	1.6%	0.3%	5.9%
	Other (e.g technical school...)	0.8%	-	-	-	0.8%
Total		41.0%	17.4%	36.2%	5.4%	100.0%

In tables 2.2, 2.2bis and 2.3 the relation between the education level of users and their criminal history is described.

**Table 2.2 Bis. education level related to arrest history (conditional distributions) 373 respondents**

		Arrested				Total
		Never	Yes, for dealing	Yes, for others crimes	Yes, both for dealing and others crimes	
Educational Level.	No level	66.7%	-	33.3%	-	100.0%
	Primary school	41.5%	29.3%	24.4%	4.9%	100.0%
	Middle school	32.9%	26.6%	38.0%	2.5%	100.0%
	Secondary school	34.4%	20.0%	38.4%	7.2%	100.0%
	Pre-university	47.4%	6.2%	40.2%	6.2%	100.0%
	University	63.6%	4.5%	27.3%	4.5%	100.0%
	Other (e.g technical school...)	100.0%	-	-	-	100.0%
Total		41.0%	17.4%	36.2%	5.4%	100.0%

Almost the same trend as in the precedent relation can be found in Table 2.3: education level correlates strongly to criminal activity either for an arrest without consequences or for incarceration.

**Table 2.3. distribution of patients that have served or have not served alternative sentences to prison according to their educational level 352 respondent**

		Alternative sentences to prison		Total
		yes	no	
What is your educational level?	No level	-	2.4%	1.7%
	Primary school	8.1%	12.3%	11.1%
	Middle school	29.3%	17.4%	20.7%
	Secondary school	38.4%	32.4%	34.1%
	Pre-university	23.2%	26.9%	25.9%
	University	1.0%	7.5%	5.7%
	Other (e.g technical school...)	-	1.2%	0.9%
Total		100.0%	100.0%	100.0%

A last but no less important analysis, can be conducted with regard to those who have obtained an alternative sentence to prison (such as house arrest, house arrest in a therapeutic community or participating in social services for drug addicts).

As shown in table 2.3 those who entered into facilities as a substitute to prison tend to be less qualified. 26.9% of those who didn't receive an alternative sentence to prison had a pre-university qualification vs 23.2 %

of those who have did receive an alternative sentence; the greatest differences can be found in the case of a university degree (7.5 % vs 1%).

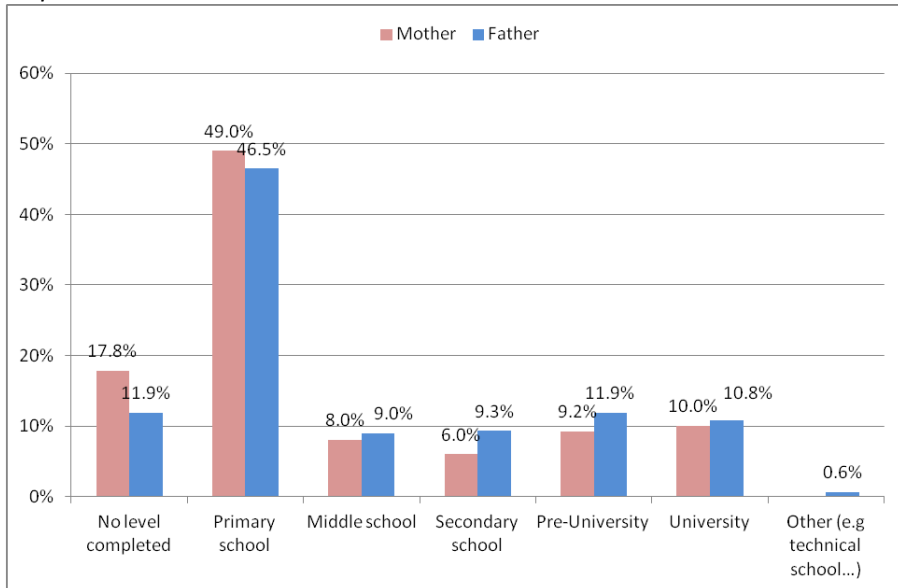
## 2.2. Education of users' parents

Now we are going to analyze the relation between the educational qualification of respondent parents and some variables regarding drug users.

Figure 2.6 shows the distribution of the respondents' parents according to the education level reached. Mothers seem to be less qualified than fathers.

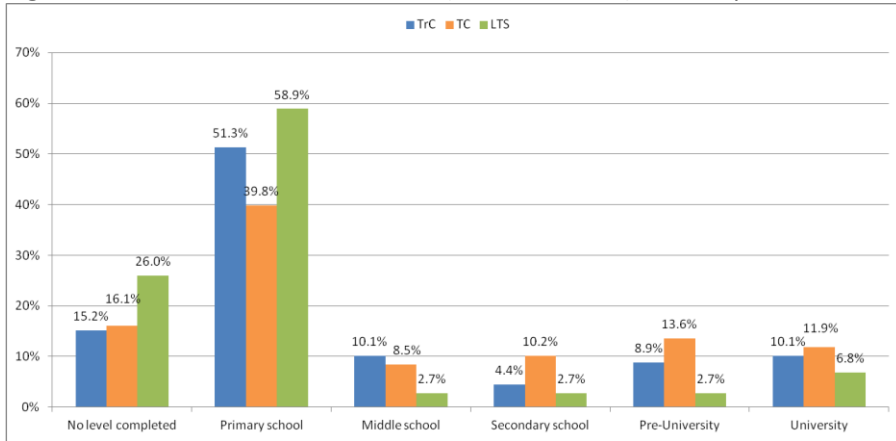
Figure 2.7 is an examination of mothers' education level distribution, in reAltion to whether their children were in LTS TrC or TC. Mothers of those in TC tend to be more educated than mothers of those in TrC and LTS. This latter category of mothers is the least educated.

**Figures 2.6. Parents' education level 349 (Mother) 344 (Father) respondents**



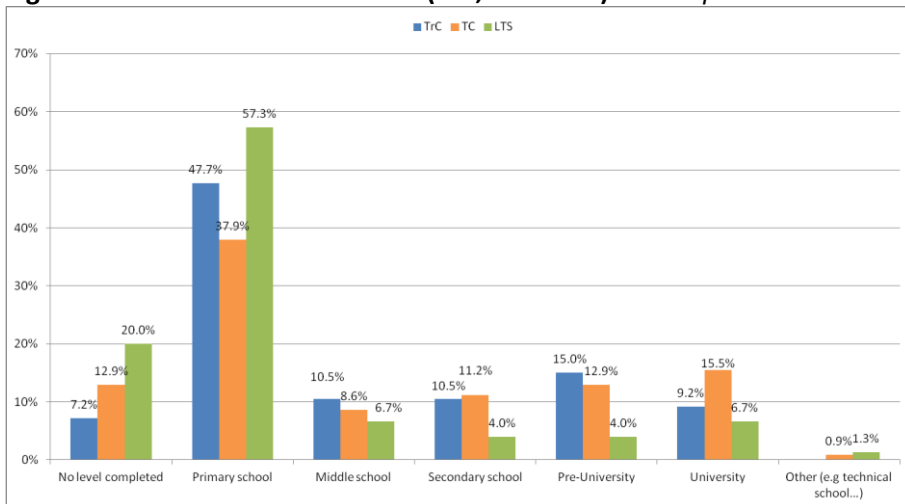


**Figure 2.7. Mothers education level ( TrC, LTS or TC). 349 respondents**



Trends for the mothers and fathers level of education are similar. Concluding, mothers of the patients of TC are more qualified than mothers of those in TrC and LTS. Almost the same happens for fathers.

**Figure 2.8. fathers education level (TrC, LTS or TC) 344 respondents**



**Table 2.4. education level of respondents related to education level of their fathers (row conditional distributions) 338 respondents**

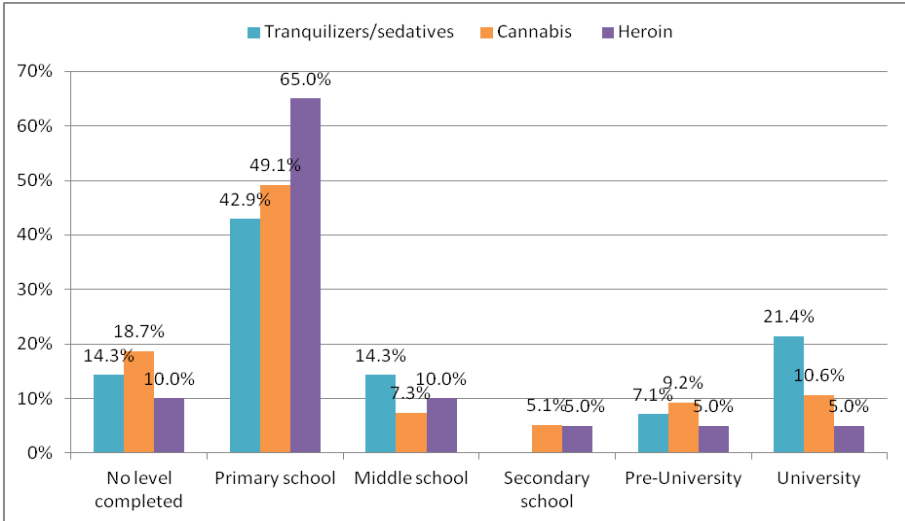
		Father's educational level							Total
		No level	Primary school	Middle school	Secondary school	Pre-university	University	Other	
Users education level	No level	66.7%	33.3%	-	-	-	-	-	100.0%
	Primary school	35.5%	58.1%	-	-	6.5%	-	-	100.0%
	Middle school	15.7%	65.7%	4.3%	4.3%	8.6%	1.4%	-	100.0%
	Secondary school	12.3%	50.9%	8.8%	13.2%	7.9%	7.0%	-	100.0%
	Pre-university	1.1%	32.6%	15.2%	12.0%	22.8%	15.2%	1.1%	100.0%
	University	-	13.6%	4.5%	4.5%	13.6%	59.1%	4.5%	100.0%
	Other	-	33.3%	-	33.3%	-	33.3%	-	100.0%
Total		12.1%	46.7%	8.3%	9.2%	12.1%	10.9%	0.6%	100.0%

**Table 2.5. education level of respondents related to education level of their mothers (row conditional distributions) 346 respondents**

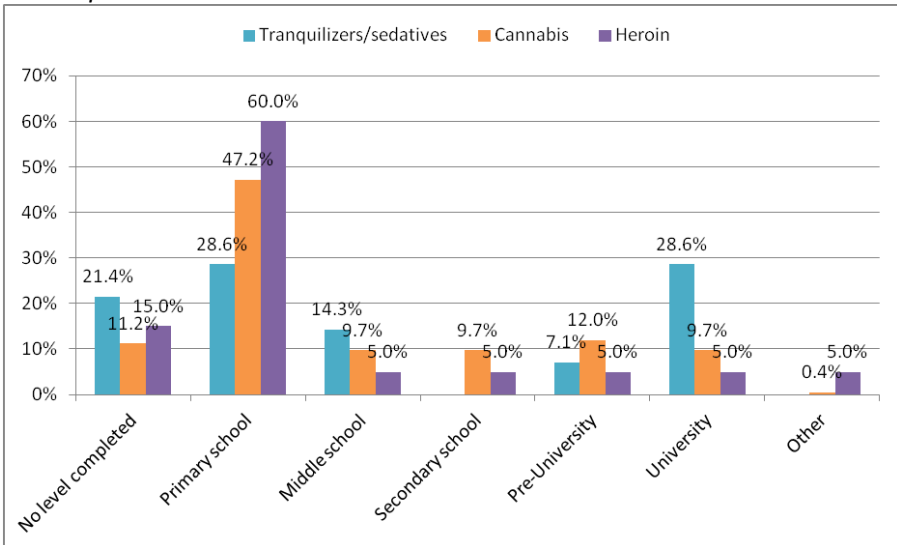
		Mother's educational level						Total
		No level	Primary school	Middle school	Secondary school	Pre-university	University	
Users educational level	No level	50.0%	50.0%	-	-	-	-	100.0%
	Primary school	38.2%	52.9%	8.8%	-	-	-	100.0%
	Middle school	29.7%	58.1%	6.8%	1.4%	4.1%	-	100.0%
	Secondary school	19.3%	56.1%	3.5%	6.1%	6.1%	8.8%	100.0%
	Pre-university	2.2%	37.6%	11.8%	11.8%	19.4%	17.2%	100.0%
	University	-	22.7%	13.6%	9.1%	18.2%	36.4%	100.0%
	Other	-	66.7%	-	-	-	33.3%	100.0%
Total		17.9%	49.1%	7.5%	6.1%	9.2%	10.1%	100.0%

If we compare the relation between first use and the mothers' education level with the relation between first use and the education level of the fathers there is an important difference. In this case the mothers' of tranquilizer and sedatives users are more qualified than heroin and cannabis users.

**Figure 2.10. first drug experimented related to mothers' educational level**  
307 respondents



**Figure 2.11. first drug experimented related to father educational level**  
301 respondents



Figures 2.10 and 2.11 underline the relation between first drug used and the education level of the users' mother and of users' father. We can see how the mothers and the fathers of those who used tranquillizer and sedatives for their first drug used have a higher education level compared

to the parents of those who started by consuming heroin and cannabis. 21.4% of mothers and 28.6 of fathers have a university degree and 7.1% for both parents have a pre-university school diploma.

Mothers and fathers of heroin users are distinguished by lower educational levels rather than mothers of cannabis and tranquillizer first-timers. They are for the most part contained in the educational group “primary school” (65% and 60%), then score relevant percentages among those without any qualifications (10% and 15%).

Generally, parents of those who used tranquillizers and sedatives as a gateway drug are more qualified than parents of those who started with cannabis or heroin use. Parents of heroin and cannabis users present different situations regarding their education.

### 2.3. Employment -Status

The working condition of respondents is an important element for the analysis of the user's lifestyle and especially their purchasing power.

**Table 2.6. last employment situation (TrC, LTS and TC). 379 respondents**

	Last work situation							Total
	Student	Long term contract	Short term contract	Self-employed or professional work	Occasional worker	Never employed	Unemployed	
TrC	1.7%	13.3%	6.9%	3.5%	8.7%	0.6%	65.3%	100.0%
TC	8.1%	8.9%	8.9%	4.0%	4.0%	1.6%	64.5%	100.0%
LTS	-	17.1%	1.2%	3.7%	3.7%	-	74.4%	100.0%
Total	3.4%	12.7%	6.3%	3.7%	6.1%	0.8%	67.0%	100.0%

Most respondents reported that they were unemployed at the time of interview (almost 7 out of 10 users). In fact the specific work categories with the largest number of respondents among TrC, LTS and TC users were unemployed (67%) and long term job (12.7%), followed by short term job (6.3%) and occasional worker (6.1%). 3.4% of users reported they were

students while 0.8% reported that they had never been employed. 3.7% were self-employed or professional workers.

**Figure 2.12. last employment situation of TrC users by gender 173 respondents**



Figure 2.12 shows the distribution of the last employment situation for TrC users. Unemployment rates are high both for male and female respondents (65.2% and 65.9% respectively). Higher rates of occasional workers were reported from the female cohort (14.6% vs 6.8% of men). “Long term contract” is the category with the highest percentage of men who have a job (15.2%), vs. just 7.3% of women.

**Figure 2.13. last employment situation of TC users by gender 124 respondents**

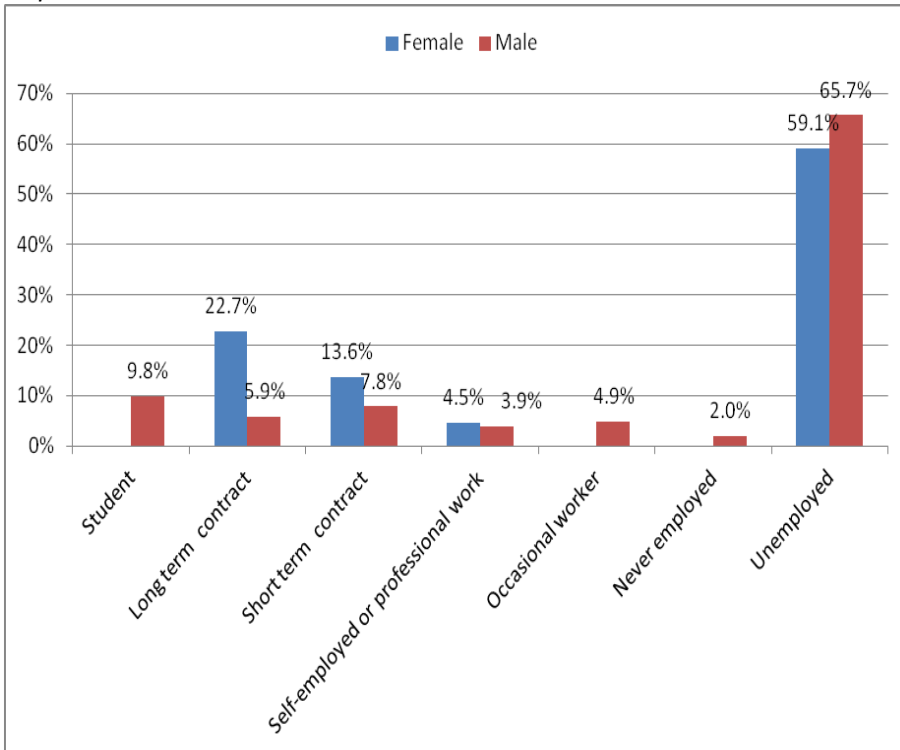


Figure 2.13 shows a different situation for TC. The most significant disparity between women and men is in the long term contract category (22.7% vs 5.9%). Females are not represented at all in the categories of occasional worker, students and those who have never been employed. Thus men in TC are less stable than women in their work condition. The margin between men and women who are unemployed is significant: men are 6.6% more likely to be unemployed.

**Figure 2.14. last employment situation of LTS users by gender. 81 respondents**

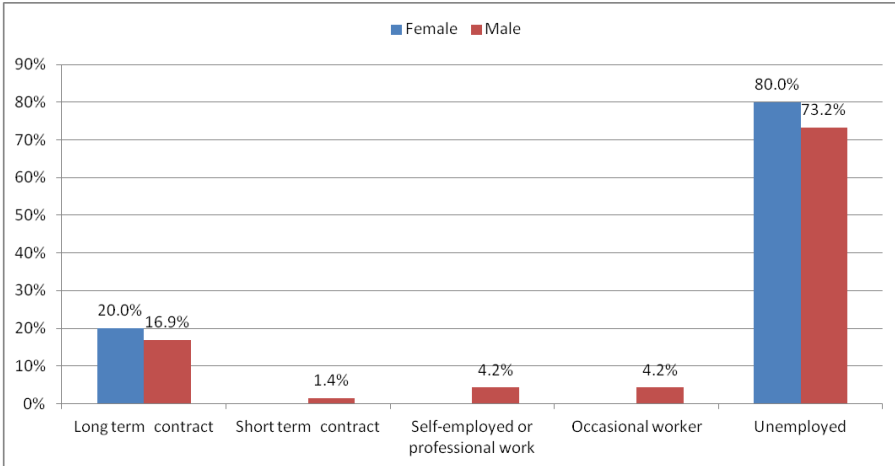


Figure 2.14, which refers to LTS, shows a split distribution between the long term contract and unemployed categories. Women are most likely to be unemployed (80% vs 73.2% of men) but they are the most likely also to have a long term contract (20% vs 16.9% of men). The rest of the male sample in LTS is distributed among the other three work categories; here women are not represented at all. Notable is the absence of students and those who have never been employed among LTS patients.



**Table 2.7. last employment situation of TC and non-TC users 379 respondents**

		Therapeutic community		Total
		I've been / i'm therapeutic community	I've never been in a therapeutic communities	
Work	Student	3.9%	-	3.4%
	Long term contract	11.3%	22.7%	12.7%
	Short term contract	7.2%	-	6.3%
	Self-employed or professional work	3.3%	6.8%	3.7%
	Occasional worker	6.6%	2.3%	6.1%
	Never employed	0.9%	-	0.8%
	Unemployed	66.9%	68.2%	67.0%
Total		100.0%	100.0%	100.0%

Table 2.7 shows the different employment situation of respondents in relation to their contact with therapeutic communities.

Users who have never been in therapeutic communities report lower percentages of users with long-term employment, but higher rates of occasional work were reported from this kind of user (6.6%). Most unemployed users have never had contact with TC (68.2%).

Table 2.8 shows the last employment situation of users according to their contact with prison. Respondents who had never been in prison, have the highest percentage for "long term contract" (15.9%). Also those who have been incarcerated for both drug crimes and other crimes have a high percentage of employment with a long-term contract (12.5%) but most of them are unemployed (87.5%).

**Table 2.8. last employment situation of users related to their contact with prison (column conditional distributions) 374 respondents**

		Prison				Total
		Never	For dealing	For other crimes	Both for dealing and other crimes	
work	Student	3.3%	1.9%	5.0%		3.5%
	Long term contract	15.9%	9.6%	8.0%	12.5%	12.8%
	Short term contract	5.1%	15.4%	5.0%		6.4%
	Self-employed or professional work	5.6%		2.0%		3.7%
	Occasional worker	3.7%	7.7%	11.0%		6.1%
	Never employed	0.9%		1.0%		0.8%
	Unemployed	65.4%	65.4%	68.0%	87.5%	66.6%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

**Table 2.8 bis. last employment situation of users related to their contact with prison (row conditional distributions) 374 respondents**

		Prison				Total
		Never	For dealing	For other crimes	Both for dealing and other crimes	
work	Student	53.8%	7.7%	38.5%	-	100.0%
	Long term contract	70.8%	10.4%	16.7%	2.1%	100.0%
	Short term contract	45.8%	33.3%	20.8%	-	100.0%
	Self-employed or professional work	85.7%	-	14.3%	-	100.0%
	Occasional worker	34.8%	17.4%	47.8%	-	100.0%
	Never employed	66.7%	-	33.3%	-	100.0%
	Unemployed	56.2%	13.7%	27.3%	2.8%	100.0%
Total		57.2%	13.9%	26.7%	2.1%	100.0%

Users who have been imprisoned for drug trafficking present important rates whether in the category of short term workers (15.4%) or in the group of occasional workers (7.7%). Those who have been imprisoned for trafficking or for both drug and other crimes are not represented at all in the categories of never employed and self employed or professional workers.

**Table 2.9. last employment situation related to the use of alternatives to prison 356 respondents**

		Alternative sentences to prison		Total
		No	yes	
work	Student	3.1%	3.0%	3.1%
	Long term contract	14.9%	6.9%	12.6%
	Short term contract	5.1%	7.9%	5.9%
	Self-employed or professional work	5.1%	1.0%	3.9%
	Occasional worker	3.9%	11.9%	6.2%
	Never employed	0.8%	1.0%	0.8%
	Unemployed	67.1%	68.3%	67.4%
Total		100.0%	100.0%	100.0%

Table 2.9 reports the frequency of patients who received alternative sentences listing them according to their last working condition.

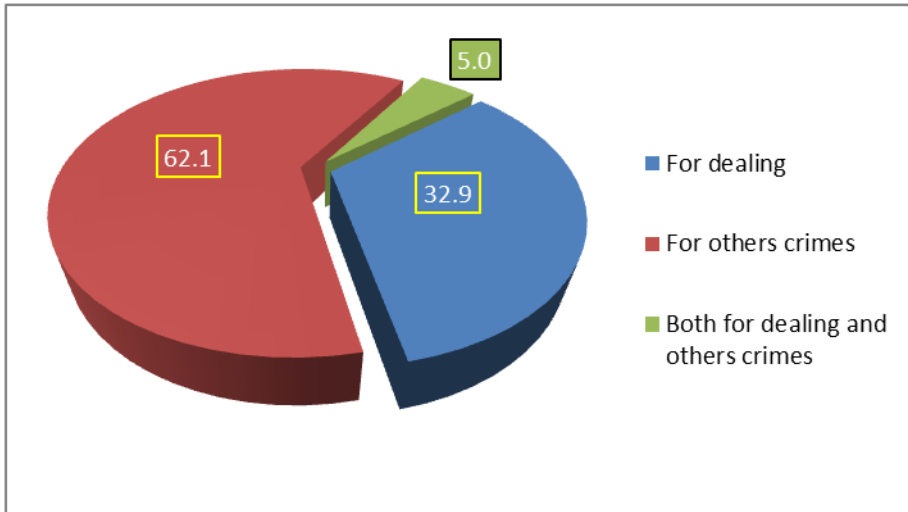
## 2.4. Contact with Prison

This sample contains people who had been convicted, 42.8% of the respondents have been incarcerated (Table 2.10) and more than half of them have been convicted for crimes not related to drugs (62% in Figure 2.16).

**Table 2.15. typology of crime committed 376 respondents**

Prison				
Never	For dealing	For other crimes	Both for dealing and other crimes	Total
57.2%	14.1%	26.6%	2.1%	100%

**Figure 2.16. typology of crime committed**



**Figure 2.17. typology of crime committed (TrC, TC or LTS).**

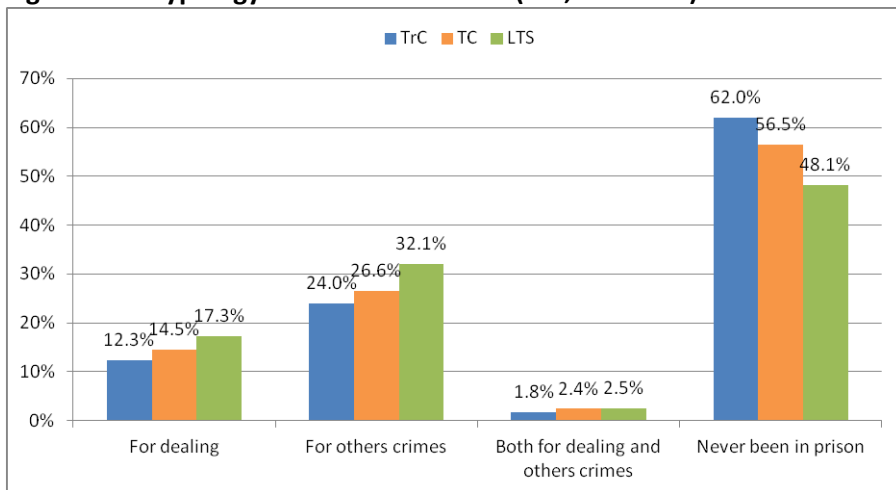
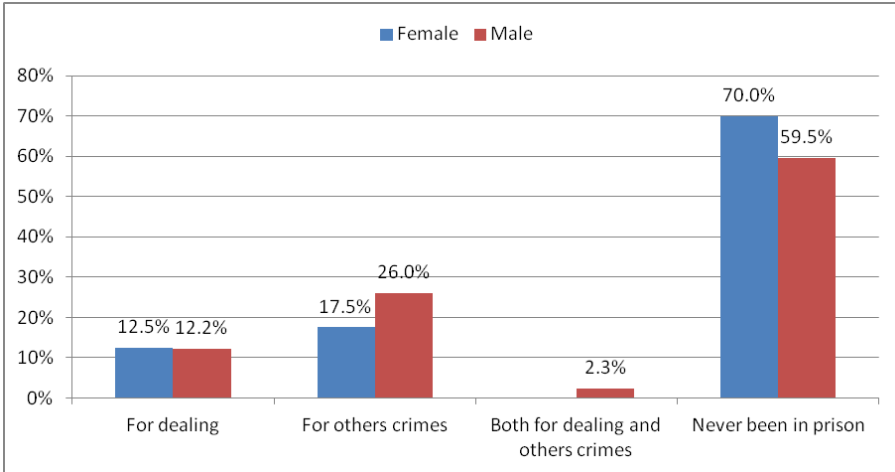


Figure 2.17 displays the prevalence rates for each specific typology of crime that was committed by LTS, TrC and TC respondents.

LTS respondents report the highest percentage for “imprisoned” while TrC users reported higher percentages for “never been in prison” (62%).

**Figure 2.18. typology of crime committed by gender (TrC) 171 respondents**



When sorting out by gender in each crime category we see that 70% of women in TrC have never been in prison, and just 59.5% men. A relative high percentage of men have committed crimes not related to drugs (26%) while dealing is reported by men and women almost at the same level (12.2% and 12.5% respectively). Women are not represented at all in the category “both for dealing and other crimes”.

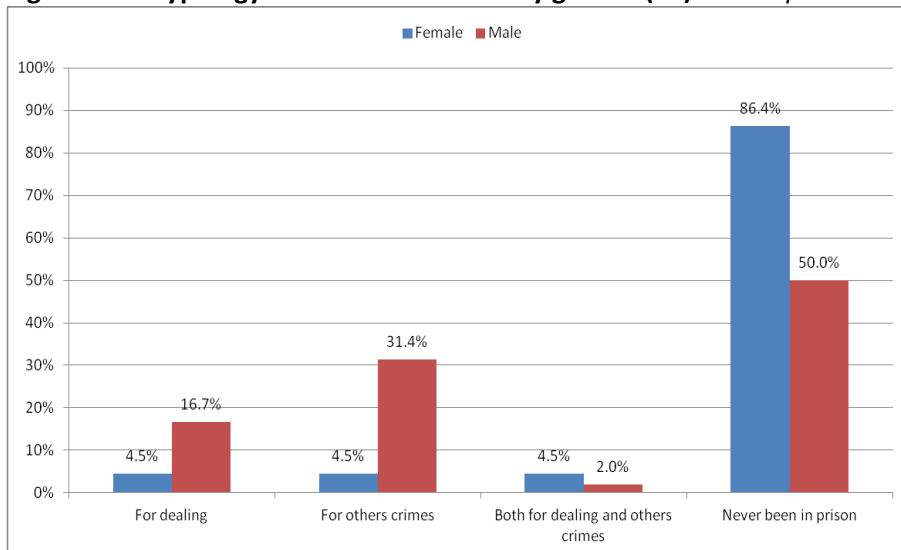
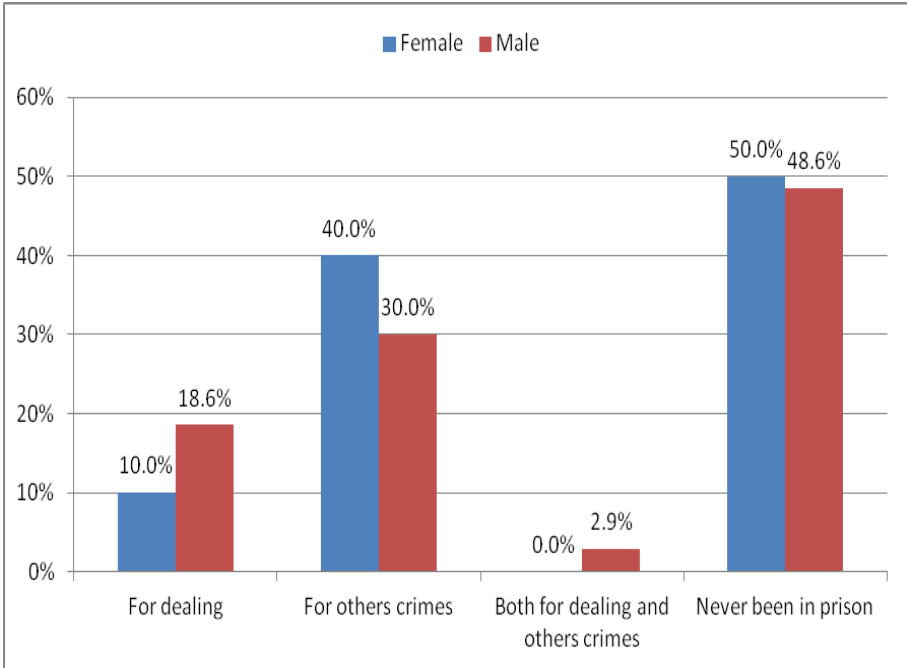
**Figure 2.19. typology of crime committed by gender (TC) 124 respondents**

Figure 2.19 shows a prevalence of male TC patients in every category of single crimes. The class with the highest frequency of men is “for others crimes” (31.4%), higher than the other class, “for dealing” (16.7 %). Women who have never been imprisoned are in the majority (86.4% vs 50% of men).

**Figure 2.20. typology of crime committed by gender (LTS) 80 respondents**



Even among users in TC (Figure 2.20) the difference between men and women is quite relevant except in the class that have never been imprisoned where men comprise 48.6% and women 50%.

Crimes not related to drugs are the most usual offense (40% women and 30% men) followed by dealing (10% women and 18.6% men) and dealing and other crimes. In this group women are not represented.



**Table 2.11. typology of crime committed by age 376 respondents**

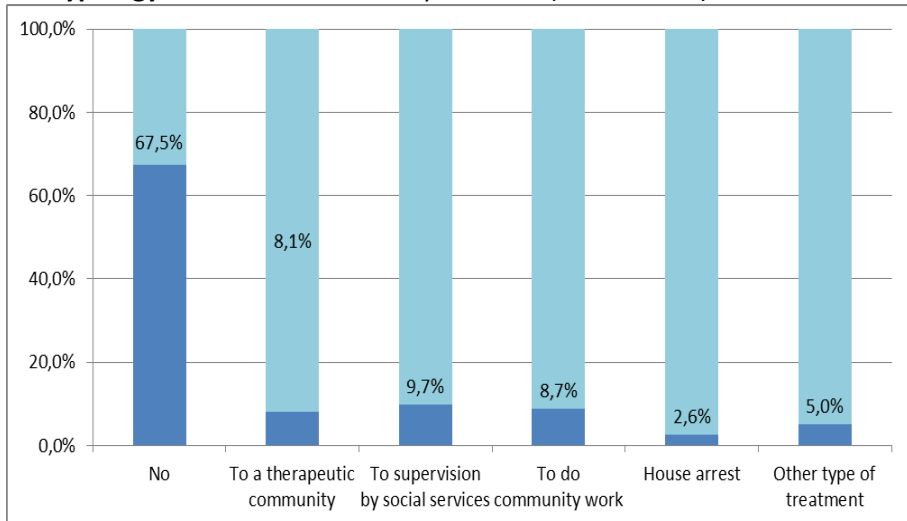
		Age						Total
		<18	18-24	25-34	35-44	45-54	>54	
Prison	For dealing			17.6%	11.8%	13.4%	38.5%	14.1%
	For other crimes	100.0%		31.1%	28.5%	21.6%	15.4%	26.6%
	Both for dealing and other crimes		20.0%	4.1%	1.1%	1.0%	7.7%	2.1%
	No		80.0%	47.3%	58.6%	63.9%	38.5%	57.2%
Total		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Looking at Table 2.11 a first analysis of the trend in each single row leads to the conclusion that the first crime – in the case of imprisonment - is “other crimes”; “dealing” is more important for the age group over 54.

## 2.5. Alternative Sentencing

After having analyzed the respondents’ relations with prison it is interesting to proceed elaborating the characteristics of users who received an alternative sentence.

**Figure 2.21. patients who received alternative sentence or not related to the typology of alternative 358 respondents. (Question 29)**



67.5% respondents couldn't obtain any sort of alternative to prison (Figure 2.21) and around 1 out of 4 of the rest of respondents reported having received more than 1 alternative sentence.

Therapeutic Community is not the most popular alternative, received by just 8.1% of those who could skip prison. Those attending other alternatives to prison are very little. Supervision by social services with a rate of 9.7% respondents and community – social - work , reported by 8.7%, are more important than TC treatment as alternative to prison in Portugal.

**Figure 2.22. female patients who got alternative sentence related to the typology of alternative 73 respondents**

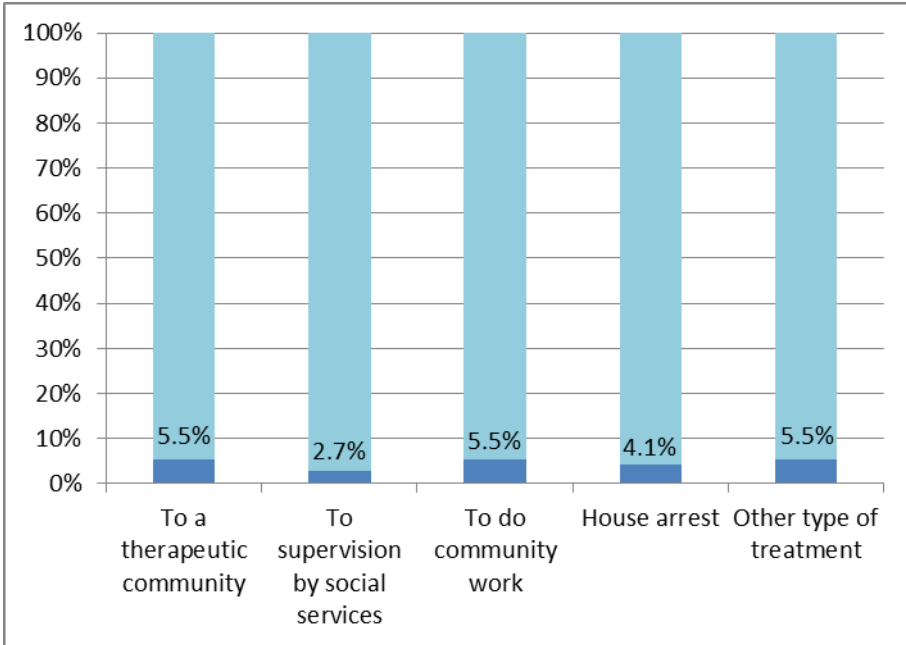
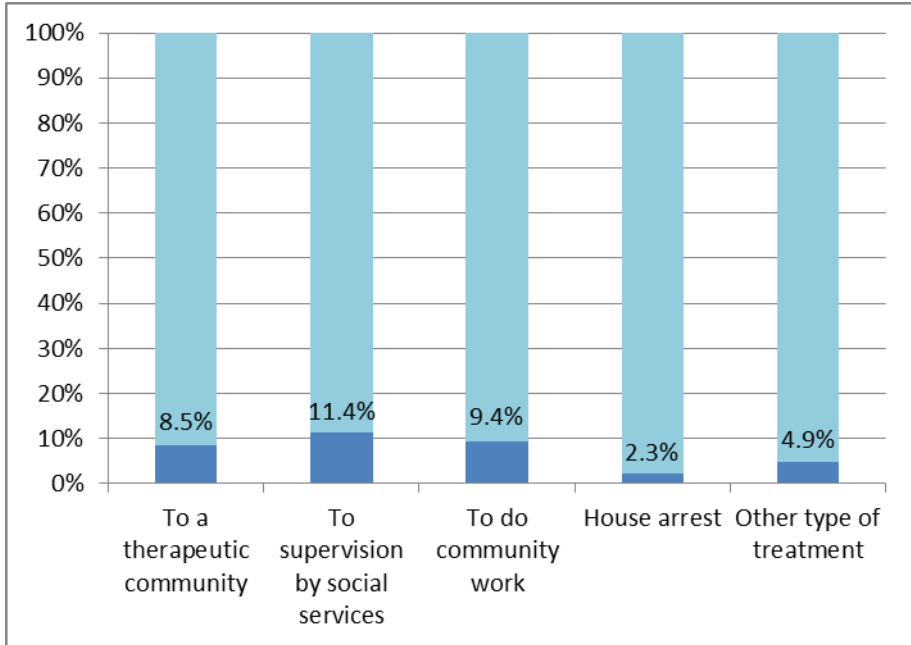


Figure 2.22 and 2.23 take into consideration only the users who benefited from alternative sentences distinguishing them by gender. In general men report a higher percentage among all the types of alternative classes than women except for house arrest.

**Figure 2.23. male patients who got alternative sentence related to the typology of alternative 307 respondents**

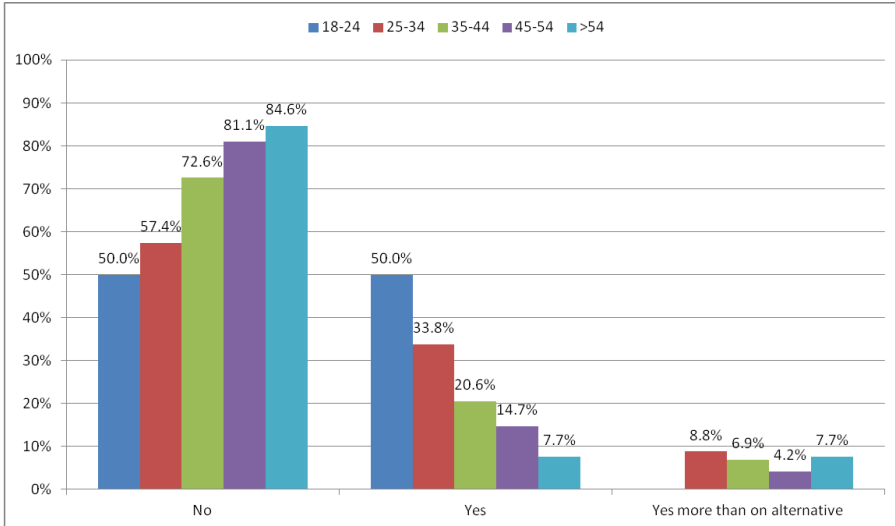


The most frequent alternative for men is “supervision by social service” (11.4%) , whereas women reported the minimum value for this kind of alternative (2.7%); women had mostly reported “other type of treatment”, “therapeutic community” and “community work options” (5.5%). The latter alternative is the second most frequent alternative chosen by men. Following that, we have therapeutic community and house arrest. The fourth most usual alternative for women is “house arrest” (4.1 % vs. 2.3 % of men), “supervision by social service” is the last category, as noted above.

Data from figure 2.24 documents how many alternative sentences users received in relation to their age. The distribution shows an inverse correlation between age and the chance to receive an alternative sentence to prison. An increase of age corresponds with a decrease in the number of patients who could make use of an alternative sentence.

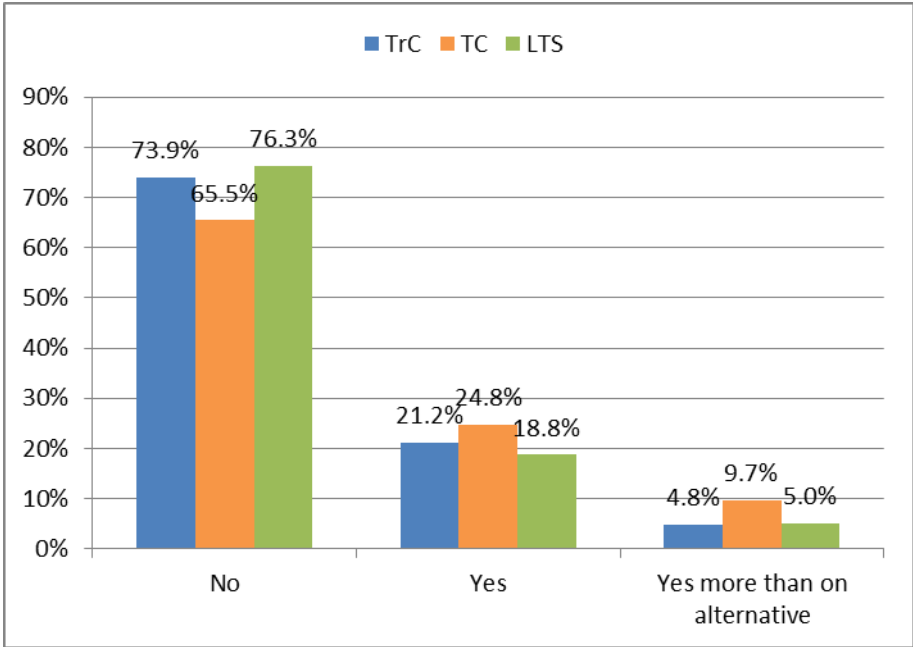
Looking at the 3 classes (“yes”, “yes, more than one” and “no”) we can see how among those who benefited from more than one alternative, an increase in age corresponds with a decrease in the number of patients in this category.

**Figure 2.24. patients who got alternative sentence related to the number of alternative. Distinguished by age. 358 respondents**



The distributions of TrC, LTS and TC patients according to their use of alternative sentences (Figure 2.25) are pretty evenly spread among the 3 categories . Thus we might state that the margin rates between TrC, TC and LTS users are not relevantly high, although meager differences are shown in the histogram. There is just a slight difference for TC patients that reported having had one or more alternative sentences more often than the other two kinds of users.

**Figure 2.25. patients who got alternative sentences, or not, related to the number of alternative Distinguished by services: TrC, LTS and TC.**



# CHAPTER 3

## Consumption, Doses, Prices.

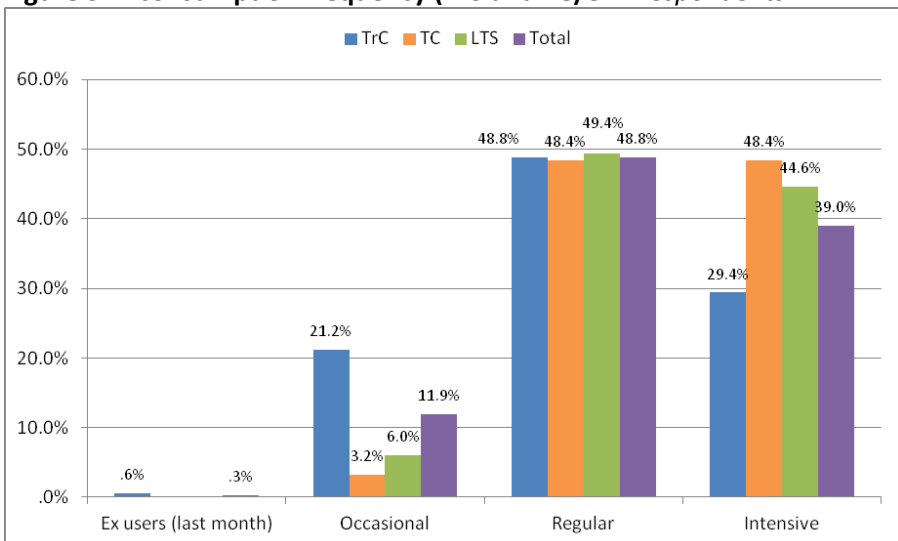
### 3.1. Drug Consumption

This chapter concerns the analysis of consumption in the last 30 days for LTS and TrC patients, in the case of TC patients it refers to the last month before entering into the current therapeutic community.

Therefore it is possible to have 4 different categories: ex users, occasional users (1-5 times in the last 30 days), regular (6 – 19 times) and intensive users (20 times and more).

The last month is not always a month of high consumption because the patients could already be in treatment (for detoxification) before starting a treatment period in a TC or they could simply be reducing their normal consumption whilst keeping in touch with a health care structure.

**Figure 3.1. consumption frequency (LTS and TC) 377 respondents**



Ex users or temporary “ex” users represent 0.3% of respondents. Among “regulars” there are no relevant differences between TrC, TC and LTS patients (all around 48%, Figure 3.1). Among intensive consumers high rates are found in TC (48.4%) and LTS users (44.6%). TrC make up 29.4% of intensive users and 21.2% among occasional consumers. In this last consumption category users from TC and LTS are few (3.2% and 6% respectively).

In the general distribution (Total) regular consumers represent around 49% and intensive users 39 %.

In Table 3.1 the rate of consumers are distinguished by gender and service .

**Table 3.1. Consumption frequency of TrC, TC and LTS users distinguished by gender 376 respondents**

	TrC		TC		LTS	
	Female	Male	Female	Male	Female	Male
Ex users (last month)	-	.8%	-	3.9%	-	-
Occasional	17.5%	22.3%	54.5%	47.1%	10.0%	4.2%
Regular	47.5%	49.2%	45.5%	49.0%	30.0%	52.8%
Intensive	35.0%	27.7%	100.0%	100.0%	60.0%	43.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

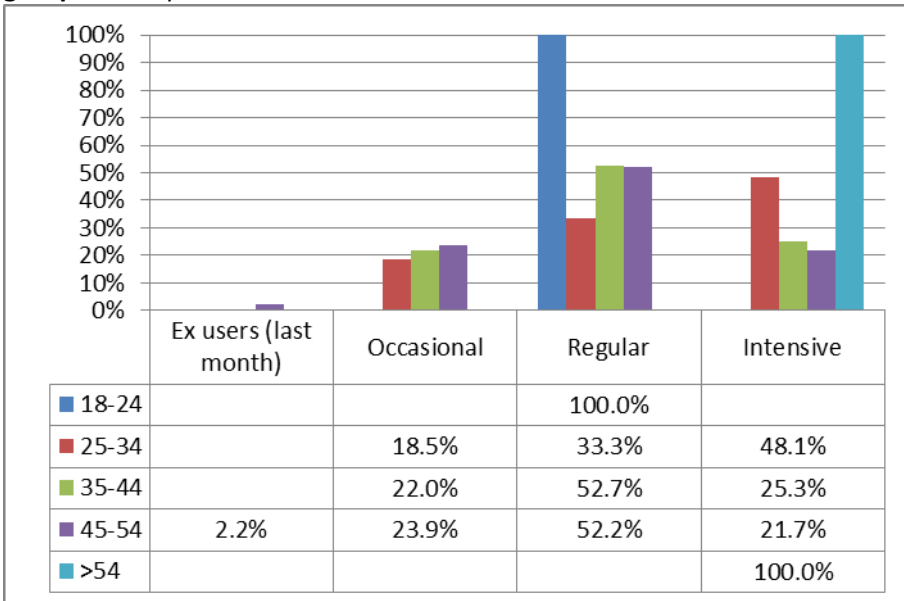
Among LTS patients, high rates of women are intensive consumers (60%) while men are most commonly regular users (52.8%). In TrC services the modal value is regular consumers for both male and female (49.2% and 47.5% respectively).

Data also shows that women in TrC and TC had used drugs more frequently than men in the last month.

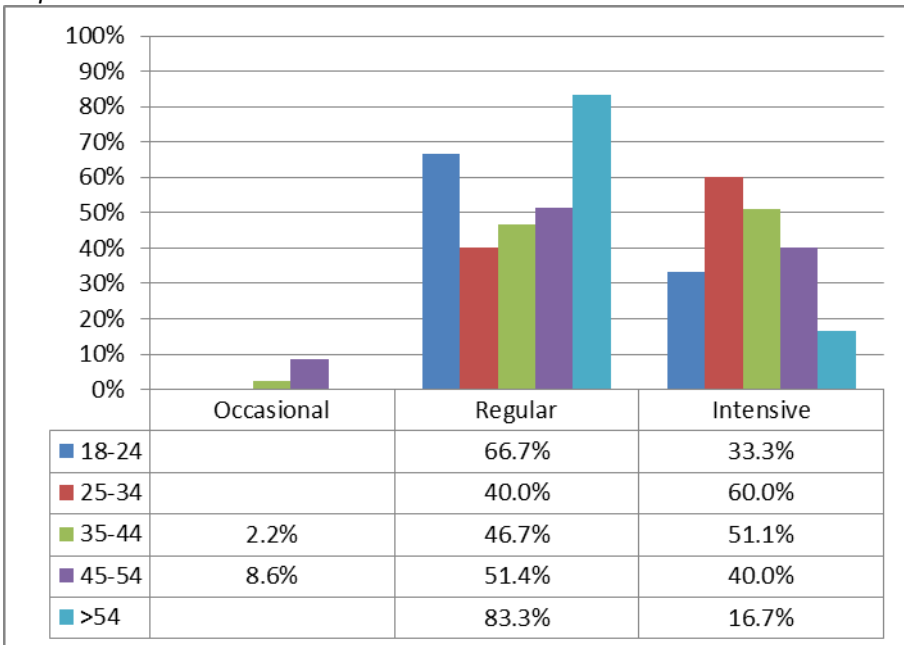
In figure 3.2, which refers to TrC users, the whole sample aged 18-24 reported a regular consumption. The same concentration in one consumption category happens for those over 54 that are all intensive consumers. Users in the 25-34 age group are mostly intensive consumers (48.1%) while those aged 35-54 are frequently regular users (all around 52%).



**Figure 3.2. consumption frequency of TrC patients related to their age group 170 respondents**



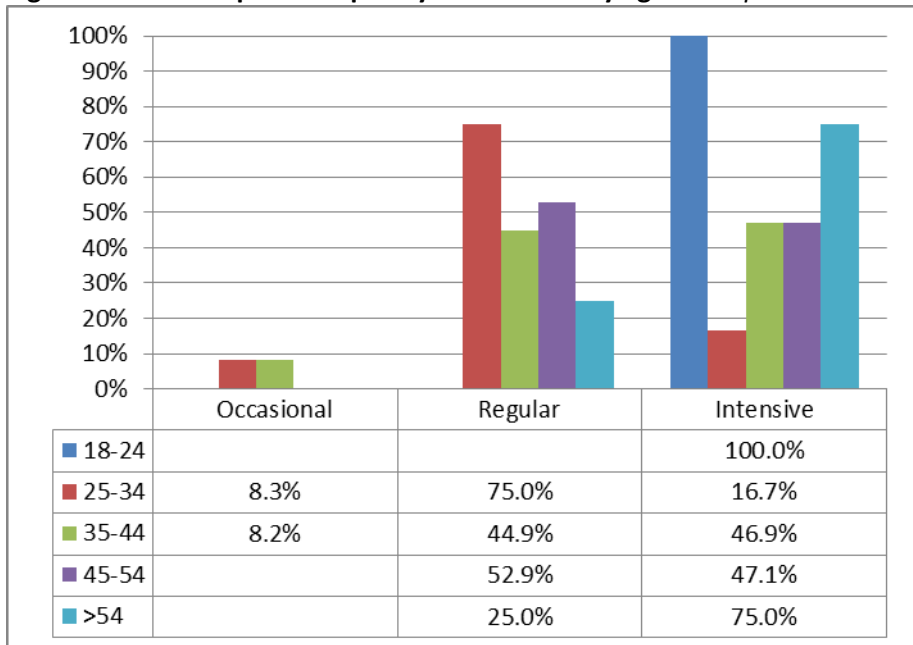
**Figure 3.3. consumption frequency of TC users by age 124 respondents**



As shown in figure 3.3 (which refers to TC patients) most young users aged 18-24 are regular consumers (66.7% of the total of young users). The remaining 33.3% of these users reported an intensive consumption. The same trend is followed by users older than 45 which are mostly regular consumers.

Looking at the age groups 25-34 and 35-44, higher rates were reported in the consumption category "intensive" (60% and 51.1% respectively).

**Figure 3.4. consumption frequency of LTS users by age 83 respondents**

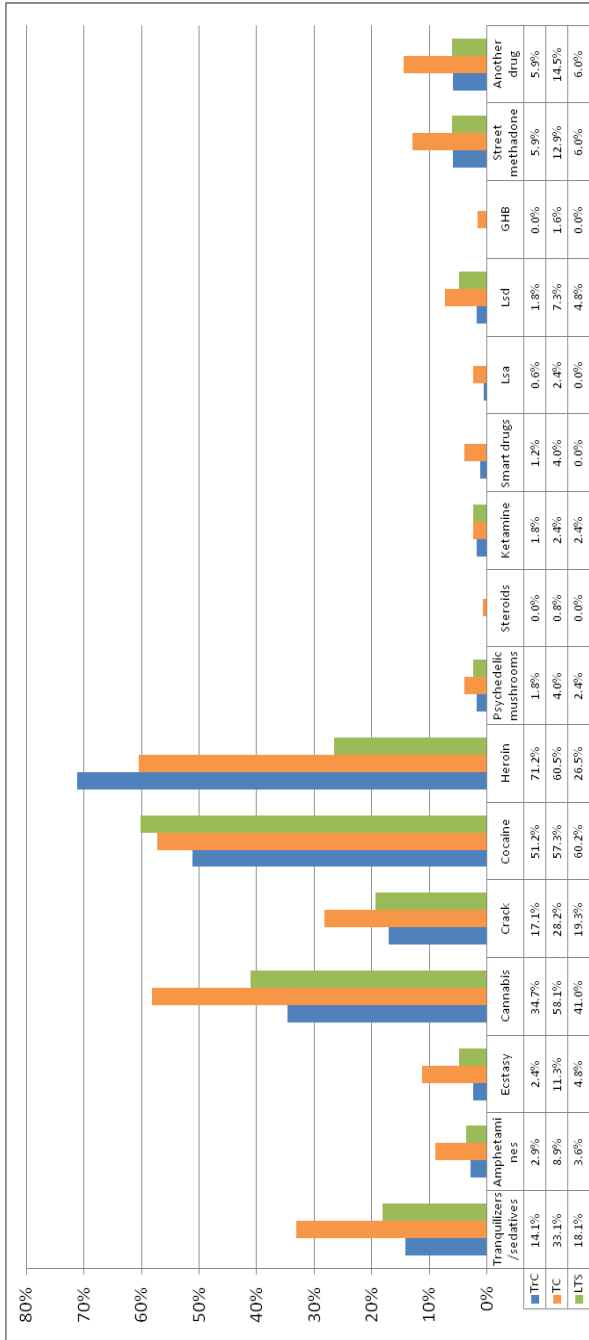


Trends vary across different services. In LTS all the younger users (18-24) are intensive consumers while users aged 25-34 are in nearly every case regulars (75%).

Rates of 35-44 years old users are spread among regular (44.9%) intensive (46.9%) and occasional consumers (8.2%). The older users (>54) are mostly intensive consumers.

In the following figures and tables we are going to analyze the consumption frequency of each kind of substance.

**Figure 3.5. last month drug consumers (TrC, TC and LTS patients) 377 respondents**



Cocaine, cannabis and heroin continue to be the most popular drugs (Figure 3.5). Cannabis was more appreciated by TC patients (58.1% of TC users vs 41% of LTS and 34.7% of TrC users) while heroin was favored by TrC patients (71.2%), followed by TC (60.5%) and LTS users (26.5%).

Percentages of cocaine users are spread among TrC, TC and LTS patients (51.2%, 57.3% and 60.2%). Consumption of tranquilizers, sedatives and crack is also relevant. These substances comes immediately after cannabis and are preferred by TC users followed by LTS and then by TrC users.

To be considered in descending order are: Street methadone, ecstasy, amphetamines, LSD and psychedelic mushrooms. These types of drug are all used more often by TC users.

**Figure 3.6. frequency distribution of the last month's drug consumption by gender 376 respondents**



Distinguishing consumers by gender data shows a considerable difference between men and women for heroin, that is the most used drug by men (71.7% vs 54.2% of women), followed by cannabis (47.4% vs 29.2% of women). Tranquillizer and sedatives are used the most by women (27.7% vs. 19.4%).

Slight differences are reported for amphetamines and smart drugs consumption, more used by women . Men more generally are prevalent for ecstasy, psychedelic mushrooms and LSD. “Other drugs” (that often concern alcohol) are used mostly by women (11.1% vs 8.2%).

Regarding tranquillizers or sedatives, crack, amphetamines and smart drugs consumption women are again the main consumers.

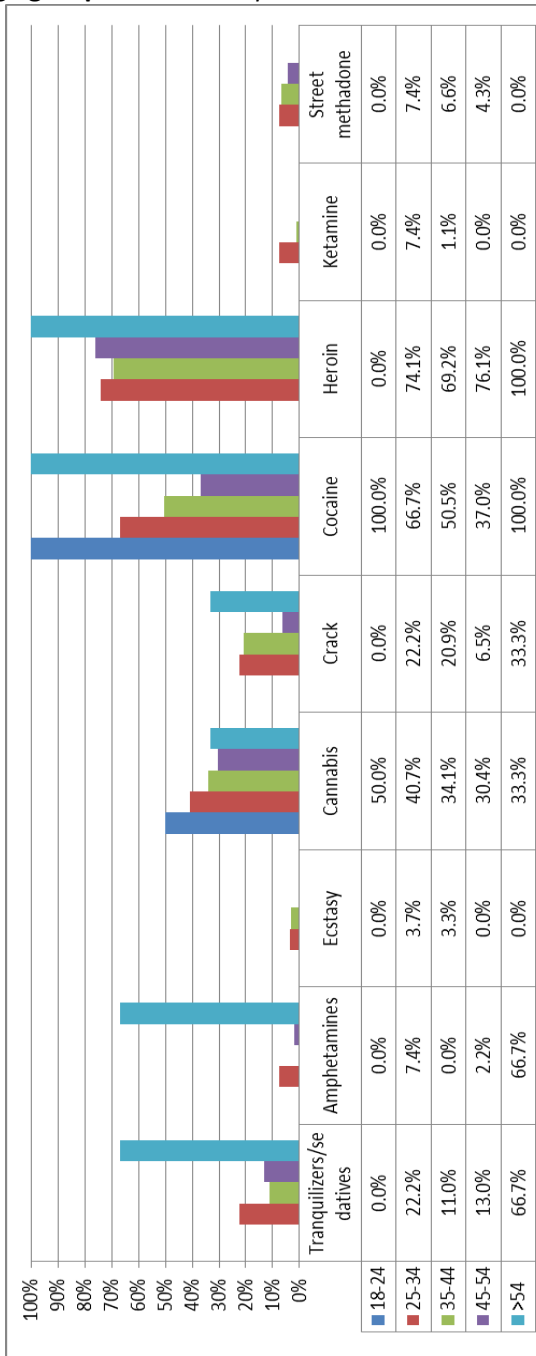
Men more generally consume ecstasy, psychedelic mushrooms and LSD. “Other drugs” (that often concern alcohol) are used mostly by women (11.1% vs 8.2%).

We can also distinguish users by age and analyze what different types of drug have been used by respondents during the last month of consumption.

Figure 3.7 reports the rate of drug consumption among TrC patients: young patients are the most important consumers of cannabis and cocaine. Older patients (>54) are the most common consumers of tranquillizer and sedatives, amphetamines, crack, cocaine and heroin. This data is important in understanding how much poly-drug use is widespread among adults.

Except for these age groups at the two extremes the trend in consumption follows a descending relation for the main drugs used (Cannabis, cocaine, crack and tranquillizer and sedatives). As the age increases the prevalence of these drugs decreases. For heroin the opposite trend is true .

**Figure 3.7. frequency distribution of the most used drugs during the last month by age group - TrC 170 respondents**



**Figure 3.8. frequency distribution of the most used drugs during the last month by age group - TC 124 respondents**

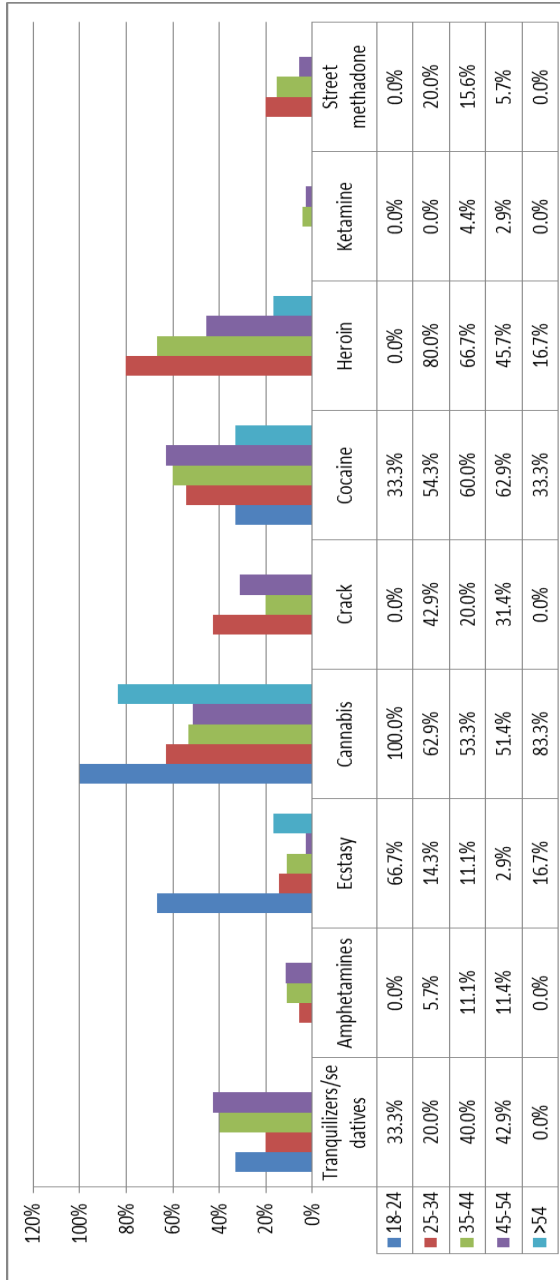




Figure 3.8 reports the rates of drug consumption among TC patients: young patients are the most important consumers of ecstasy and cannabis. The other age groups reported a prevalence of heroin and cocaine with the exception of the age group of over 54 year olds, where cannabis is prevalent over cocaine and heroin use. Heroin is strongly descendent in relation to age. The prevalence of cocaine increases with the increase of age; 33.3% (18-24), 54.3% (25-34), 60% (35-44), 62% (45-54) with the exception of the last group. Prevalence of cannabis follows the opposite trend (always with the exclusion of the over 54). Young users in TC reported higher percentage of consumption than those in TrC.

**Figure 3.9. Frequency distribution of the most used drugs during the last month by age group - LTS 83 respondents**

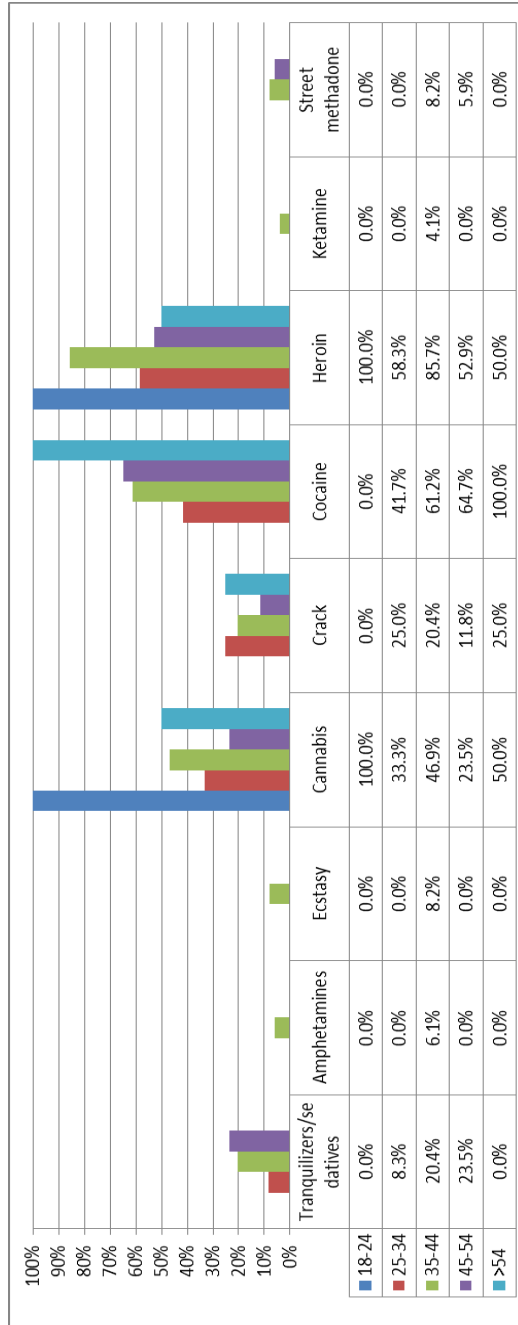
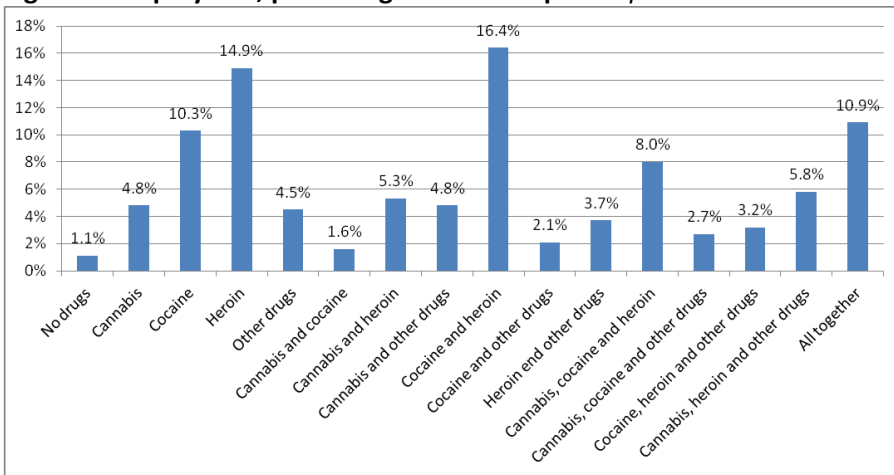


Figure 3.9 concerns drug consumption among LTS patients: young patients are the most important consumers of cannabis and heroin and their consumption rates are split among these two kinds of drugs. After young adults the most important consumers of these two drugs are those aged 35-44. They are heavy consumers also of cocaine but older respondents (>54) are the main consumers of this drug. In fact the prevalence of cocaine increases with the increase of age.

Only one drug consumed was indicated by 39% of respondents and among them only heroin was used by 14.9 %, only cocaine by 10.3% and only cannabis by just 4.8 %. The prevalence of hard drugs is quite important in this population. Cocaine and heroin together were also used by 38.5% respondents: just cocaine and heroin 16.4%; cannabis, cocaine and heroin 8%; cocaine, heroin and other drugs (\*) 3.2%; all together (\*\*) 10.9%.

**Figure 3.10. poly-use, percentage of the sample Respondents 377**



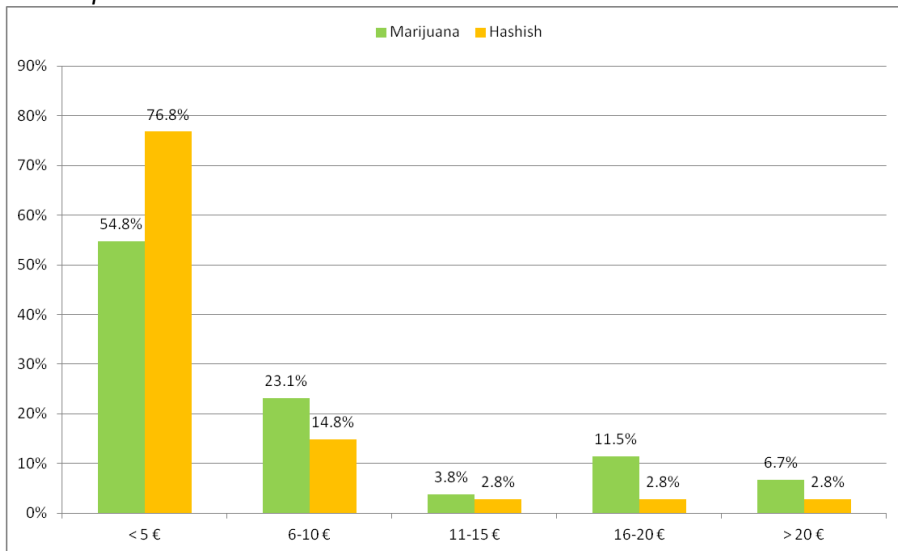
\*" Other drugs" means that at least one of the drugs listed other than the main three (cannabis, cocaine and heroin) is consumed.

\*\* All together includes consumers of cannabis, cocaine, heroin and at least one of the "other drugs".

### 3.2. Prices and Substances

Information on drug prices comes from the answers to question number 23 of the questionnaire. Users were asked to indicate the latest known prices per dose, gram or pill of a list of 9 main drugs, with a specification in case of heroin and cocaine of top or poor quality.

**Figure 3.11. price for 1 gram of marijuana and 1 gram of hashish 104 and 142 respondents**



The majority of respondents indicated the prices of marijuana and hashish at less than 5 €. A considerable percentage of users (23.1% for marijuana and 14.8% for hashish) reported a price between 6 and 10 €. The remaining users priced the two substances over 11 € per 1 gram. Notably, 11.5% of respondents reported a price between 16 and 20€. Hashish was priced by 76.8% of users at less than 5€ and by 14.8% at between 6 and 10€. Other percentages are negligible. Thus the price of marijuana is surely less than 20€ per 1 gram while 1 gram of hashish costs less than 10€

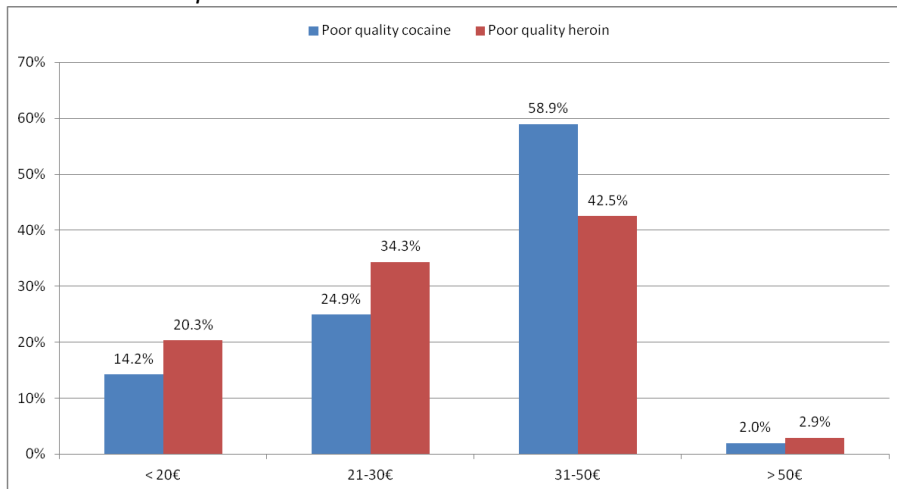
Figure 3.12 shows the prices of poor quality heroin and poor quality cocaine.

Low quality cocaine was priced by most of respondents at between 31 - 50 €, while the reported price of top quality cocaine was 41-60 €.

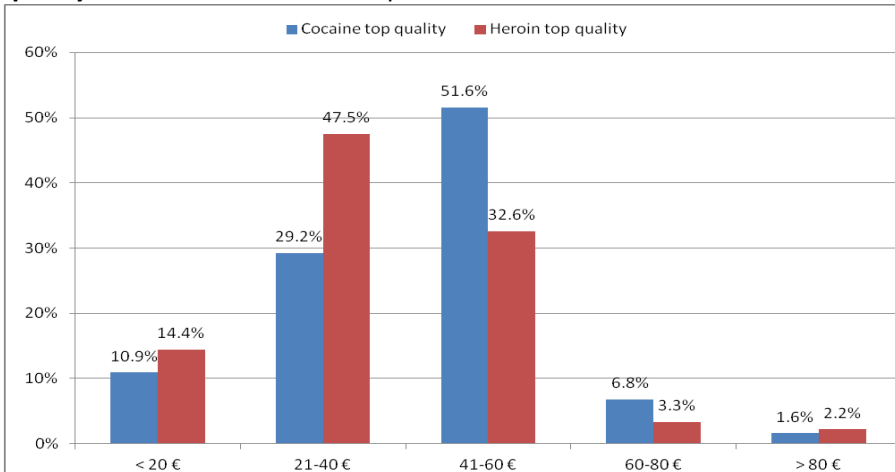
Considerable rates of users assigned to poor cocaine a price lower than 31 €; 24.9% priced it between 21-30€ and 14.2% at less than 20€. Looking at top quality cocaine distribution the second biggest price group is 21-40€

(29.2%) followed by less than 20€ (10.9%). Concluding, poor quality cocaine price is certainly lower than 50 € per gram while a top quality cocaine price is lower than 60 € per gram.

**Figure 3.12. price for 1 gram of poor cocaine and 1 gram of poor heroin**  
*197 and 207 respondents*

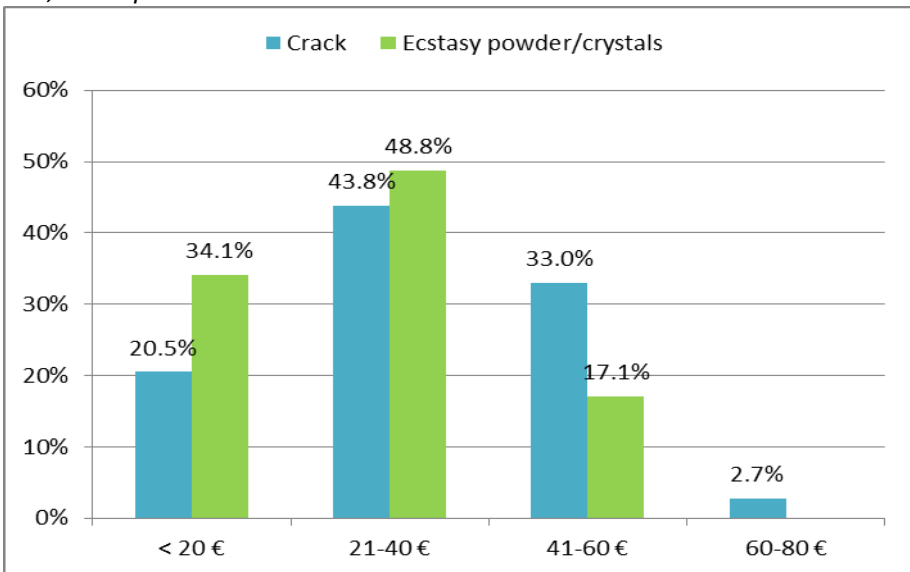


**Figure 3.13. price for 1 gram of top-quality cocaine and 1 gram of top quality heroin** 192 and 181 respondents



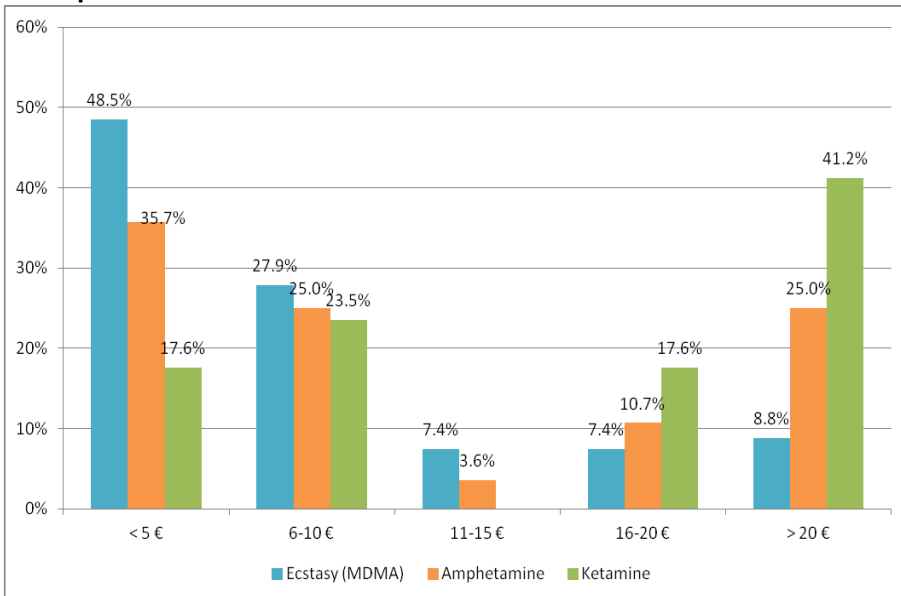
The modal value of poor quality heroin is within the class 31-50 € (42.5%). Top quality heroin is indicated by 47.5% respondents at 21-40 € and by 32.6% at 41-60€. Generally, low quality heroin costs less than 60€ while top quality heroin is never less than 60€.

**Figure 3.14. price for 1 gram of crack and 1 pill of ecstasy powder/crystals** 112, 41 respondents



The majority of interviewees (43.8%) said the price of crack was 21-40€ per gram, followed by those who said it usually costs 41-60€ (33%) and those who priced it at under 20€. Just 2.7% reported prices higher than 60€. The modal value for ecstasy is the same as for crack (21-40€) but the second biggest price group is “<20€” followed by 41-60€. Nobody priced ecstasy at over 60€.

**Figure 3.15. price Ecstasy (MDMA), Amphetamine and Ketamine. 68, 28, 17 respondents**



Almost half of users (48.5%) indicated the MDMA price <5 € per gram, but the second modal value (27.9%) was between 6-10 €.

The prices distribution of amphetamine is variegated. 35.7% reported a price under 5€, 25% within 6-10€ and over 20€ and 10.7% between 16-20€. The price distribution of ketamine is variegated as well as for amphetamine but the modal class for this drug is “>20” (41.2%). Conversely 41.1% of users reported a price under 10€.

Further analysis can be done drawing from data surveyed separately in occasional, regular and intensive consumers most noticeably. The aim is to obtain an estimation of prices from those who had more recent experience.

**Table 3.2. estimated price for 1 gram of marijuana expressed by cannabis consumers according to their consumption frequency**

		< 5 €	6-10 €	11-15€	16-20€	> 20 €	Total
<b>Cannabis consumers</b>	Occasional	100.0%	-	-	-	-	100.0%
	Regular	45.8%	33.3%	-	20.8%	-	100.0%
	Intensive	62.8%	18.6%	4.7%	4.7%	9.3%	100.0%

Table 3.2 displays estimated prices the users gave to marijuana according with their consumption habit.

Most respondents, whether they are occasional, regular or intensive marijuana users, estimated marijuana prices at less than 5 €. Considerable levels of regular users declared a price between 6-10 € (33.3%) and within 16-20€ (20.8%).

Hashish distribution is more concentrated among two price groups; all kinds of users indicated a price lower than 5€ with rates over 80%. Around 9% of intensive consumers reported prices between 6 and 10€.

**Table 3.3. estimated price for 1 gram of hashish expressed by cannabis consumers according to their consumption frequency**

		< 5 €	6-10 €	11-15€	16-20€	> 20 €	Total
<b>Cannabis consumers</b>	Occasional	100.0%	-	-	-	-	100.0%
	Regular	83.3%	5.6%	2.8%	8.3%	-	100.0%
	Intensive	88.7%	9.4%	-	-	1.9%	100.0%



**Table 3.4. estimated price for poor heroin and poor cocaine per 1 gram, expressed by consumers of these substances according to their consumption frequency**

		< 20€	21-30€	31-50€	51-60€	> 60€	Total	
<b>Cocaine and heroin consumers</b>	Poor cocaine	Occasional	6.3%	25.0%	68.8%	-	-	100.00%
		Regular	25.0%	25.0%	48.2%	1.8%	-	100.00%
		Intensive	7.2%	20.3%	69.6%	1.4%	1.4%	100.00%
	Poor heroin	Occasional	29.4%	35.3%	35.3%	-	-	100.00%
		Regular	25.0%	30.3%	39.5%	3.9%	1.3%	100.00%
		Intensive	13.9%	40.5%	44.3%	-	1.3%	100.00%

Table 3.4 depicts the estimated prices of poor cocaine and poor heroin expressed by those who were consumers of these two drugs. Analysis was conducted distinguishing users according to their consumption frequency. The estimation price for poor cocaine is between 31-50€. Levels of occasional, regular and intensive consumers are concentrated in the price class between 21 and 50 € per gram. 68.8% of occasional users, 48.2% of regulars and 69.6% of intensive users reported a price between 31-50 €. The data about poor cocaine in figure 3.12 is confirmed.

Confirmation comes also from data about poor heroine prices given by consumers of this substance. Percentages are variously spread among price classes thus an exact estimation can't be given. The price of poor heroin is less than 50 € per gram.

**Table 3.5. estimation price for top quality heroin and top quality cocaine per 1 gram, expressed by consumers of these substances according to their consumption frequency**

			< 20 €	21-40 €	41-60 €	60-80 €	> 80 €	Total
<b>Cocaine and heroin consumers</b>	Top quality Cocaine	Occasional	-	27.3%	72.7%	-	-	100.00%
		Regular	10.5%	35.1%	47.4%	5.3%	1.8%	100.00%
		Intensive	7.7%	23.1%	60.0%	9.2%	-	100.00%
	Top quality Heroin	Occasional	9.1%	54.5%	36.4%	-	-	100.00%
		Regular	19.6%	42.9%	30.4%	1.8%	5.4%	100.00%
		Intensive	14.8%	48.1%	32.1%	4.9%	-	100.00%

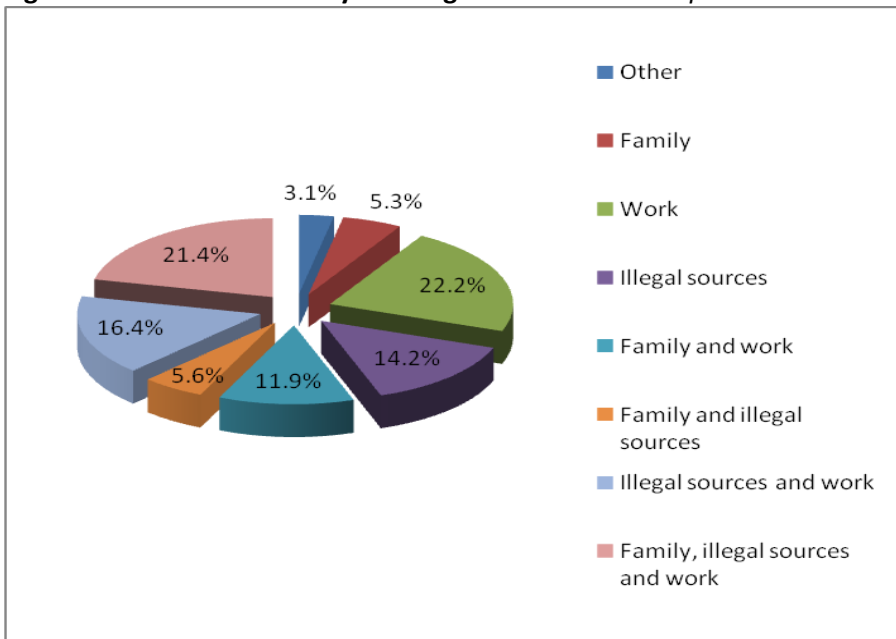
For top quality cocaine and top quality heroin, modal price class is the same for all three typologies of consumer (41- 60€) followed by the price class 21-40€. Thus the analysis in table 3.13 can be improved upon: the top quality cocaine price is between 21 and 60€ while the estimate of the top quality heroin price remains under 60€.

# CHAPTER 4

## Legal and Illegal Sources of Revenue for Drug Addicts

This chapter aims to analyze the sources of income (legal and illegal) through which users get money to buy drugs. The issue of income sources is strongly related to the question of illicit drug market funding. There are three main sources of revenue for a drug user: money from family, work and illegal activities. The question “How did you get usually money to buy the drug(s)?” required the respondent to indicate more than one answer and the respondents have been aggregated into 8 categories according to the combination of the three main sources identified.

**Figure 4.1. sources of money for drug consumers 360 respondents**



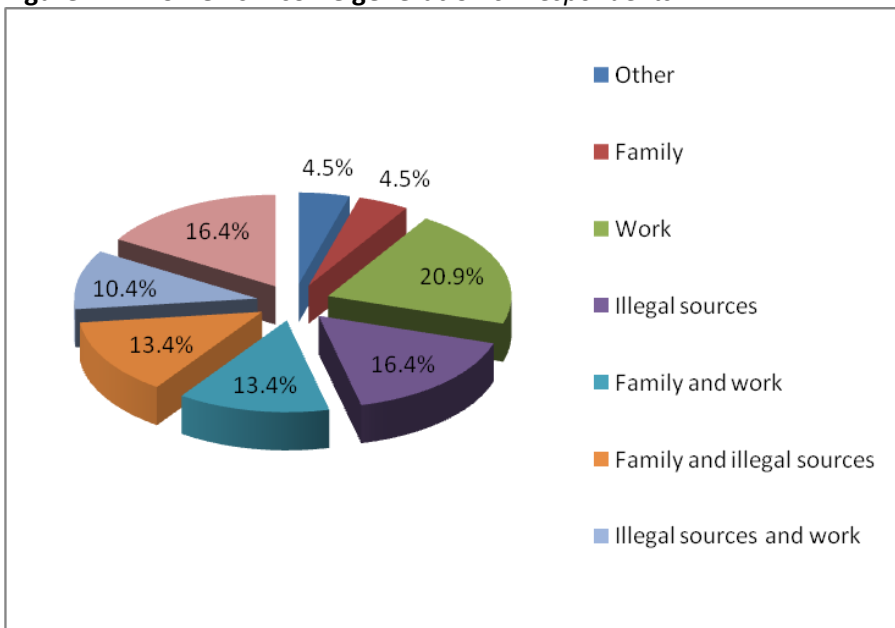
“Family”- alone- is the income source of 5.3% of users. 11.9% collected money from family and work salary while 5.6% sourced money from family and illicit activities. Families have a powerful prevalence as income for drugs addicts, as seen also in rprevious chapters, but to varying degrees across different countries. 21.4% of respondents draw from family savings, nearly always in conjunction with other sources. This could mean that money from the family is not enough to maintain the level of consumption for most users, so they necessarily have to draw from other sources.

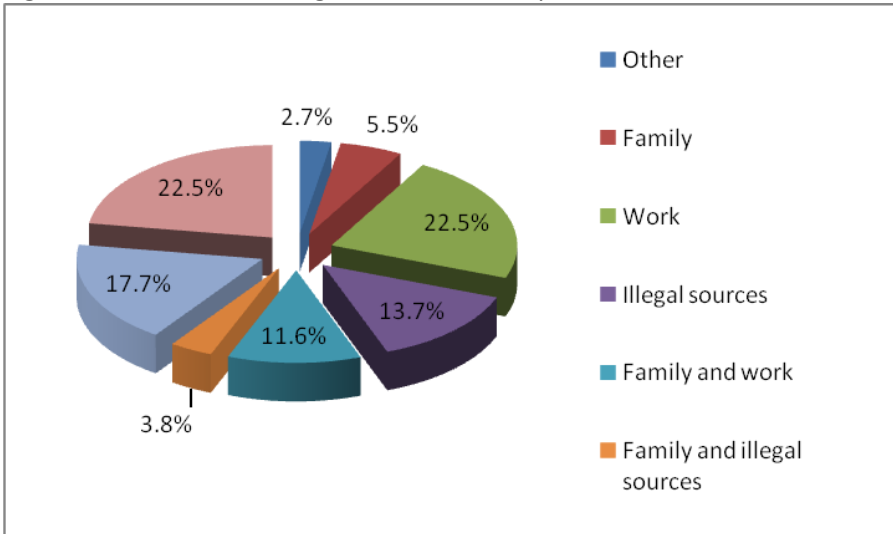
Work is an important source of income for the purchase of drugs for 22.2% of users while illegal activities is the only one source of income for 14.2% of users.

21.4% of users use the three income sources all together to get money to spend on drugs ; 16.4% cite two income sources “illegal activities” and “work”.

The income sources of women are different from those of men: family is more important for men (Figure 4.2 and 4.3) than for women but women use family in conjunction with illegal activities more than men. Women report illegal sources of income more than men.

**Figure 4.2. women’s income generation 67 respondents**



**Figure 4.3. men's income generation 293 respondents**

Other important features can be observed in relation to the age of the respondents.

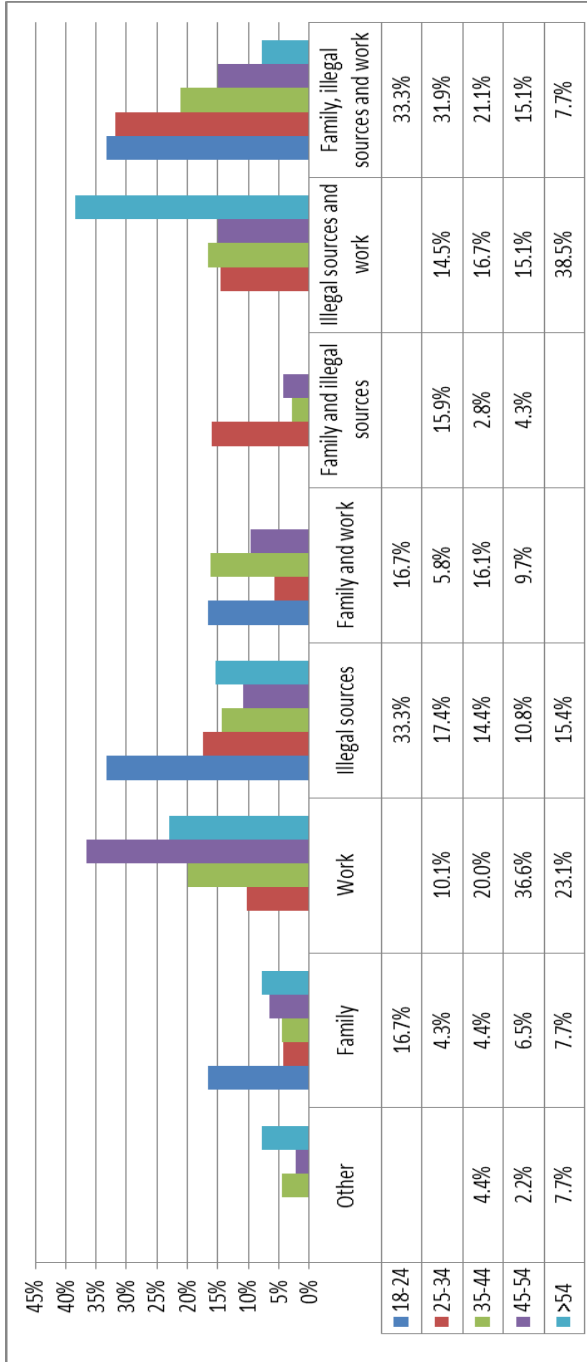
33.3% of young adults aged 18-24 (Figure 4.4) received revenue from “illegal activities” and “family, illegal activities and work”. Family as well as family combined with work is an important source for 16.7% of young adults. No young adults reported only work as an income source.

Looking at the group 25-34 age group “family, illegal activities and work” was still the modal value but less important (31.9%) than for younger group. Illegal activities (17.4%) and illegal activities combined with family resources (15.9%) are the two main sources of income for users in the 25-34 age group.

Work is the main source of income for the respondents aged 45-54 years old.

As the age increases, the frequencies of respondent are more distributed among classes of combined sources of income except for respondents age 45-54. 36.6% reported “work” as the only income source.

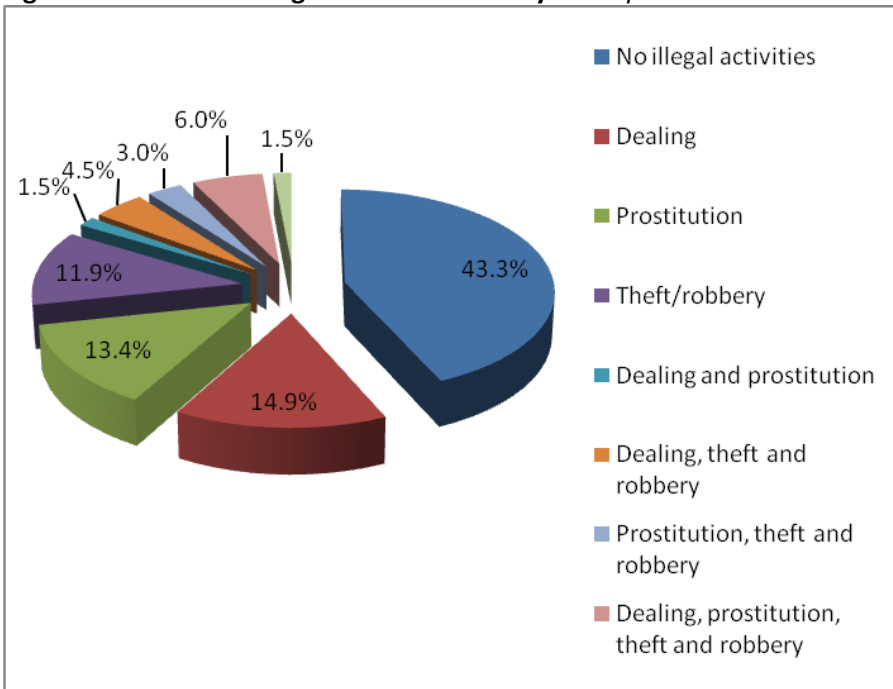
Figure 4.4. sources of money by age 361 respondents



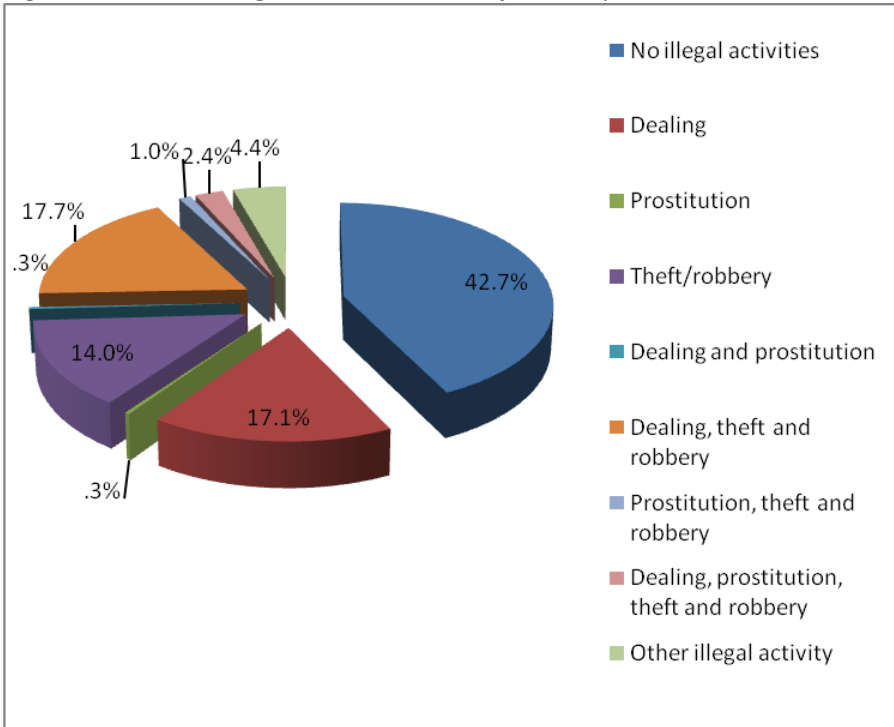
The survey also allows a deeper analysis concerning the main illegal activities: dealing, prostitution and theft/robbery. In order to better understand the phenomenon we built seven different clusters containing one or more of the above-mentioned activities according to the multiple or single choices of respondents.

Figure 4.5 displays the illegal sources of funding for females. The main illegal sources of revenue are drug dealing (14.9%), prostitution (13.3%) and theft and robbery (11.9%). Women seem to prefer only one illegal source of funding rather than several combined together. In fact just 6% of female use all three sources together.

**Figure 4.5. women's illegal sources of money 67 respondents**



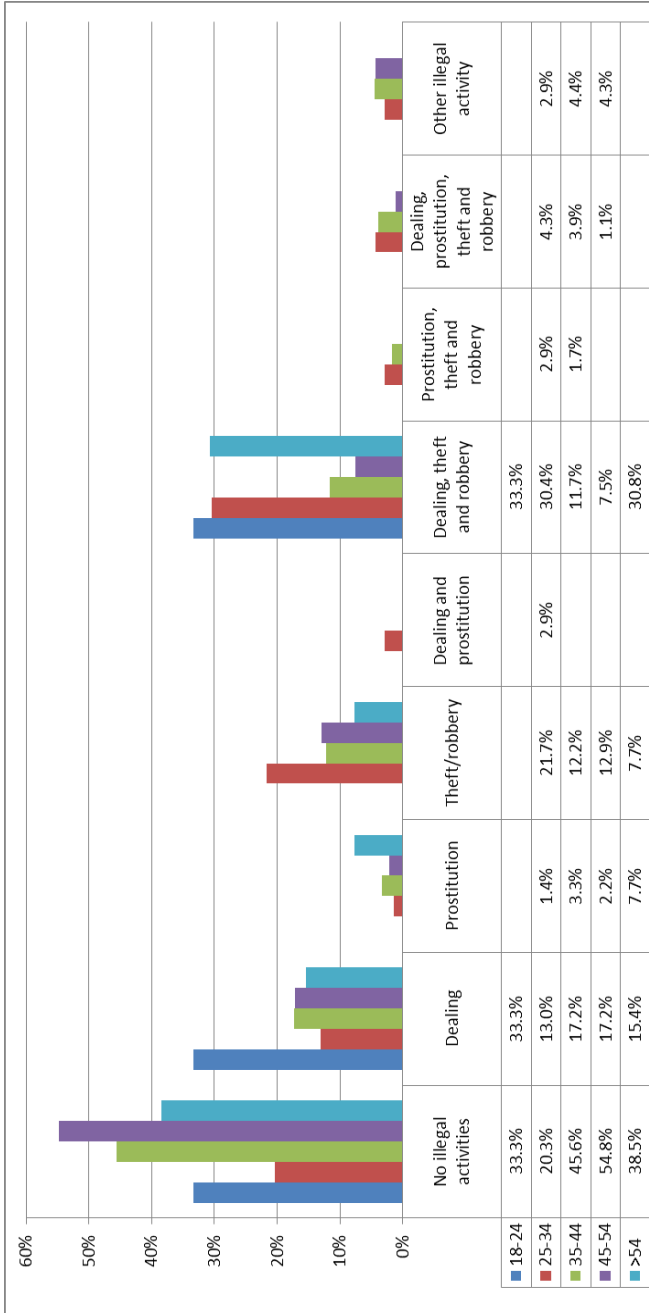
**Figure 4.6. men's illegal sources of money 293 respondents**



The main source of funding for men is drug dealing and theft and robbery (17.7%) followed by only dealing (17.1%) and only theft and robbery (14%). Prostitution was declared by 1.3% men (summing up only prostitution and dealing and prostitution).



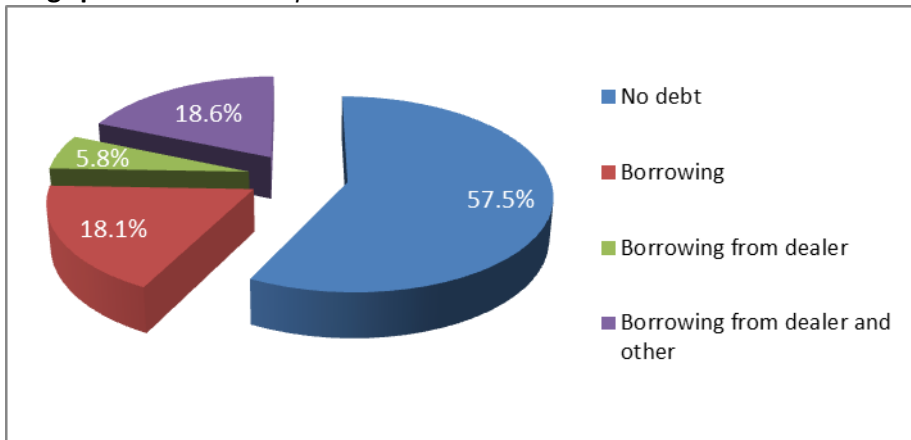
Figure 4.8. illegal source of money by age 361 respondents



Drug dealing, on the individual level, is among the main activities used as an illegal income source to purchase drugs. That applies to all of the age groups. Drug dealing is still more widespread among the younger generation (18-34 years old), especially combined with theft and robbery (Figure 4.8).

Prostitution is more frequent among older users.

**Figure 4.8. distribution of respondents who contracted a debt or not for drugs purchases 360 respondents**



Among those who borrowed money to buy drugs, 18.6% borrowed both from the dealer directly and from other subjects, 5.8% reported to have borrowed money just from dealer and 18.1% only from other subjects. The majority of respondents (57.5%) have never received a loan to buy drugs.

**Figure 4.9. distribution of respondents who contracted a debt or not for drugs purchase by gender 360 respondents**

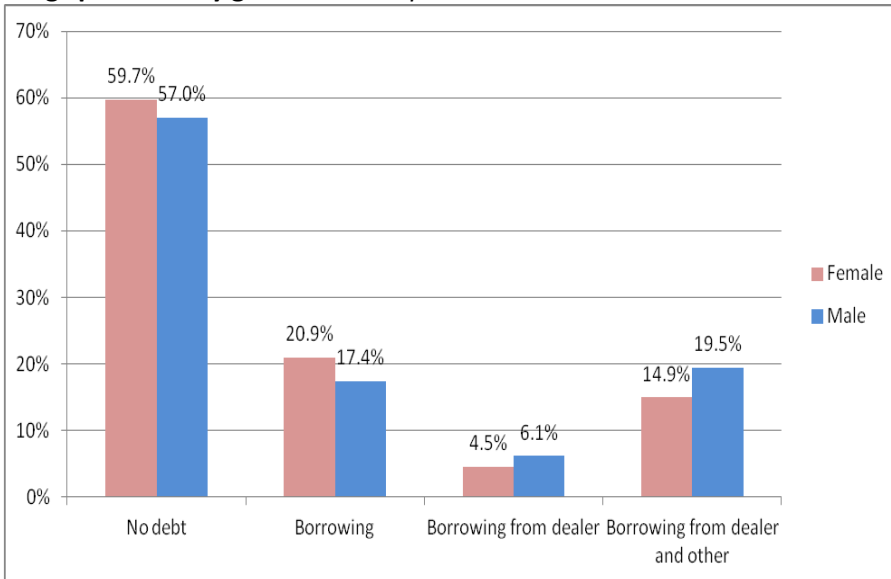
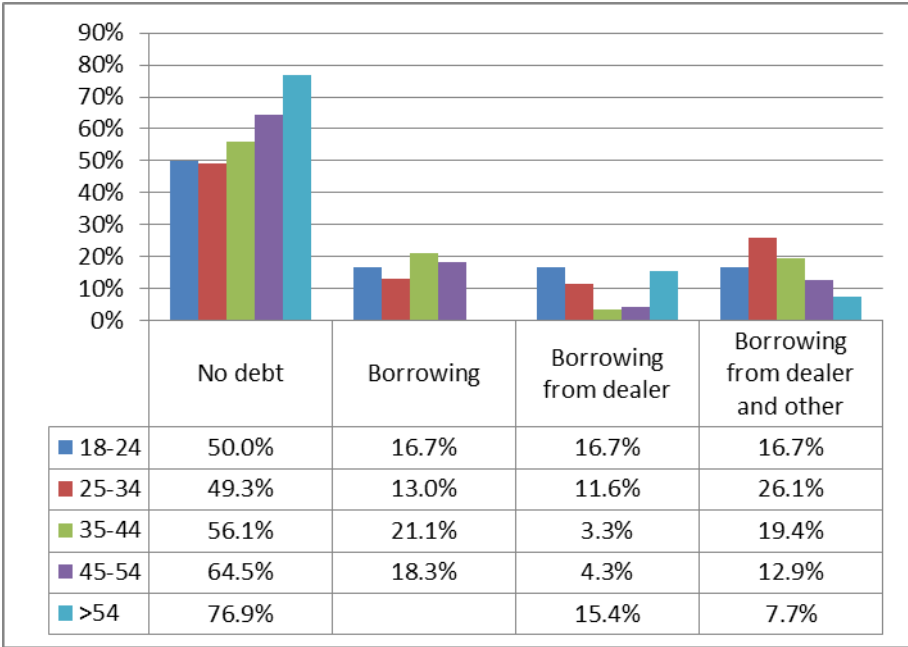


Figure 4.9 displays users distribution by gender and the way to purchase drugs by means of borrowing money. Data shows little difference between men and women in all the categories.

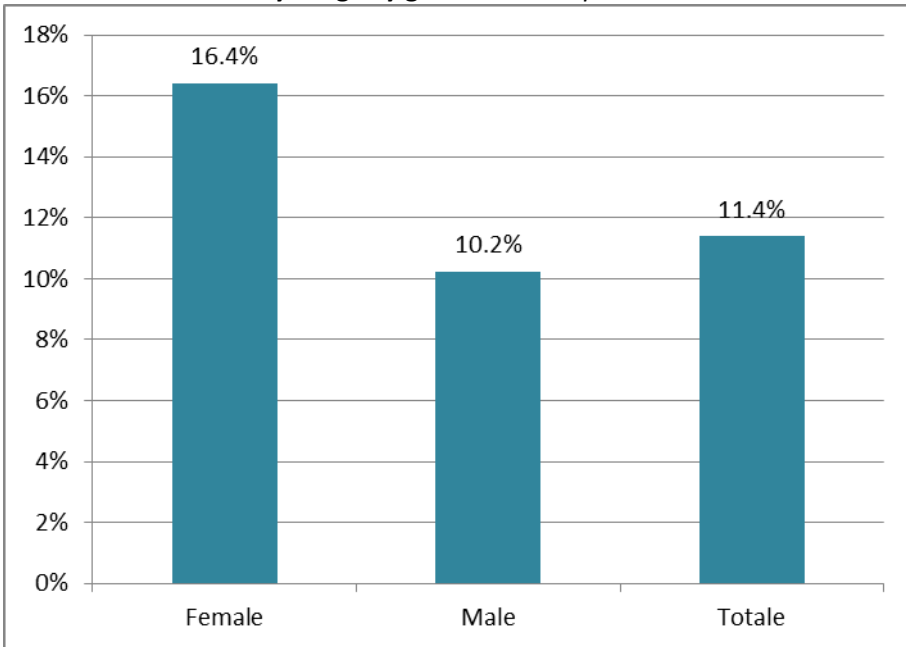
Men mostly prefer borrowing directly from a dealer or both from a dealer and other subjects.

Men had incurred a little more debt than women.

**Figure 4.10. distribution of respondents who contracted a debt or not for drugs purchase by age 361 respondents**



**Figure 4.11. distribution of respondents who used contributions from social assistance to buy drugs by gender 360 respondents**



The last analysis concerns those who also used contributions from social assistance for drugs. They comprise 11.4% of the whole sample and they are mostly women (16.4% of the whole female sample). Men comprise 10.2% of the whole male sample.





# CHAPTER 5

## Evaluation of Services

Patient satisfaction is the major indicator of the quality of services provided by a health facility. In this chapter the aim is to assess the level of satisfaction of patients within various aspects of health care in said facilities.

### **5.1. Satisfaction with Services**

Respondents were asked about the usefulness of assistance received during their treatment program in care facilities. The usefulness of services has been expressed through a utility score ranging from 1 to 5, where 1 represents the minimum benefit and 5 the maximum one. Services under assessment are: psychological assistance, medical assistance, the chance of sharing experiences with others, getting back to living in regard of communal rules, access to drug substitutes and assistance in job hunting.

**Figure 5.1. average rate of patient satisfaction for health care services**  
 317, 279, 269, 281, 266, 275 respondents

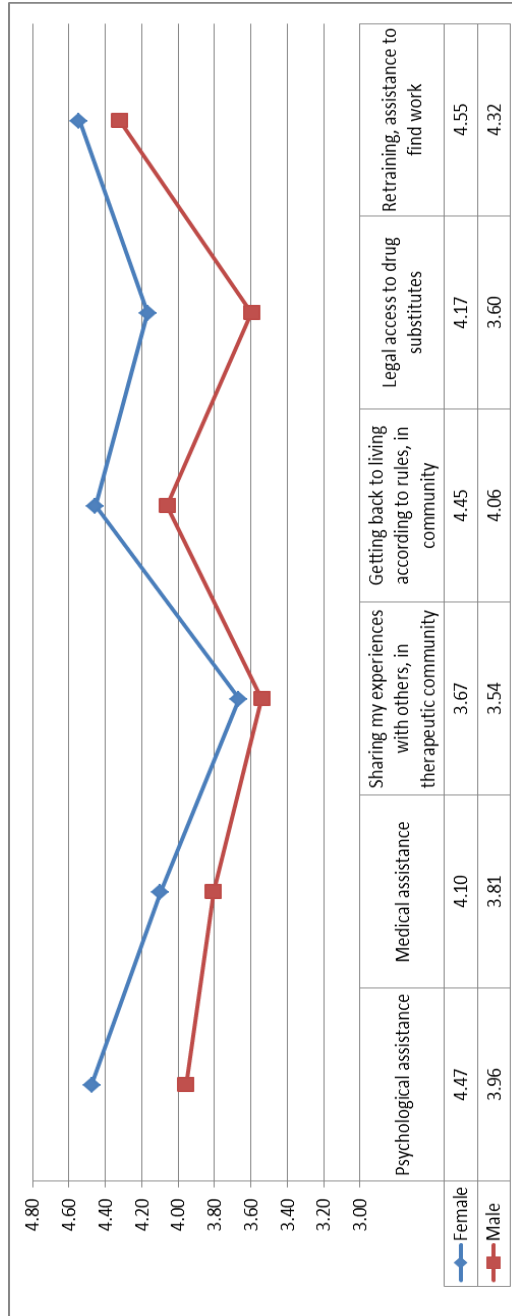




Figure 5.1 shows the average level of satisfaction expressed by women and men. On average women evaluated all services higher than men, but the distribution of the evaluations presents the same trend as regards ranking services, with the exception of “legal access to drug substitution” that is well appreciated by women

In Table 5.1 more details are reported about the distribution of these evaluations: Getting back to living according to rules within a community (53.9%), psychological assistance (52.1%) and social and work reinstatement assistance (65.5%) receive the highest percentage on the maximum utility score (5 points). About 10% of users evaluated the utility of these services to be lower than 2 points.

“Legal access to drug substitutes” and “medical assistance” are particular services offered in the LTS, they also received high scores. Around 43% of users rated these services at 5 points. The first services were also negatively evaluated (1 point score) by 17% of users and this is the lowest appreciation rate among all the services. About 40% of respondents rated medical assistance at between 3 and 4.

**Table 5.1. evaluation of services usefulness [1= lowest rating \_ 5 = highest rating] 317. 279. 269. 282. 266. 275 respondents**

	<i>Psychologica l assistance</i>	<i>Medical assistance</i>	<i>Sharing my experiences with others. in therapeutic community</i>	<i>Getting back to living according to rules. in community</i>	<i>Legal access to drug substitutes</i>	<i>Retraining. assistance to find work</i>
Values						
1	6.6	7.9	12.6	5.7	17.3	5.5
2	5.7	6.1	12.3	5.0	5.6	3.3
3	15.5	20.8	16.4	14.2	12.8	5.8
4	20.2	22.6	23.8	21.3	18.4	20.0
5	52.1	42.7	34.9	53.9	45.9	65.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

Further analysis can be undertaken in distinguishing users between those who have never entered a therapeutic community and those who have been patients in these structures at least once in their life.

**Table 5.2. evaluation of service usefulness by TC patients. at least in the past [1= lowest rating \_ 5= highest rating] 283. 244. 242. 255. 239. 248 respondents**

	<i>Psychological assistance</i>	<i>Medical assistance</i>	<i>Sharing my experiences with others. in therapeutic community</i>	<i>Getting back to living according to rules. in community</i>	<i>Legal access to drug substitutes</i>	<i>Retraining. assistance to find work</i>
Values						
1	6.4	6.6	9.1	3.9	17.2	4.4
2	4.9	5.7	12.8	4.7	6.3	3.2
3	15.2	20.5	16.9	14.1	12.1	6.0
4	19.4	20.9	24.0	20.8	19.2	18.1
5	54.1	46.3	37.2	56.5	45.2	68.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

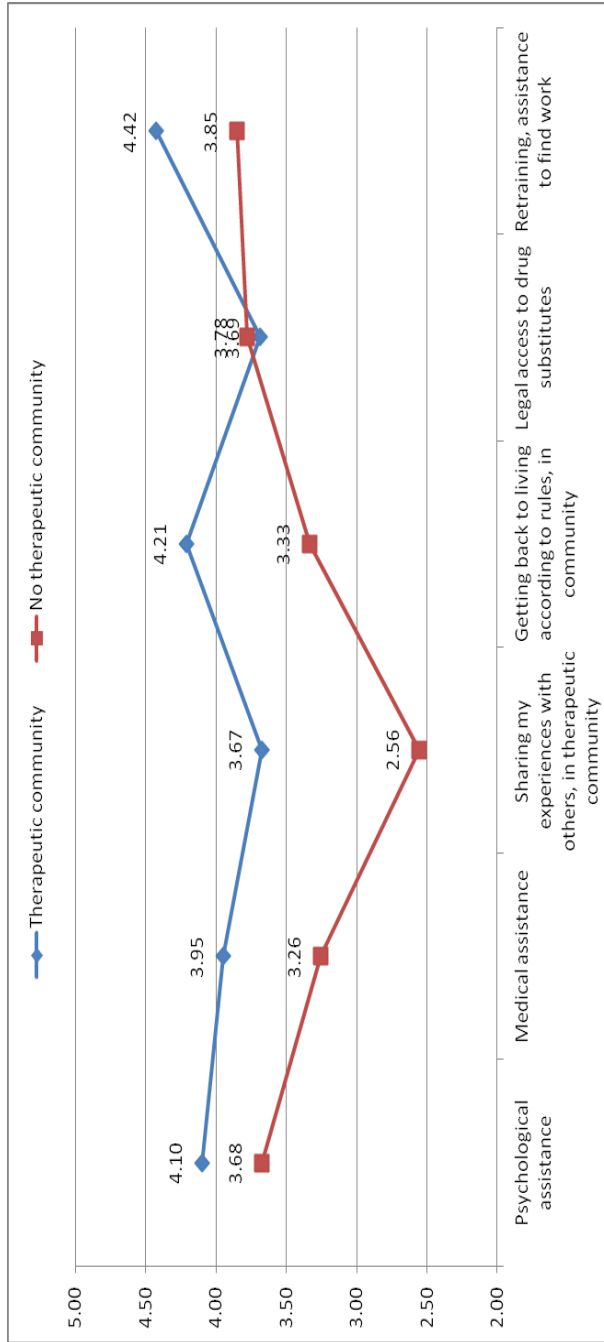
The service considered to be the most useful by both TC residents and non-TC residents, is 'legal access to drug substitutes'. Percentages of users who gave to this service the maximum utility score are almost the same among these two kinds of patients but the never-been- in-TC appreciate it more than those who have been in TC. All the other services are evaluated better by TC users than the never-been- in-TC. In fact the latter users tend to rate services at between 3 and 4 points. Another service appreciated by both cohorts is assistance in job seeking.

Sharing experiences with others and getting back to living according to rules is more appreciated by those who have been in therapeutic communities (68.1% of users assigned the maximum score). On the contrary, the never-been- in-TC cohort assigned lower satisfaction rates to these services. The minimum values were assigned by 44.4% to the experience of sharing and by 22.2% to "getting back to living within the rules".

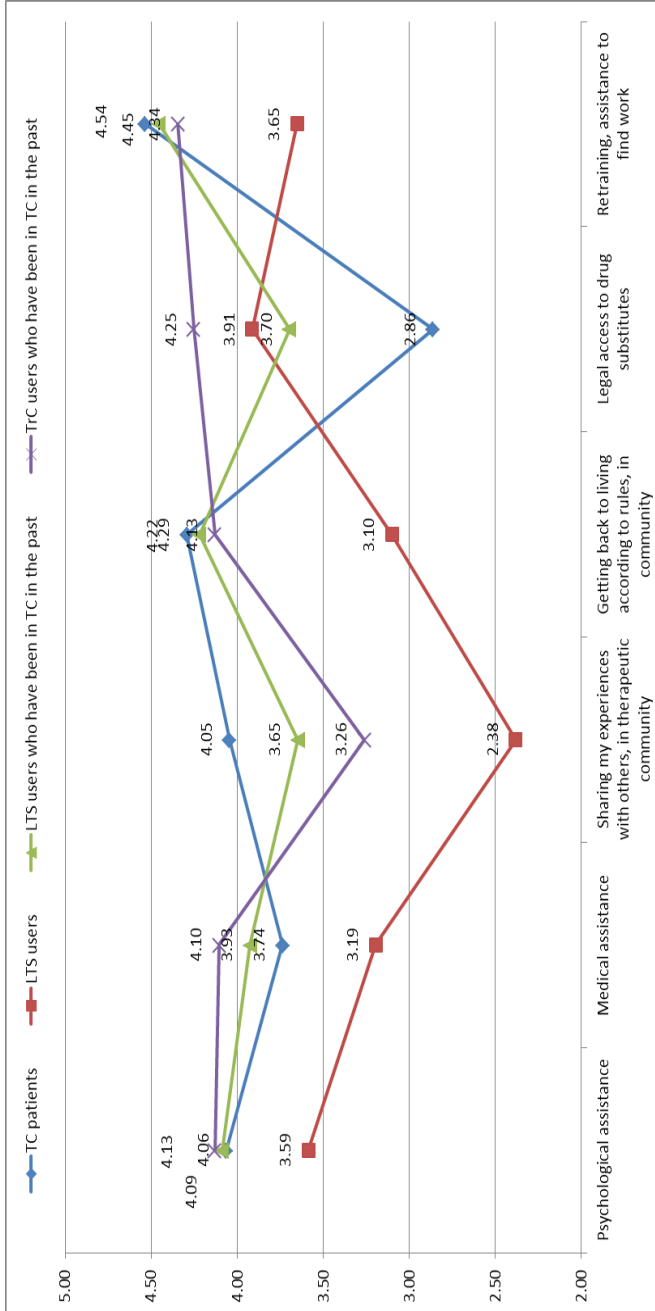
The never-been-in-TC gave importance to psychological assistance (4/5 points 61%). Medical assistance is perceived useful mostly by TC patients.



Figure 5.2. average evaluations according to enrollment in TC [1= lowest rating\_ 5 = highest rating]



**Figure 5.3. comparison of the evaluations by TC patients, LTS users and LTS users been in TC, regarding the utility of services [1= lowest rating \_ 5= highest rating]**



Comparing differences in patient characteristics and average utility scoring among the 4 patient groups reported in figure 5.3, we can see that the lowest evaluation for the psycho-social treatments is given by LTS patients who probably have never experienced these kinds of treatments. The lowest rate was assigned also to “sharing experiences with others” followed by “getting back to rules”. The most useful service for LTS patients is the 'legal access to drug substitutes' (3.91) followed by retraining (3.65). All the other services were evaluated at under the 3.5 average score.

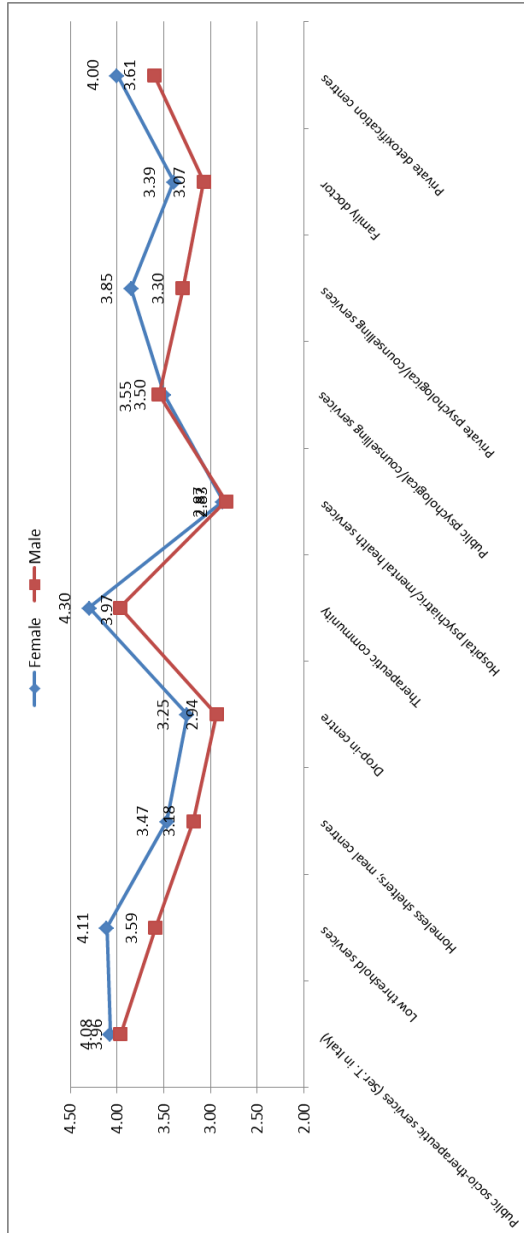
Except for LTS users “psychological assistance”, “getting back to rules” and “retraining assistance” are well evaluated by all the users with scores higher than 4.

Users who have been both in TC and LTS gave a lower rating to “sharing experiences with others” and “Getting back to rules” rather than those who have experienced only TC.

Users who have been both in TC and TrC gave a higher rating to “medical assistance” and “legal access to drug substitutes” rather than those who have experienced only TC.

## 5.2. Satisfaction with Institutes

**Figure 5.4. average rate of patient satisfaction for typology of institute**  
 Female min. 12, max 53 respondents; male min. 60, max 190 respondents



In this kind of evaluation, men and women do not show particular differences (Figure 5.4), but in the evaluation of private psychological and counseling services where men gave a negative evaluation compared with women. On average women have a better opinion than men about all the kinds of institutes on offer except for public psychological and counseling services, but the differences here is little.

47.3% of respondents gave services the maximum quality scores to public socio-therapeutic services and another 40.4% gave them 3 to 4 points. TC follows public socio-therapeutic services with excellent scores: 46.5% of patients gave 5 points and another 26.3 % gave 4. Private detoxification centers are well considered too with about 80% of users giving it between 3 and 5 points.

**Table 5.4. Evaluation of service quality by whole sample [1= lowest rating \_ 5 = highest rating]**

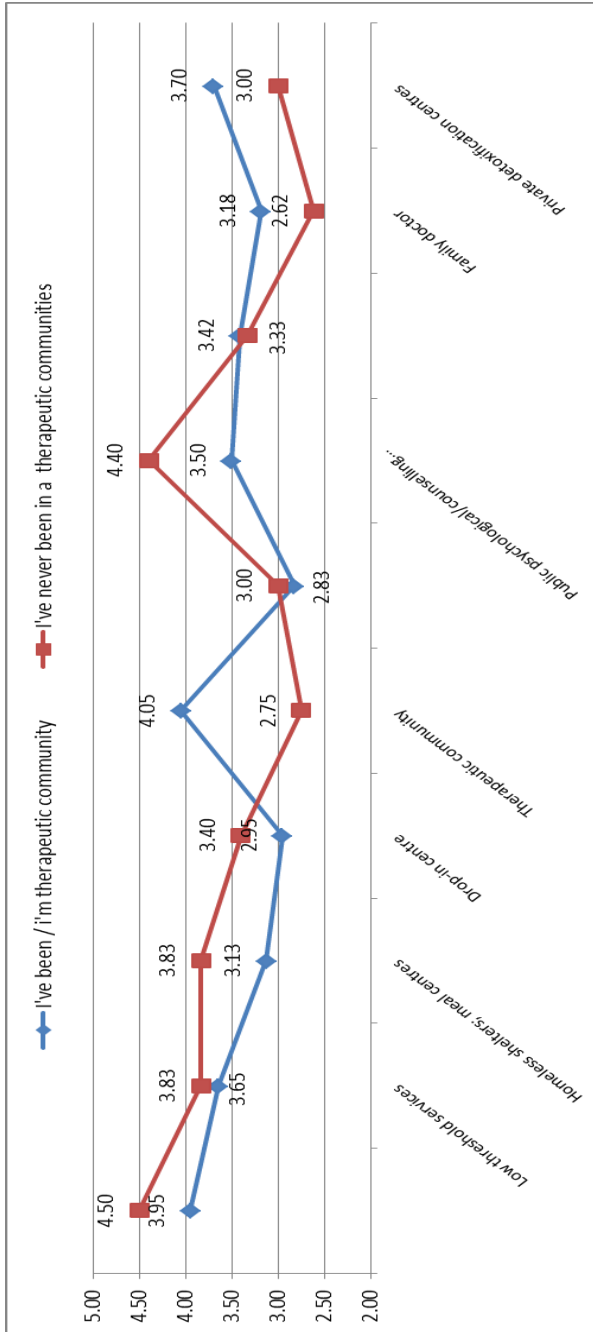
	Public socio-therapeutic services	Low threshold services	Homeless shelters; meal centres	Drop-in centre	Therapeutic community	Hospital psychiatric/mental health services	Public psychological/counseling services	Private psychological/counseling services	Family doctor	Private detoxification centres
Values										
1	3.7	7.3	14.2	18.7	4.7	25.3	7.9	10.3	16.9	8.5
2	8.6	9.8	17.5	19.8	7.0	13.3	14.9	12.4	16.3	11.3
3	20.2	23.6	24.2	26.4	15.5	32.0	22.8	27.8	25.6	20.6
4	20.2	27.6	19.2	15.4	26.3	10.7	23.7	24.7	18.8	22.7
5	47.3	31.7	25.0	19.8	46.5	18.7	30.7	24.7	22.5	36.9
Total	100	100	100	100	100	100	100	100	100	100

Institutes as Psychiatric hospitals are the worst. About 7 users out of 10 scored the quality of these structures at under 3 points.

Homeless centers. drop-in and family doctors have an average quality score equal or below 3 points.



Figure 5.5. difference between TC and non-TC users services evaluation [1 = poor 5 = excellent]



**Table 5.5. evaluation of institute by TC patients [1= lowest rating \_ 5= highest rating]**

	Public socio-therapeutic services	Low threshold services	Homeless shelters; meal centres	Drop-in centre	Therapeutic community	Hospital psychiatric /mental health services	Public psychological/counselling services	Private psychological/counselling services	Family doctor	Private detoxification centres
Values										
1	4.0	8.1	15.7	19.8	4.3	25.7	8.3	9.9	15.6	8.8
2	9.3	10.8	18.6	19.8	6.7	14.3	15.6	13.2	15.6	11.7
3	20.7	23.4	24.5	25.6	15.3	31.4	22.9	26.4	26.5	18.2
4	19.8	23.4	19.6	15.1	26.8	8.6	23.9	26.4	19.0	23.4
5	46.3	34.2	21.6	19.8	46.9	20.0	29.4	24.2	23.1	38.0
Total	100	100	100	100	100	100	100	100	100	100

Tables 5.5 and 5.6 make a comparison between quality evaluation expressed by users who have tried therapeutic community services and by those who never made use of such a facilities. As we saw in figure 5.5 , respondents who have never been in a therapeutic community gave a very negative evaluation of the family doctor and a neutral evaluation of therapeutic communities services.

**Table 5.6. evaluation of institutes by non-TC patients [1= lowest rating \_ 5= highest rating]**

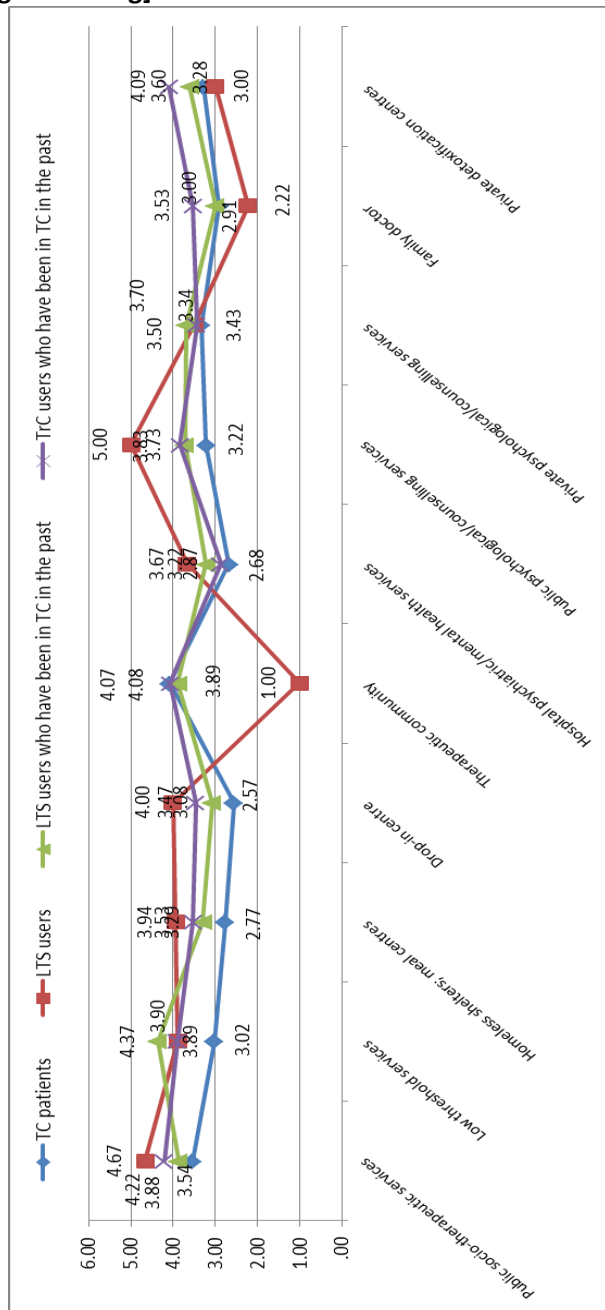
	Public socio-therapeutic services	Low threshold services	Homeless shelters; meal centres	Drop-in centre	Therapeutic community	Hospital psychiatric /mental health services	Public psychological/counseling services	Private psychological/counseling services	Family doctor	Private detoxification centres
Values										
1	-	-	5.6	-	-	20.0	-	16.7	30.8	-
2	-	-	11.1	20.0	25.0	-	-	-	23.1	-
3	12.5	25.0	22.2	40.0	25.0	40.0	20.0	50.0	15.4	100.0
4	25.0	66.7	16.7	20.0	25.0	40.0	20.0	-	15.4	-
5	62.5	8.3	44.4	20.0	25.0	-	60.0	33.3	15.4	-
Total	100	100	100	100	100	100	100	100	100	100

For never-been-in- TC the best quality services are provided by public structures such as psychological/counseling and socio-therapeutic services: 6 users out of 10 gave the maximum quality score to these two facilities. For therapeutic communities' patients the best quality structures are also public socio-therapeutic services and therapeutic communities.

The satisfaction regarding psychiatric hospitals is very negative for TC users: about 40% of them scored the quality of this public service between 1 and 2 points. Although there are considerable percentages of those who evaluated psychiatric hospitals as a positive service (28% scored between 4 and 5 points), users who had never been in TC expressed an average score of between 3 and 4 for hospital services.

Private detoxification centers are scored at 3 by the whole population of users who have never been in TC while for patients of TC this service is evaluated by the majority at between 4 and 5 (61.4%).

**Figure 5.6. mean of the evaluations by TC patients, LT users and LT users who have also been in TC, regarding the quality of services [1= lowest rating \_ 5= highest rating]**



In figure 5.6 we isolated from LTS users, subjects who attended a TC structures in the past.

As shown in figure 5.6 the subsequent evaluation of all the services follows almost the same trend for all 4 kinds of users. The only one nonconforming case regards LTS patients, who perceive therapeutic communities as a very bad service and scored it with an average of 1 point. In contrast the whole population from LTS gave the maximum score to public psychological/counseling services. LTS users have also the highest opinion of mental health services.

To recap, TC patients have a lower consideration of all the services in the list in comparison with the other groups of users. Evaluation of those who attended both TC and LTS structures tends to follow the assessment line of those who attended both TrC and TC structures and those who attended solely TC.

Among those patients who have attended both LTS and TC structures, LTS services have been perceived in a more positive way compared to the feedback provided by attendees of solely LTS services. On the contrary, the opinion of TC services by patients of both LTS and TC structures was more negative, than those who attended only TC services.



## APPENDIX 1 – Question 8: drugs used along three periods

During the first year of use - After three years of use - Last time  
Question 8 is the first multiple question of the questionnaire. It was asked which drugs have been used in three different periods and how much in each period.

The question aimed to investigate doses taken and levels tolerance.

*The descriptive analysis.*

Almost every respondent answered this question, but just around 2/3 of the respondents declared the daily doses for each period. The maximum number of respondents was reached with the answer for the 1<sup>st</sup> year of use in the case of cannabis (80%) and in this case 55% respondents also declared the doses.

The case of cannabis is quite interesting because the number of respondents decreases along the three periods (at 44% in the most recent time period) and this confirms that cannabis is a drug for beginners and is less appreciated among intensive users of hard drugs. Heroin (60%) decreases only 8 points in the last time period. Cocaine (48 %) reaches 35% in the most recent period, but is compensated for in the large diffusion of crack.

Around 20% of respondents had been collected for Tranquillizers, Ecstasy, Amphetamines. More than 30% for freebase (crack). The other drugs in the list are very residual.

Looking at the different distributions for Heroin, Cocaine and Cannabis – that are not presented at the moment, because a deeper analysis has been required - there are slight differences among the three periods, the modal values are almost the same for Cocaine and Heroin, Cannabis has a modal value for the most recent period at just one dose, that confirms the observation made above and in the preceding chapters that it is a “drug for beginners”.

- *A better description of tolerance.*

To give a better description of tolerance three new variables can be introduced.

Given X= doses used in the first year; Y= doses used in the third year; Z= most recent doses:

(A1) =  $(Y-X)/X$ \*100 measures if the consumption is increased or decreased between the first and the third year;

(A2) =  $(Z-Y)/Y$ \*100 measures if the consumption is increased or decreased between the third year and most recent use;

$(A3) = (Z-X)/X * 100$  measures if the consumption is increased or decreased between the first and most recent use.

The comparison between A1, A2, A3 is an attempt to gain a clear idea of the tolerance level induced by the use of each drug.

Cannabis seems to generate a low degree of tolerance and a greater possibility of being substituted; Heroin use on the contrary, especially in the third year, decreases just for a small percentage of respondents.



## APPENDIX 2 – Question 26: How many doses sold weekly?

This question was been answered by 297 respondents, 78% of the sample, and 60% of them reported to have never sold drugs. It is assumed (but just for a statistical convenience) that non – respondents have never sold drugs and this assumption can be considered a good proxy of the real situation, therefore - in keeping with the methodology adopted for other countries - the “never-sold-drugs” comprise 69% of the sample. Almost all the dealers sell at least 2 drugs; nobody had sold GHB and the most usual drugs are: Cocaine (by the 55.2% of the respondents); Heroin (by 52.9%); Cannabis (by 51.7%). The other drugs are less likely to be sold by our respondents: Ecstasy (by 15%); Crack (by 9.8%); LSD (by 8.1 %); Amphetamine (by 7.6 %); Ketamine (by 7 %).

In the following Table A2.1 doses and respective percentages of dealers of the main drugs are listed.

In table A2.1, a very simple classification for dealers is proposed, in order to to highlight how important the single dealer is within the market.

**Table A2.1. weekly doses sold by dealer respondents 297 respondents**

dealers		Ecstasy		Cannabis		Cocaine		Heroin	
		% on dealers population	9.3%		39.0%		50.0%		72.0%
	% on sample population		2.9%		12.1%		15.5%		22.3%
small dealers		doses	% dealers	doses	% dealers	doses	% dealers	doses	% dealers
		1	0.8%	3	0.8%	5	2.5%	2	0.8%
		10	0.8%	5	0.8%	7	0.8%	3	1.7%
		20	0.8%	8	0.8%	10	1.7%	4	3.4%
				10	2.5%	12	0.8%	5	2.5%
				20	3.4%	20	3.4%	6	0.8%
				27	1.7%	25	0.8%	10	0.8%
						30	5.9%	13	3.4%
								15	0.8%
								20	1.7%
								25	0.8%
								26	3.4%
								30	0.8%
	<b>Sub-total</b>		<b>2.4%</b>		<b>10.1%</b>		<b>16.1%</b>		<b>20.3%</b>

	Ecstasy		Cannabis		Cocaine		Heroin	
<b>Street dealers</b>	50	0.8%	35	0.8%	40	0.8%	35	1.7%
	150	0.8%	50	1.7%	50	2.5%	40	0.8%
			70	1.7%	60	0.8%	50	4.2%
			100	3.4%	90	0.8%	60	2.5%
			140	0.8%	100	2.5%	70	0.8%
			150	0.8%	120	1.7%	80	2.5%
					140	0.8%	100	7.6%
	<b>Sub-total</b>		<b>1.6%</b>		<b>10.1%</b>		<b>10.1%</b>	
<b>expert dealers</b>	200	0.8%	200	3.38%	200	1.7%	120	1.7%
	300	2.5%	250	1.41%	300	6.8%	140	0.8%
	4000	0.8%	320	1.97%	500	4.2%	150	2.5%
			400	0.28%	1000	2.5%	200	1.7%
			500	5.92%	3000	2.5%	300	4.2%
			1000	0.28%	4000	0.8%	400	2.5%
			1500	0.28%	5000	0.8%	500	5.1%
			24000	4.23%	7000	0.8%	1000	3.4%
							1400	0.8%
							2000	0.8%
							4000	0.8%
							5000	0.8%
							7000	0.8%
<b>Subtotal</b>		<b>4.1%</b>		<b>19.5</b>		<b>20.3%</b>		<b>26.3%</b>

Specialization in the market is also another factor and poly dealing is described in Table A2.2.

**Table A2.2. composition of the dealers market by number of substances sold. Frequencies of the respondents.**

Sold substances	% on sample population
Never sold	69.03%
Only cannabis	3.41%
Only cocaine	1.57%
Only heroin	6.56%
Only other substances	0.26%
Cannabis and cocaine	0.26%
Cannabis and heroin	0.00%
Cannabis and other substances	1.84%
Cocaine and Heroin	6.30%
Cocaine and other substances	1.05%
Heroin and other substances	1.31%
Three or more substances	8.40%
Total	100.00%

### APPENDIX 3 – Question 38: Characteristics of users older than 25 years

This multiple question was the most complex. it was successful considering its position at the bottom of the questionnaire.

At least 2 out of 3 of the possible respondents for this question (> 25 years old) answered all the answers of this complex part of the questionnaire.

Also for this question it was necessary to generate new variables for a simple description of the data.

3	<b>Civil status - parameters</b>
	Single 1
	Married /living together with a partner 2
	Divorced/widow 3
	NO ANSWER 5
First position	Age of first use
Second	25 years old
Third	35
Fourth	Now

91% of 361 respondents are single at the age of first use; at the age of 25 55% are single, while the married respondents reach the higher percentage of 41%; at the age of 35 single people comprise 52%, married respondents 36 %, whilst a consistent percentage of divorced people (12%) appear. Looking at 'current status', married respondents comprise only 19%, while 23% are divorced and 58% single.

#### Children

At the ages of 25 and 35, 24% and 27% live with their children; 'currently' only 19% do.

#### 4 How do you live? And where?

10% respondents live alone when they first use drugs. This percentage increases regularly and arrives at 23% at currently.

82% respondents live with parents when they first use; at 25 years old this percentage falls to 41%; at 35 it reaches the minimum (27%); but it rise again in the current moment to 35%.

At the current point just 21% respondents live with his/her partner and 16% live in a hospital/therapeutic facility/nursing home.

## **5 Employment**

Respondents with a permanent job all their life comprise just 1.6 %.  
11.8 had a permanent job at the age of 25 years old and only 10 % at 35 years old.

The complexity of the question CAN be summarized by an index of marginalization that combines the four variables here considered; in a separated file you can find the values.

## APPENDIX 4 – Main parameters of the sample

Age by sex	Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
Males	40.52	8.04	41	35.5	47.5	17	59
Females	40.54	7.78	40	35	45	20	65

First use by sex		Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
First use drugs	Males	14.55	3.14	14	13	16	7	30
	Females	14.32	3.11	14	12	16	9	25
First use hard drugs	Males	18.02	4.76	17	15	19	9	38
	Females	18.16	6.05	16	14	20	12	39
First time selling drugs	Males	20.51	7.14	18	16	24.75	10	50
	Females	22.32	8.48	19	16	27.50	12	40
Latency	Males	3.47	5.67	2	2	4	0	21
	Females	3.84	3.44	2	0.5	4	0	25

Prices	Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
Marijuana	12.33	11.48	10	5	15	5	50
Hashish	7.53	7.36	5	5	5	3	30
Cocaine	44.5	6.96	42.5	40	50	37.5	60
Eroine	40.33	7.43	40	37.5	45	27.5	55
Amphetamine	17	11.92	10	5	30	5	40

Age at first contact	Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
Street units	28.95	7.67	27.5	23.5	34	20	45
Public treatment centers	27.65	5.33	28	24.25	30	19	38
Therapeutic communities	29.45	8.29	30	21.75	36.25	19	38
Private detoxification centers	28.75	7.34	28	24	34	17	40





# PART 5

## Catalonia Survey

Antonia Domingo Salvany and  
Albert Sanchez Njubo

Sampling design, data collection, data entry and analysis have been conducted by the Easy and Faster s.r.l. working group coordinated by Roberto Ricci and composed of: Francesco Fabi, Umberto Ialiccio, Claudia Musella and Claudia Restelli.





# INTRODUCTION

## 1. Methodology of sampling<sup>2</sup>

Subjects in the sampling frame comprised illegal drug users in the region of Catalonia.

Contacts were held with the socio-sanitary premises helping users to face their drug addiction.

Three types of centers were approached: Treatment Centers (TrC), Low Threshold Services (LTS) and Therapeutic Communities (TC).

In order to select centers several considerations were taken into account:

- To reach, as far as possible, the whole territory of Catalonia.
- The main bulk of the project was based on Treatment Centers given that they are the most geographically spread out and provide the most comprehensive premises. They include opioid substitution treatment. From a total expected sample of 500, 300 were allocated to TrC.
- Only treatment centers with a minimum number of visits per year (n=45) would be considered for inclusion.
- Patients in treatment centers were selected according to different lengths of time (first visit, > 6 month, 6-12 month, 1 year or more).

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<sup>2</sup> Data collection in Spain for this research was coordinated by the IMIM-Hospital del Mar Drug Abuse Epidemiology Research Group, supported by the Local (Barcelona) and Regional Plans on Drugs, under the financial support of a Spanish grant. They added many other questions in the questionnaire concerning epidemiology and other medical information on drug addicts. The part of THE Spanish questionnaire related to the project and this report WAS finalized by Easy and Faster s.r.l. under the supervision of the University of Rome Tor Vergata within the framework of the EU project JUST/2010/DPIP/AG/1410: New methodological tools for policy and programme evaluation.

- A number of patients were assigned to each center, according to the number of visits held, not through an exact proportion.
- Geographical complementarity between TrC and LTS and TC was taken into account.
- Associations offering Flats and Therapeutic communities were contacted and they were kind to collect 100 questionnaires from their patients.
- LTS facilitators with 100 assigned interviews should recruit patients according to some proportions: women 20-25%; foreigners (living a minimum 6 months in Spain) 25%; 70% in BCN-city and Metropolitan Area (Sant Adrià, Hospitalet, El Prat, Badalona, Santa Coloma, Gavà), 10% rest of Barcelona province, and 10% each in Tarragona and Lleida. No LTS available during 2012 in Girona.

In general, patients approaching therapeutic services can be divided in three groups:

*1. Users who enter the socio-sanitary circuit autonomously.*

They are the majority. These individuals have usually gained an adequate consciousness of their condition. When they meet the health care structures, they have entered into the critical stage of addiction and the desire to get out of this severe condition is strong.

*2. The patients of LTS might only have the intention of avoiding a worsening of their situation and may not be truly determined to quit substance abuse.*

They get in touch with these services only in order to "reduce the harm" inflicted by their addiction. In any case, this is the first step towards a possible way out from the vicious cycle of dependence.

*3. Users who enter the health care structures as an alternative sentence.*

In Spain, these individuals can be found both inside residential therapeutic communities and in outpatient treatment centers. When in TC they have been allowed to convert their prison sentence into a kind of house arrest. If a minor administrative sentence (i.e. cannabis use in the street) has been committed it can be substituted by an appropriate outpatient treatment plan.

Such patients do not have the same motivation that brings users into the rehabilitation process (conscious choice and willingness to be relieved from the pain of the critical phase). They can be addicts, but the decision to look for help in socio-sanitary services may be motivated by the desire to get rid of the sentence rather than the desire to start a rehabilitation process.

## 2. Typology of services

**Low Threshold Services.** LTS can provide a support for the drug addict. In Spain, they are not necessarily a first contact source. They are structures for people who don't want to withdraw their drug use and you can meet beginners and old users. LTS are services aiming to provide material for reducing the risks associated with consumption and seeking to meet basic needs, as well as motivating addicts for treatment in health and social services, including treatment units. They also provide basic health care, provision of basic hygiene and needle exchange, access to the screening of infectious diseases and psychosocial support that allows an effective approach to treatment facilities.

The main structures who provide these services are “harm reduction teams” and “mobile units”.

The main goals of these structures are:

- the reduction of the harms associated with heroin or cocaine use, such as safe injection practices to avoid HIV infections, or quick assistance to overdoses
- the increase and regularity of consumer contacts with professionals from a social-health team may contribute, namely, to future abstinence.

**Therapeutic communities (TC)** are drug-free environments distinguished by a residential long-term approach and they are designed to ensure a response to addicts requiring prolonged inpatient care, with psychotherapeutic support under psychiatric supervision concerning, namely, the creation of conditions for their social reintegration. Patients are derived to TC by treatment centers physicians when their evolution requires so.

**Treatment centers (TrC)** are non-residential structures designed to ensure comprehensive and global care to drug users. In Spain the centers are called CAS, meaning centers for care and follow-up. Besides global medical assistance including infectious diseases evaluation, in CAS individual cognitive-conductual therapies or therapeutic groups are provided with psychiatric and psychological support. Methadone treatment programs are provided for opioid addicts. To facilitate treatment, Methadone can also be dispensed through mobile units, under the supervision of treatment centers.

Between TrC and TC there are Hospital *Drug Detoxification Units* where patients can be derived from TrC and there an average period of stay is 3 weeks. The Drug detoxification units are intended to ensure the treatment of deprivation syndromes in addicts, under medical supervision through inpatient care. No patients were selected from them.

### 3. Care phases

The medical assistance process in Spain is composed by:

- Treatment demand (manly in public treatment centers)
- Medical, psychiatric, psychological and social evaluation,
- Individual prescription plan that varies according to the patient, the substance and his social milieu. It can include: outpatient/inpatient detoxification, pharmacological outpatient treatment, individual or group psychological therapy sessions, or derivation to 'day centers'.
- Periodical Follow-ups from the different professionals: psychiatrist, psychologist and social worker.
- Prevention of new addiction episodes.
- After two years, and depending on the substance/s involved possible medical prosecution is evaluated.

Admission to TC is usually prescribed within individual prescription plans in the TrC, and by the moment financed publicly. However, some people who don't want to be registered as drug addicts can pay the TC directly. This can happen on demand by users who prefer entering into a community while keeping anonymity.

#### user distribution inside the three types of structures

Users distribution in each kind of structure			
LTS	TC	TrC	Total
98	96	319	513

# CHAPTER 1

## Characteristics of the Users

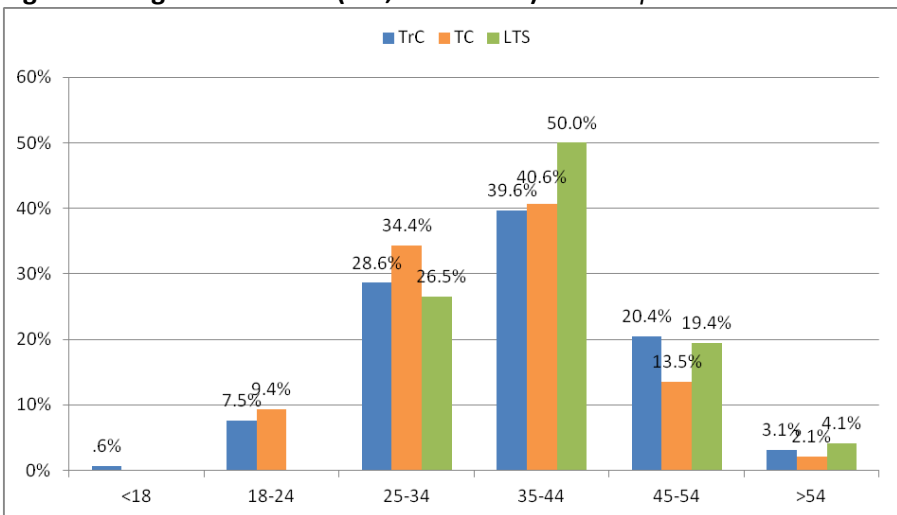
### 1.1. Age, gender and first use

Table 1.1. shows the proportion of male and female respondents in the sample. Males are the in majority (76.2%); but females are less represented among TCs (17.7 %) and more among the TrCs users (26.3%).

**Table 1.1. gender distribution (LTS and TC) . 508 respondents**

	Low Threshold	Therapeutic Communities	Treatment center	Total
Female	21.9%	17.7%	26.3%	23.8%
Male	78.1%	82.3%	73.7%	76.2%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

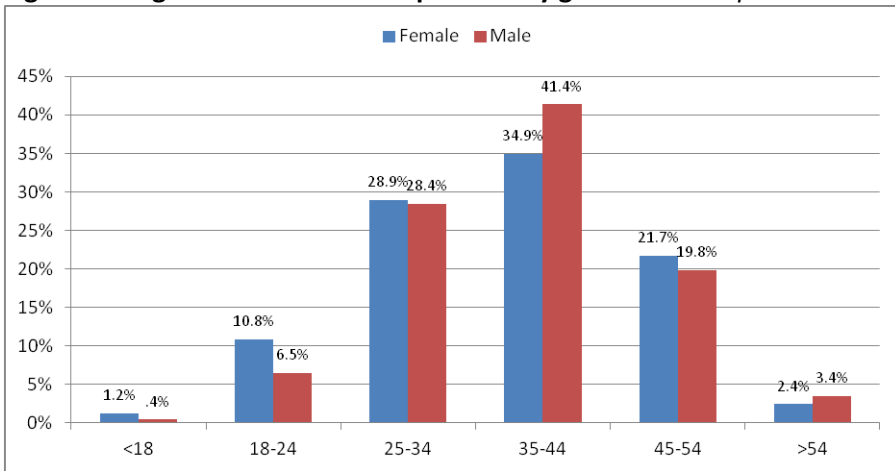
**Figure 1.1. age distribution (TrC, TC and LTS). 512 respondents.**



The respondents aged 35 - 44 are the main users of all the three kinds of services ( Figure 1.1). They are 50% out of the whole population of low threshold service users, 39.6% out of the whole population of Treatment Centers users, and 40.6% of total TC service users.

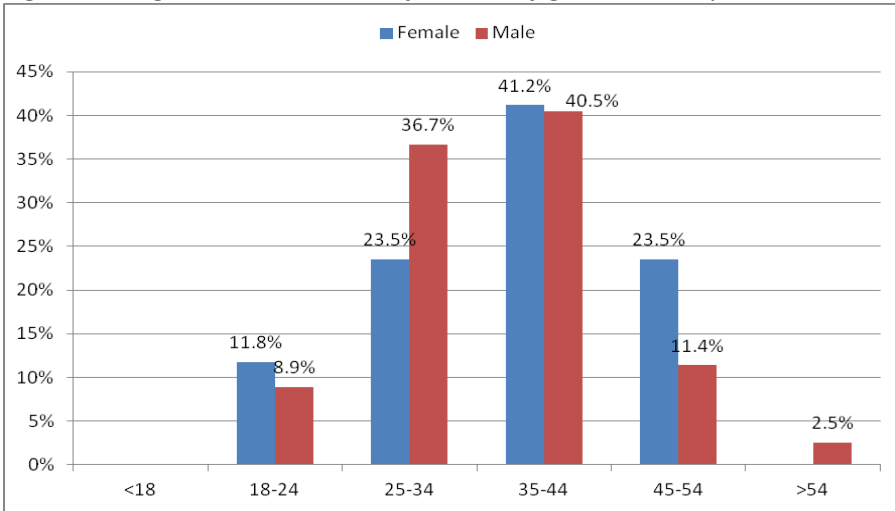
Looking at general distribution, patients of LTS services are older than the patients of therapeutic communities. This last category of users is a little bit younger than the TrC group of users.

**Figure 1.2. age distribution of TrC patients by gender 315 respondents**



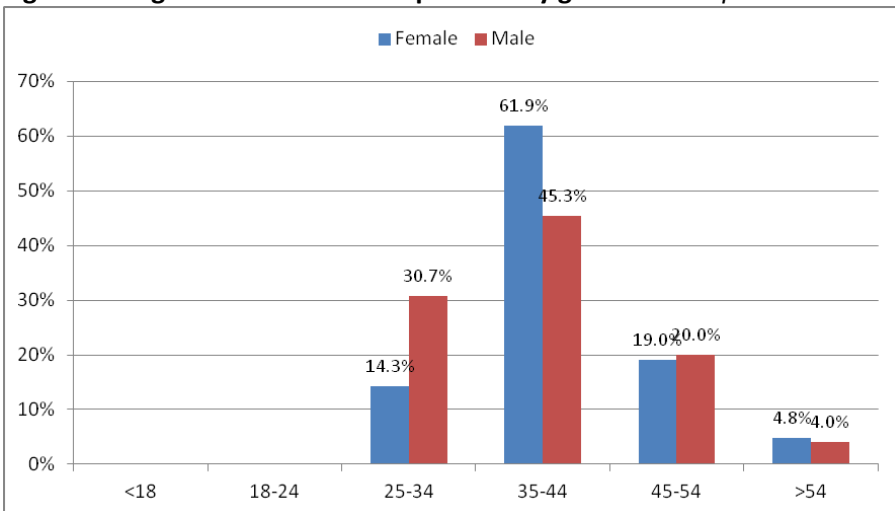
Men and women in TrC present almost the same distribution among the 6 age classes in figure 1.2. Slight differences are evidenced in the age classes between 35-44 where the percentage of men is 6.5 points more than women and in the age group 18-24 where the percentage of women is 4.3 points more than the for men.

**Figure 1.3. age distribution of TC patients by gender 96 respondents**



As we see in Figure 1.3, most men approaching TC are between 35 and 44 years old (40.5%) as well as most women (41.2%). Regarding men the second biggest age group concerns users aged 25-34 years old (36.7%), followed by those aged 45-54 where men are in the minority (11.4%) and women maintain an important percentage (23.5%). In contrast to men percentages of women are fairly evenly spread among the age classes 25-34 and 45-54 (23.5%).

**Figure 1.4. age distribution of LTS patients by gender 96 respondents**



Concerning the distribution of LTS' users, in figure 1.4, the modal value is at the age group 35-44 years old for both genders and the two distributions don't evidence great dissimilarities, but men aged 25-35 years old have a higher rate (30.7%) than corresponding women (14.3%).

**Figure 1.5. Age at first use (TrC, LTS and TC) 512 respondents**

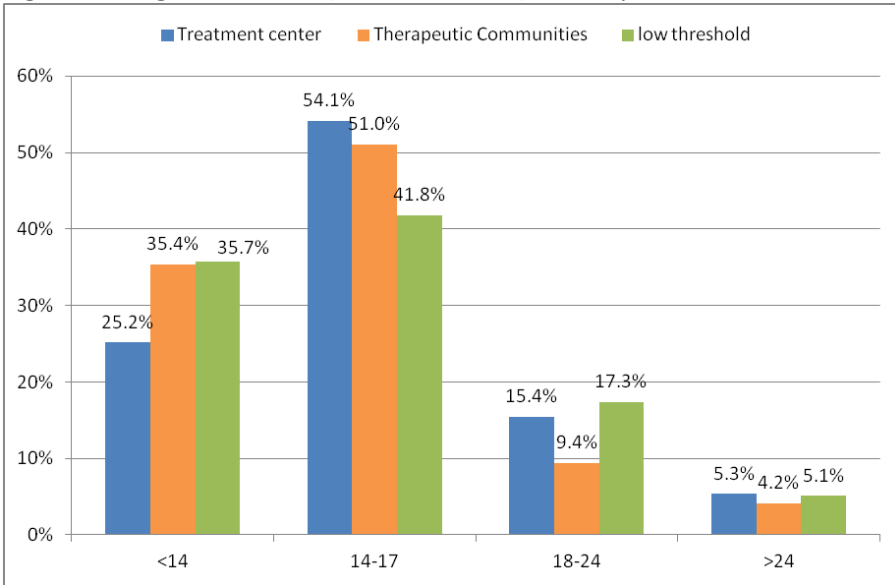


Figure 1.5 shows that first use is widespread among those in the age group of 14 and 17, both for TrC (54.1 %), TC (51%) and LTS users (41.8 %).

The second biggest age group concerns users less than 14 years old, TC and LTS are almost at the same level (35.4% and 35.7 %) while TrC scored 25.2% of users who started at this age.

The more the users get older, the more the percentage of those who approach drugs the first time decreases, moreover (Figure 1.5) the older beginners (>17) seem to prefer LTS and TRC to TC.



**Table 1.2. first drug experimented with (TrC, TC and LTS) 508 respondents**

	Treatment center	Therapeutic Communities	Low Threshold	Total
Tranquilizers/sedatives (without medical prescription)	1.6%	1.1%	1.0%	1.4%
Ecstasy (MDMA. XTC. etc...)	3.5%	4.2%	-	3.0%
Cannabis (marijuana. hash. ganja)	77.1%	76.8%	71.4%	76.0%
Cocaine	9.2%	11.6%	12.2%	10.2%
Heroin	2.9%	2.1%	9.2%	3.9%
Steroids	0.3%	-	-	0.2%
Inhalables volátiles	0.3%	-	1.0%	0.4%
LSD	0.3%	2.1%	1.0%	0.8%
Heroína+Cocaína	0.3%	-	1.0%	0.4%
Another drug	2.9%	-	-	1.8%
Total	100.0%	100.0%	100.0%	100.0%

For all groups of users (Table 1.2.) cannabis was the most usual choice at first contact with illicit drugs. Almost 8 out of 10 users (76%) started with this type of illicit drug (77.1% in TrC, 76.8% in TC and 71.4% in LTS)

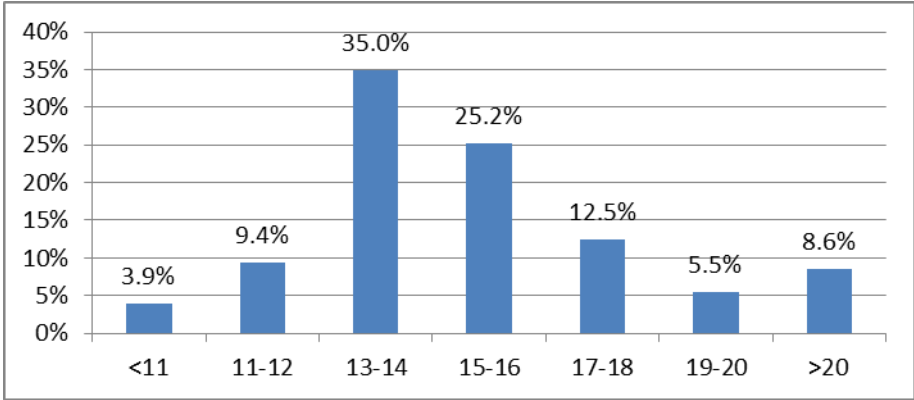
The second most popular drug is Cocaine (10.2% average value between TrC, LTS and TC patients) Heroin use was reported by 9.2% of LTS patients , by just 2.1% of patients in TC and 2.9% of TrC users.

Negligible rates regarding other drugs on the list: ecstasy is noteworthy, specifically 3.5% of TrC users and 4.2% of TC residents have used this type of substance the first time they tried drugs. Nobody from LTS chose this type of substance to experiment with the first time they took drugs.

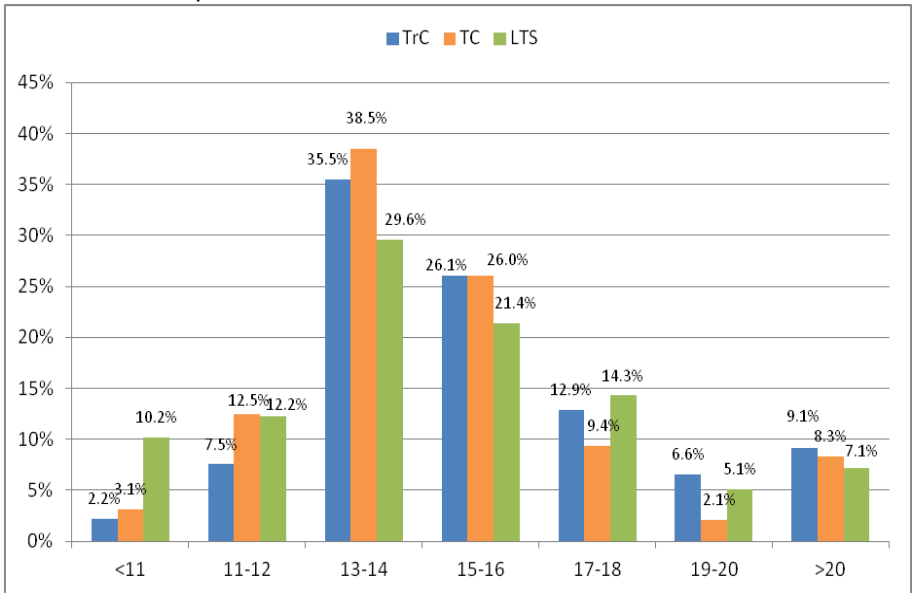
## 1.2. First contact with Drugs

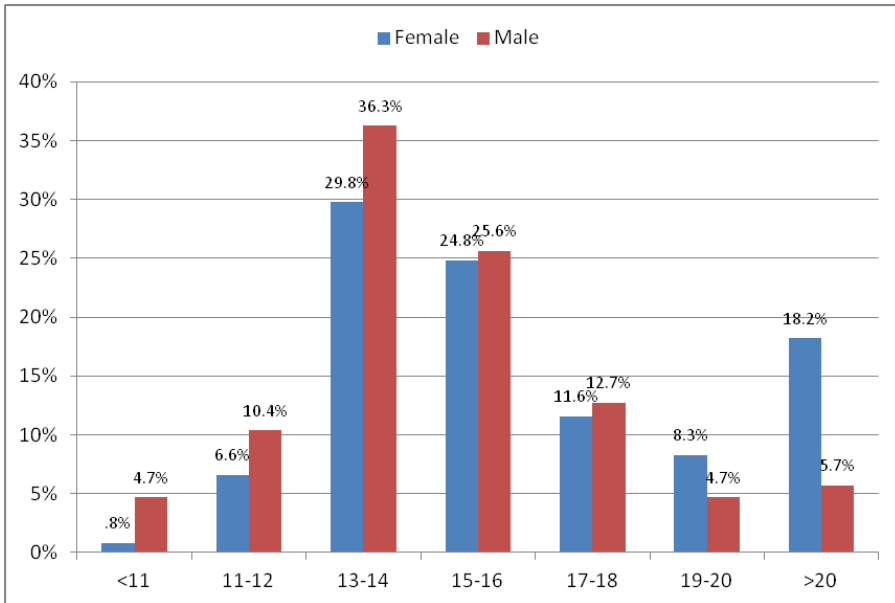
This section will attempt to provide some further information on the question of age of drug use initiation.(Figure 1.6, 1.7, 1.8).

**Figure 1.6. Age at First Use (a deeper analysis) 512 respondents**



**Figure 1.7. Age at First Use Among TrC Patients, LTS Patients and TC Patients 512 respondents**



**Figure 1.8. Age at First Use Related to Gender** 507 respondents

We can better analyze the characteristics of people who use drugs after 20 years of age. In so doing we can see that female users are prevalent over male users (18.2% and 5.7% respectively).

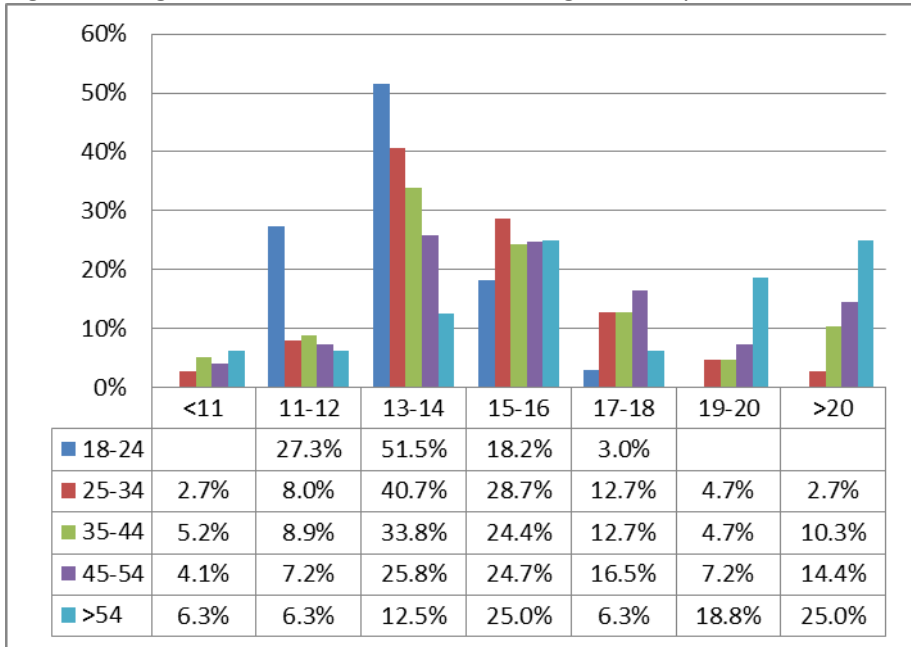
**Figure 1.9. age at first use related to current age 510 respondents**

Figure 1.9 confirms that no particular differences can be found among patients, but an increasing percentage of younger first users is evident in the distribution of the age group 18 – 24 years old in comparison with the distribution of the other groups. 27.3% in the age group 18 – 24 started at the age of 11 – 12 years old and a little more than 50% in the period 13 – 14 years old.

Relevant percentages of earlier first users are found also in the distribution of the age group older than 54; around 12.6% started before 12 years old. Most of them started after 15 years old.

**Figure 1.10. - latency period of the changeover from soft to hard drugs (cocaine, heroin, LSD, ecstasy ...) 481 respondents**

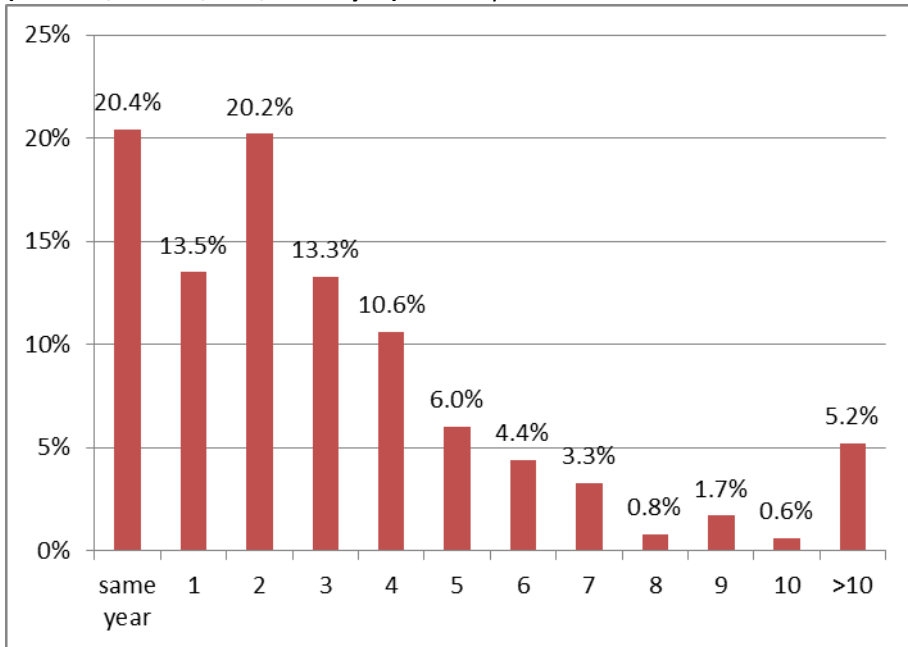


Figure 1.10 shows the latent period that elapsed between the first use of soft drugs and the first use of hard drugs. Most patients have tried hard drugs in the same year of first use: the modal value corresponds to “same year” with 20.4 % following within 2 years (20.2%).

The latency of the switchover to hard drugs is influenced by the age in which users have first experimented with drugs. Most patients who tried drugs in advanced age (>19) tend to change to hard drugs in the same year of first use (Table 1.3.).

80.5% of users who tried drugs after 20 years old and 34.1% who tried drugs when they were 19-20 years old tend to change over to hard drugs during the year of first consumption. Again from Table 1.3. those who first take drugs at about 11-14 years old pass to hard drugs after 1 or 4 years. As the age in which users experiment with drugs increases, latency rates decrease.

**Table 1.3. age at Initiation of drug use related to latency period of the changeover to hard drugs 481 respondents**

		Age of the first drug consumption							Total
		<11	11-12	13-14	15-16	17-18	19-20	>20	
Latency	same year	0.2%	1.7%	3.1%	4.4%	3.3%	1.5%	6.2%	20.4%
	after 1 year	0.4%	1.0%	6.0%	3.7%	1.7%	0.4%	0.2%	13.5%
	after 2 years	0.4%	2.3%	9.1%	5.8%	1.9%	0.6%		20.2%
	after 3 years	0.4%	1.2%	5.2%	3.7%	1.7%	0.6%	0.4%	13.3%
	after 4 years	0.8%	1.9%	5.2%	1.7%	0.6%	0.2%	0.2%	10.6%
	after 5 years	0.6%	0.4%	2.9%	1.7%	0.2%	0.2%		6.0%
	after 6 years	0.2%	0.4%	1.7%	1.9%	0.2%			4.4%
	after 7 years	0.2%		1.7%	0.4%	0.8%	0.2%		3.3%
	after 8 years				0.4%	0.2%		0.2%	0.8%
	after 9 years	0.2%	0.4%		0.4%	0.2%	0.4%		1.7%
	over 10 years	0.4%	0.6%	1.2%	1.9%	1.0%	0.2%	0.4%	5.8%
Total		4.0%	10.0%	36.2%	26.0%	11.9%	4.4%	7.7%	100.0%

### 1.3. Age of First Drug Sale

The age of the first illegal drug sale is another important characteristic to be analyzed (Figure 1.11), the modal value is the age 17-18 (27.7%) followed by those aged between 21 and 25 (22.1%) and then by the age group 15-16 (17.7%).

46.2% of respondents started to sell after they were 19 years old and 8.4% before they were 14 years old. Most users sell drugs for the first time during their secondary school years.

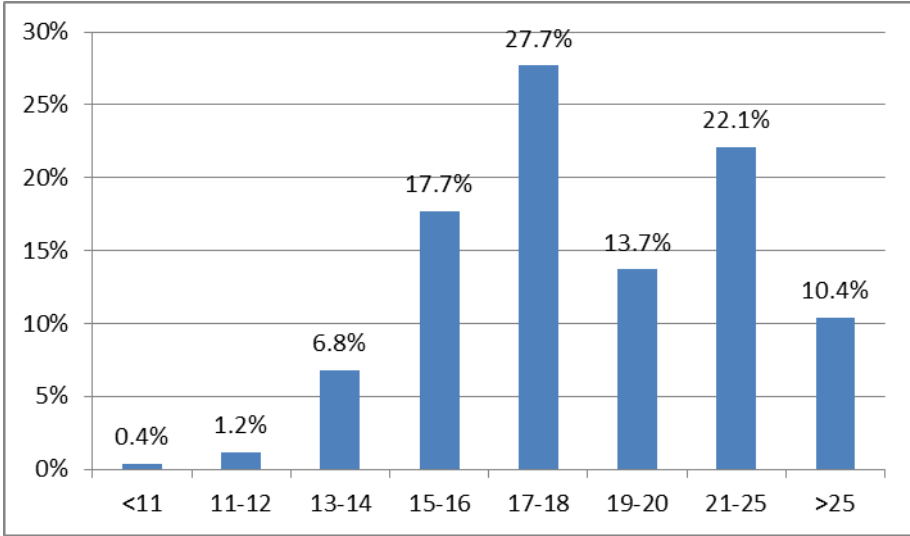
Patients of LTS started selling drugs at an older age than patients of TrC and TC services. The higher rate is in the age group aged 21-25 (21.8%). Patients of TC and TrC have their most frequent value in the age group 17-18 followed by the age group 15-16, therefore they started selling drugs at younger age (Figure 1.12).

Regarding gender the modal value is in the class 21-25 for females and in the 17-18 year olds group for male respondents. Thus men tend to start selling drugs when they are a little bit younger than women. Therefore women are prevalent in the age groups representing people older than 18 years old (Figure 1.13).

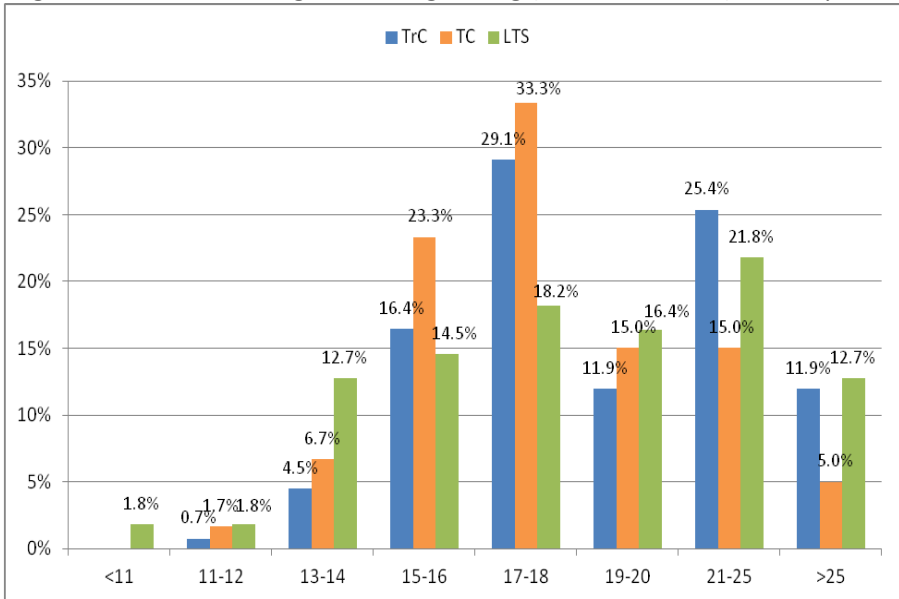
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**Figure 1.11. initiation age into drug selling 249 respondents**



**Figure 1.12. initiation age into drug selling (TrC, LTS and TC) 249 respondents**





**Figure 1.13. initiation age into drug sale by gender 246 respondents**

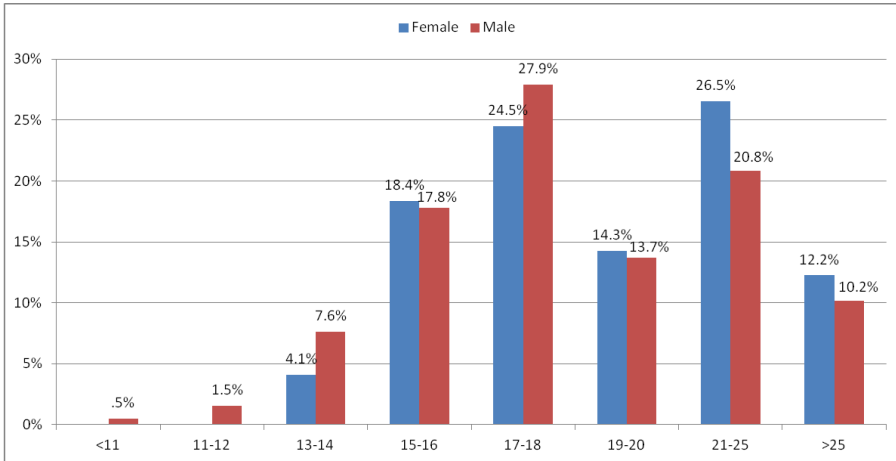


Figure 1.14 shows that patients aged 18-24 years started selling drugs at a younger age. On the contrary all patients over 55 started dealing after 17 years old. In fact most of them reported their initiation into drug dealing when they were between 17-18 years old (28.6%) and older than 21 (71.5%). The same trend can be seen for patients aged 45-54 and 25-34. For users aged 35-44 a trend in dealing starts at between 15 and 18 years old.

**Figure 1.14. initiation age into drug dealing related to current age 248 respondents**

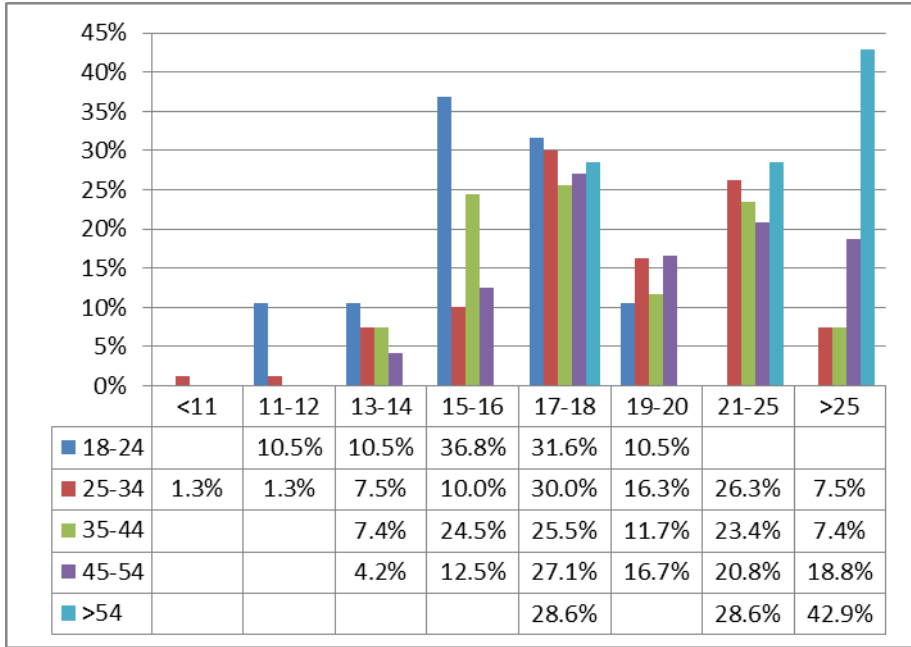


Table 1.4. shows that an inverse correlation exists between age of first drug sale and the latency period leading up to use of hard drugs.

**Table 1.4. initiation age into drug sale related to latency period of the changeover to hard drugs (conditional distributions) 244 respondents.**

		Age of first drug sale							Total	
		<11	11-12	13-14	15-16	17-18	19-20	21-25		>25
Latency	same year	0.4%		2.0%	3.3%	2.9%	2.9%	4.1%	1.2%	16.8%
	after 1 year			2.0%	4.9%	4.9%	2.0%	2.5%	1.2%	17.6%
	after 2 years		0.8%	1.6%	4.5%	7.4%	3.7%	5.3%	1.6%	25.0%
	after 3 years		0.4%		1.6%	4.9%	2.0%	3.3%	0.8%	13.1%
	after 4 years			1.2%	2.5%	4.5%	0.4%	1.6%	1.6%	11.9%
	after 5 years				1.2%		1.2%	2.9%	0.8%	6.1%
	after 6 years					1.6%		0.4%		2.0%
	after 7 years						0.8%	0.8%		1.6%
	after 8 years					0.8%				0.8%
	after 9 years					0.4%		0.4%	1.2%	2.0%
	after 10 years and over					0.4%		0.8%	1.6%	2.9%
Total		0.4%	1.2%	7.0%	18.0%	27.9%	13.1%	22.1%	10.2%	100.0%

#### **1.4. Motivations for First Drug Use**

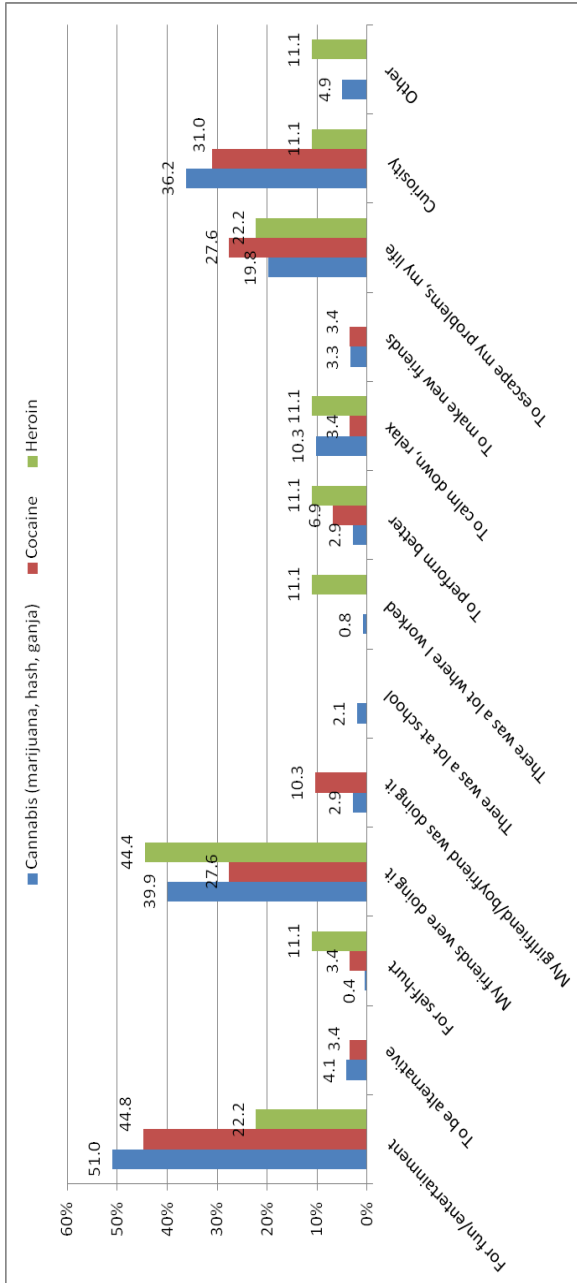
Respondents of this survey have been asked to choose 3 among 13 proposed motivations. Therefore the results are directly related to the main drugs used for the first time (Figure 1.16, 1.17 and 1.18).

Figures 1.15, 1.16 and 1.17 show respectively the motivations of TrC, TC and of LTS patients. All respondents cited “positive” or recreational motivations: fun, curiosity and emulation of friends in a different order of importance according with the service respondents were in. But some differences emerge in the case of Heroin use in TC patients. Their motivations (Figure 1.16) are split between the desire to be alternative (50%) and curiosity (50%).

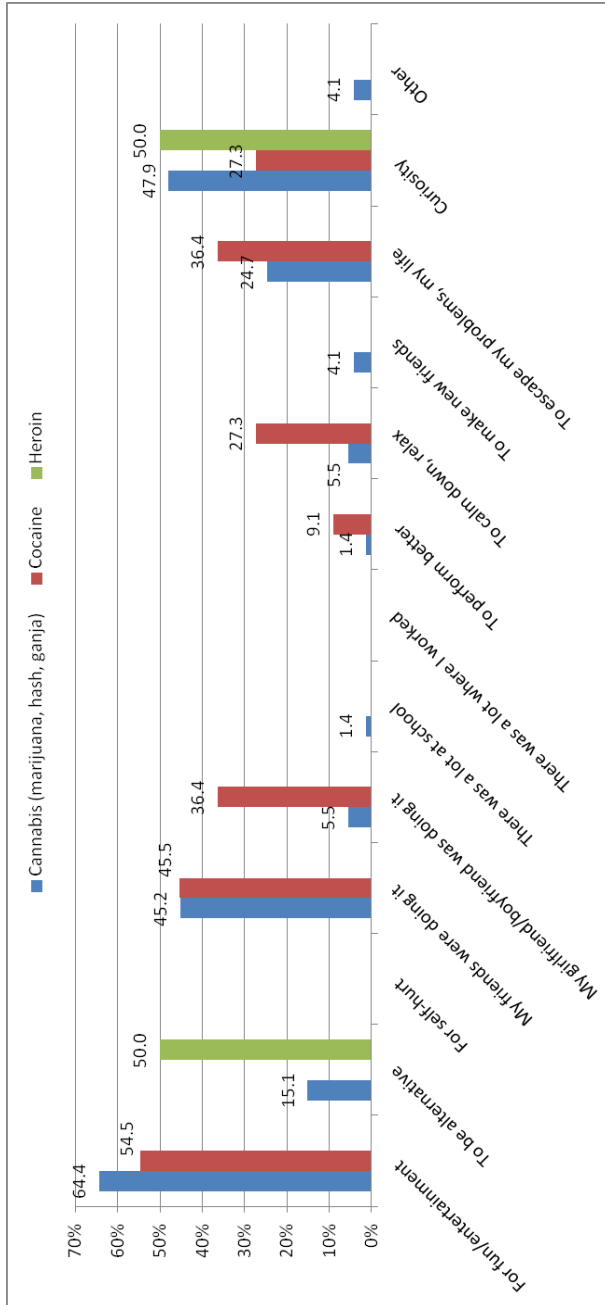
In addition to the three main choices, cannabis users from the three services assigned importance to the desire to escape life’s problems.

Regarding the distribution of cocaine consumers the three main motivations for all users are the same as for cannabis users, but TC consumers also reported with a high percentage (36.4%) the intent to emulate a partner.

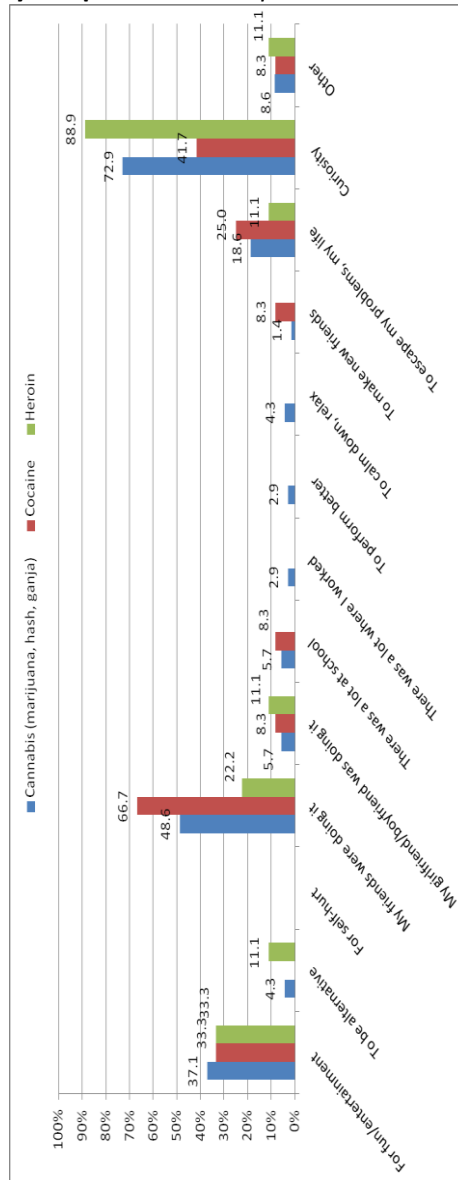
**Figure 1.15. motivations for starting drug use related to drug experimented with by TrC patients 281 respondents**



**Figure 1.16. motivations of starting drug use related to the kind of drug experimented with by TC patients 86 respondents**



**Figure 1.17. motivations of starting Drug use related to the kind of drug experimented by LTS patients 91 respondents**



As we demonstrated, motivations depend on which types of substance are used and some differences are evident between LTS, TrC and TC for the first time.





# CHAPTER 2

## Lifestyle:

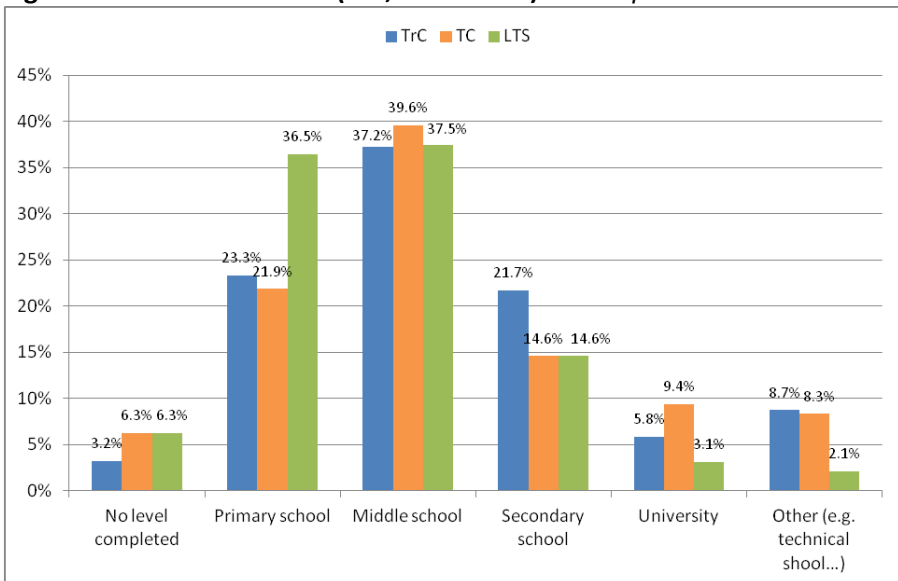
### Education, Work and Contacts with Prison

#### 2.1. Education Level of Users

**Table 2.1. Education Level 501 respondents**

Education level						Total
No level	Primary school	Middle school	Secondary school	Pre-university school	University	
4,4%	25,5%	37,7%	19,0%	6,0%	7,4%	100,0%

**Figure 2.1. Education Level (TrC, LTS and TC) 501 respondents**



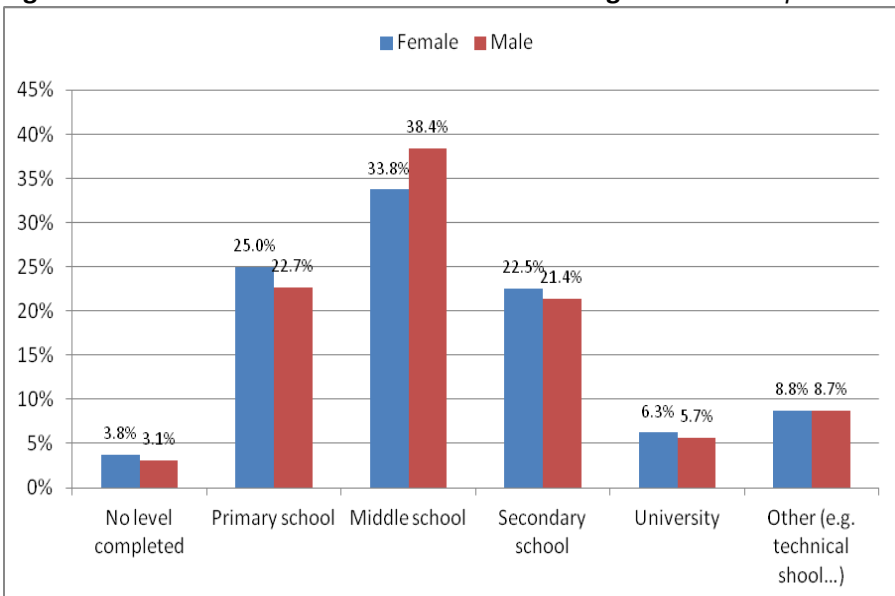
Higher proportions of middle school graduates were reported from all the three services (37.5% in LTS, 39.6% in TC and 37.2% in TrC). In fact “middle school” is the modal value for both LTS, TrC and TC users.

The second biggest education level group is primary school, reached by more LTS users (36.5%) than by TrC (23.3%) and TC users (21.9%).

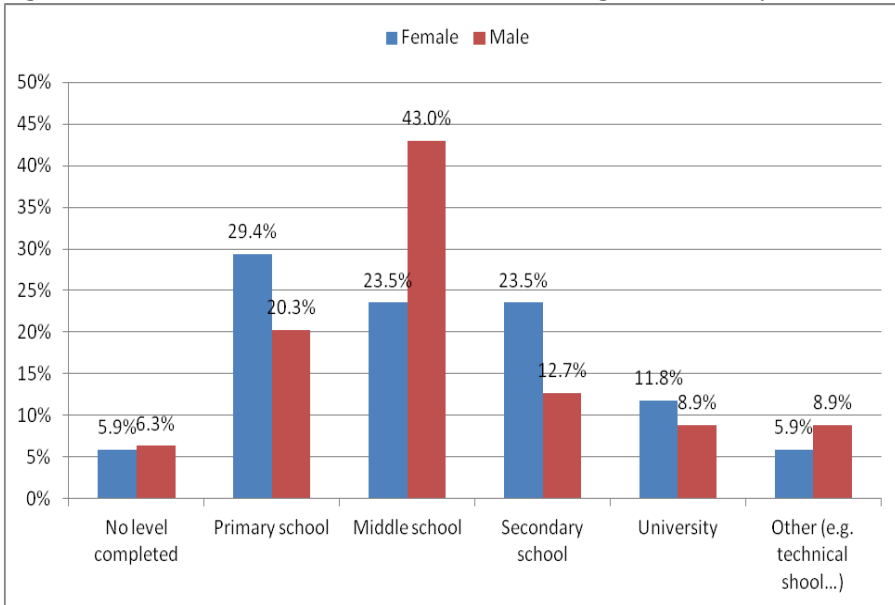
The most qualified users are those patients of TrC: 27.5% of them have a certificate equal or higher than a secondary school certificate. After TrC users come those from TC; they are the most likely to have obtained a university degree (9.4% vs 5.8% in TrC and 3.1% in LTS). On the contrary, LTS users are the lower qualified with a higher percentage among those with no level obtained and those who have a primary school diploma.

Among TrC patients, 38.4% of males vs 33.8% of females had a middle school diploma. Females are prevalent among those with a secondary school diploma (22.5%) and those with a university degree (6.3%) but the gap between genders is small. Also among those who don't have any educational qualification there are small differences between men and women (3.8% and 3.1% respectively).

**Figure 2.2. education level of TrC users related to gender 309 respondents**



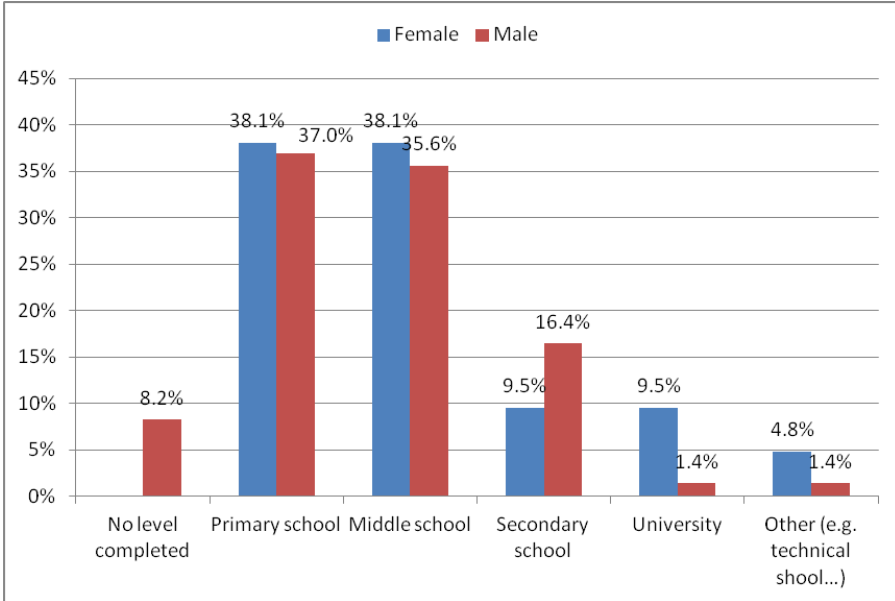
**Figure 2.3. education level of TC users related to gender 96 respondents**



Women In TC have their most frequent value (29.4%) in the education level group “Middle school”, followed by middle and secondary school diplomas where women’s rates are fairly evenly distributed (23.5%).

Men are mostly middle school educated (43%). 20.3% of them reached the primary school level while 12.7% reported a secondary school diploma. Men with a university degree are fewer than women (8.9% vs 11.8%). Men are more represented than women in the groups of those who didn’t obtain any qualification and those with ‘other qualifications’.

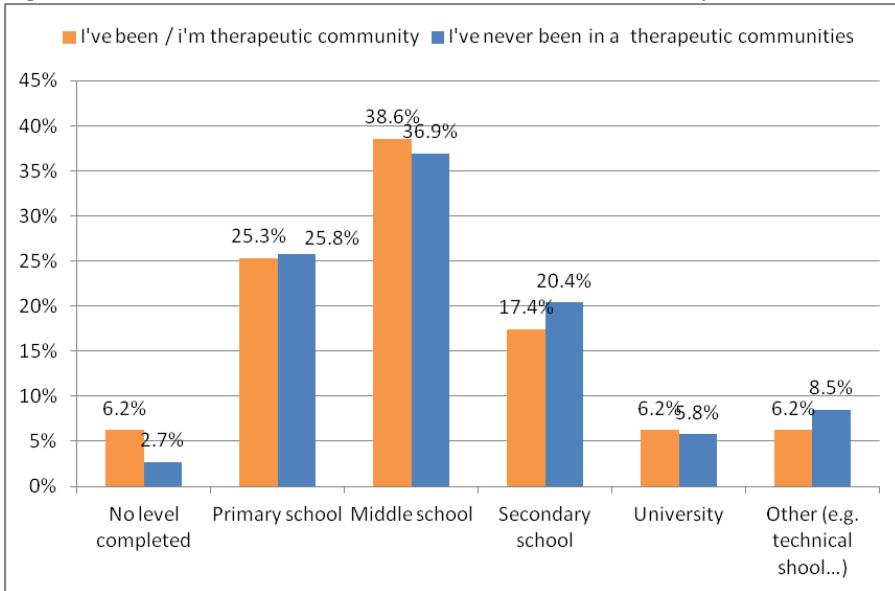
**Figure 2.4. education level of LTS users related to gender 94 respondents**



In LTS females seem to be educated to a higher level than men with higher rates in the educational group “University” (9.5%). Men are prevalent among those who obtained a secondary school certificate and among those who don’t have any education level (here women are not represented at all).

In conclusion women in LTS and TC seem more qualified than men. In contrast men in TrC seem more qualified than women.

**Figure 2.5. education level of TC and non-TC users 501 respondents**



Generally those who have never been in a TC have higher qualifications than users who have tried such a service (Figure 2.5): 26.2% reached a level equal or higher than a secondary school diploma. A slightly smaller percentage of “never been in TC” didn’t obtain any education level (2.7%) less than the users who “have been in TC”(6.2%).

**Table 2.2. education level related to arrest history (joint distribution) 497 respondents**

		Arrested				Total
		Never	Yes. for dealing	Yes. for others crimes	Yes. both for dealing and others crimes	
Educational Level.	No level	1.2%	0.2%	2.8%	0.2%	4.4%
	Primary school	7.0%	3.6%	13.3%	1.6%	25.6%
	Middle school	14.5%	2.8%	18.9%	1.6%	37.8%
	Secondary school	9.1%	0.6%	8.0%	1.0%	18.7%
	University	3.8%	0.4%	1.4%	0.4%	6.0%
	Other	4.2%	0.8%	2.4%	-	7.4%
Total		39.8%	8.5%	46.9%	4.8%	100.0%

**Table 2.2 Bis. education level related to arrest history (conditional distributions)**

		Arrested				Total
		Never	Yes. for dealing	Yes. for others crimes	Yes. both for dealing and others crimes	
Educational Level.	No level	27.3%	4.5%	63.6%	4.5%	100.0%
	Primary school	27.6%	14.2%	52.0%	6.3%	100.0%
	Middle school	38.3%	7.4%	50.0%	4.3%	100.0%
	Secondary school	48.4%	3.2%	43.0%	5.4%	100.0%
	University	63.3%	6.7%	23.3%	6.7%	100.0%
	Other	56.8%	10.8%	32.4%	-	100.0%
Total		39.8%	8.5%	46.9%	4.8%	100.0%

In tables 2.2, 2.2bis and 2.3 the relation between the education level of users and their criminal history is described.

Tables 2.2 and 2.2b concern patients who have been arrested versus those who have not.

Almost the same trend can be found in Table 2.3: the education level is a strong pattern for lifestyle in particular for the impact it has on criminal activity either for an arrest without consequences or leading to incarceration.

**Table 2.3 distribution of patients that served or not alternative sentences to prison according to their education level 470 respondent**

		Alternative sentences to prison		Total
		yes	no	
What is your education level?	No level	8.4%	3.3%	4.5%
	Primary school	29.0%	24.5%	25.5%
	Middle school	40.2%	36.6%	37.4%
	Secondary school	14.0%	20.1%	18.7%
	University	1.9%	7.2%	6.0%
	Other (e.g technical school...)	6.5%	8.3%	7.9%
Total		100.0%	100.0%	100.0%

A last but no less important analysis can be conducted in relation to those who have obtained an alternative sentence to prison (like house arrest, house arrest in a therapeutic community or passing a period of time in social services for drug addicts).

As shown on table 2.3 those who entered into facilities that were a substitute for prison tend to be less qualified. 20.1% of those who were not given an alternative to prison have a secondary school qualification vs 14 % of those who did enter into an alternative; the greatest differences can be found in the case of those with a university degree (7.2% vs 1.9%).



## 2.2. Education of Users' Parents

Hereby we are going to analyze the relation between the educational qualification of respondents' parents and some variables regarding drug users.

Figure 2.6 shows the distribution of the respondents' parents according to the education level reached. Mothers seem to be less qualified than fathers but the modal value for both mothers and fathers is "no level".

Figure 2.7 is an examination of mothers' education level distribution, in relation to whether their children have been in LTS TrC or TC. Mothers of those in TC and LTS tend to be more educated than mothers of those in TrC. This latter category of mothers is represented mostly among those without any education level.

**Figures 2.6. parents' education level 502 (Mother) 506 (Father) respondents**

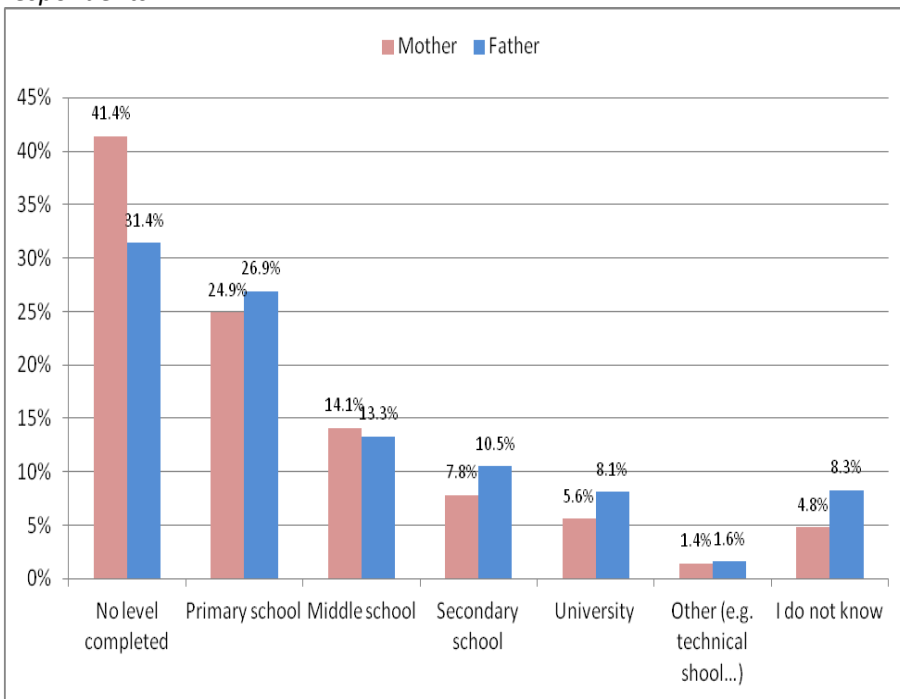
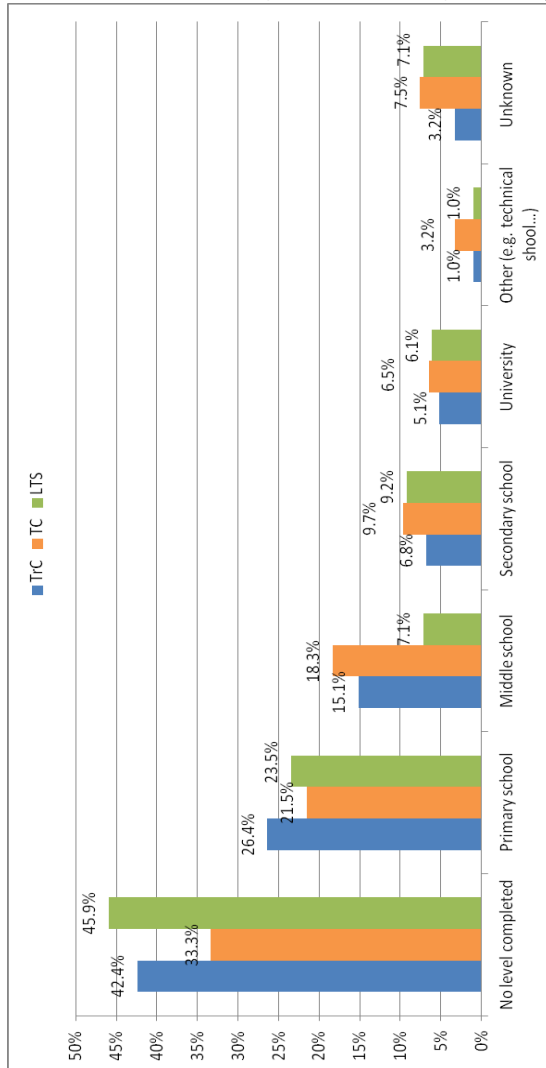


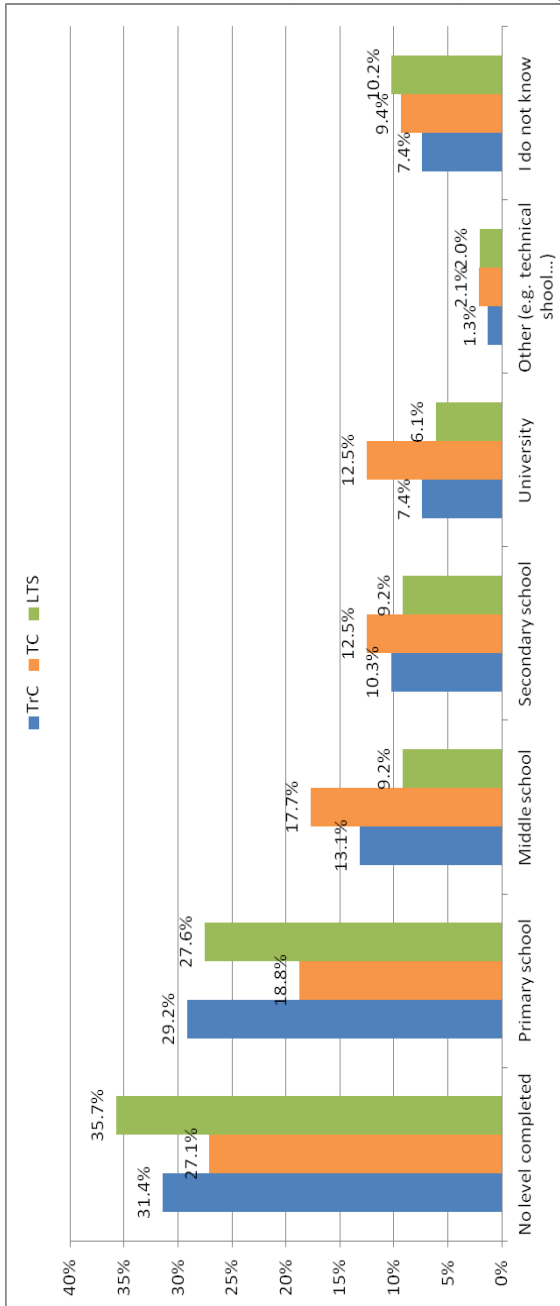
Figure 2.7. mothers' education level ( TrC, LTS or TC) 502 respondents



The same trend for mothers can be seen for fathers. Here fathers of those in TrC and LTS tend to be less educated than fathers of those in TC. This latter category presents higher percentages among those with a secondary school diploma and those with a university degree.

Concluding, mothers of the patients of TC and LTS services are more qualified than mothers of those in TrC. Almost the same happens for fathers. Here fathers of those in TrC and LTS are more qualified than fathers of those in TC.

Figure 2.8. fathers' education level (TrC, LTS or TC) 506 respondents



**Table 2.4. education level of respondents related to education level of their fathers 497 respondents**

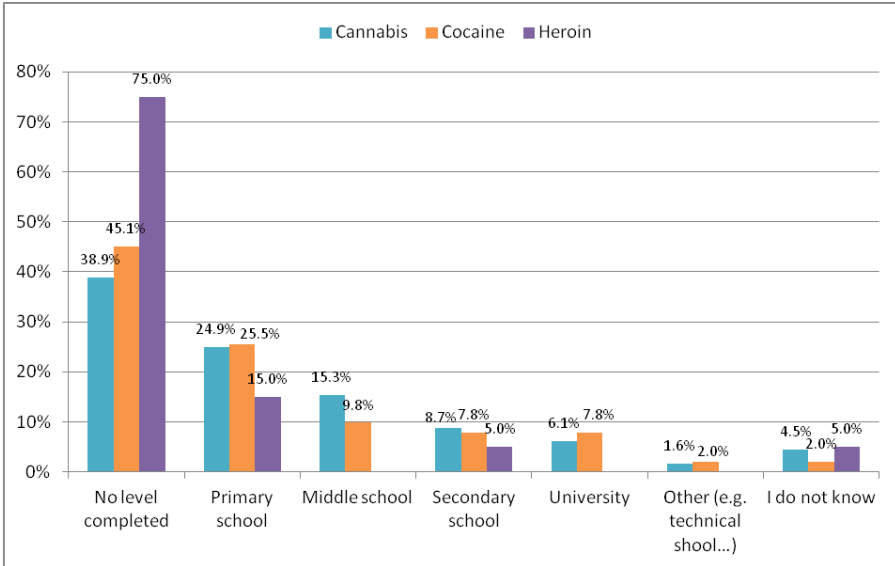
		Father's education level							Total
		No level	Primary school	Middle school	Secondary school	University	Other	I do not know	
Users education level	No level	59.1%	22.7%	4.5%	4.5%	-	-	9.1%	100.0%
	Primary school	43.0%	28.9%	4.7%	9.4%	1.6%	0.8%	11.7%	100.0%
	Middle school	28.7%	27.7%	17.6%	10.1%	4.8%	2.7%	8.5%	100.0%
	Secondary school	22.3%	20.2%	19.1%	13.8%	17.0%	2.1%	5.3%	100.0%
	University	10.0%	26.7%	16.7%	13.3%	30.0%	-	3.3%	100.0%
	Other	31.4%	31.4%	11.4%	11.4%	8.6%	-	5.7%	100.0%
Total		31.6%	26.6%	13.5%	10.7%	7.8%	1.6%	8.2%	100.0%

**Table 2.5. education level of respondents related to education level of their mothers 493 respondents.**

		Mother's education level							Total
		No level	Primary school	Middle school	Secondary school	University	Other	I do not know	
Users education level	No level	72.7%	13.6%	-	4.5%	-	-	9.1%	100.0%
	Primary school	54.3%	23.6%	7.1%	3.9%	1.6%	0.8%	8.7%	100.0%
	Middle school	37.0%	27.2%	19.0%	8.7%	2.7%	1.1%	4.3%	100.0%
	Secondary school	34.0%	24.5%	18.1%	9.6%	9.6%	2.1%	2.1%	100.0%
	University	20.7%	20.7%	13.8%	10.3%	31.0%	3.4%	-	100.0%
	Other	37.8%	27.0%	16.2%	10.8%	2.7%	2.7%	2.7%	100.0%
Total		41.6%	24.7%	14.4%	7.7%	5.3%	1.4%	4.9%	100.0%

If we compare the relation between first use and mothers' education level with the relation between first use and fathers' education level there is an important difference. In this case mothers of cocaine and cannabis users are more qualified than mothers of heroin users.

**Figure 2.9. first drug experimented related to mother education level 449 respondents**



**Figure 2.10. first drug experimented related to fathers' education level 452 respondents**

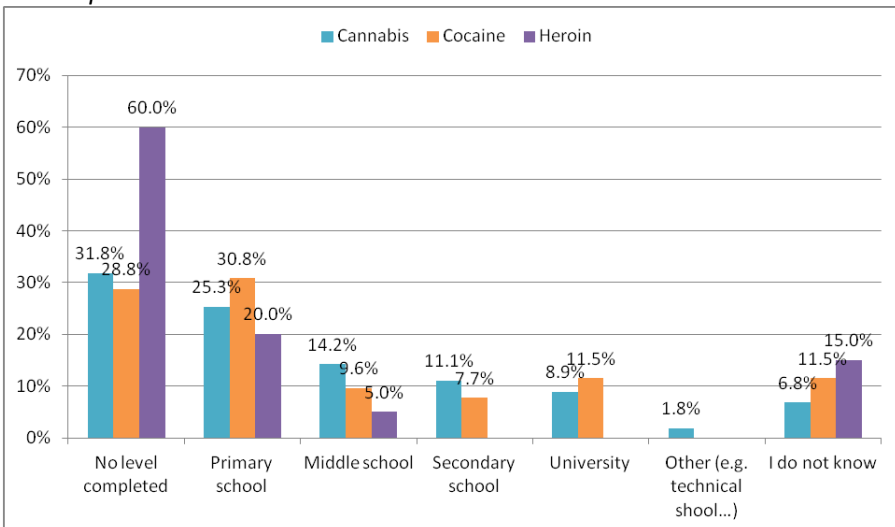


Figure 2.10 underlines the relation between the first drug used and the education level of users' fathers. We can see how fathers of those who used cannabis or cocaine the first time they used drugs have a higher

education level compared to fathers of those who started by consuming heroin. 11.5% of cocaine users' fathers and 8.9% of cannabis users' fathers have a university degree and 7.7% and 11.1% respectively have a secondary school diploma.

Fathers of heroin users are distinguished by lower education levels rather than fathers of cannabis and tranquillizer first-timers. They are for the most part in the educational group "no level" (60%), then score relevant percentages among those with a primary school level (20%).

Generally parents of those who used cannabis or cocaine as a gateway drug are more qualified than parents of those who started with heroin. Parents of cocaine and cannabis users present almost the same situations regarding their education level.

### 2.3. The employment status

The working condition of respondents is an important element for the analysis of the user's lifestyle and especially their purchasing power.

**Table 2.6 last employment situation (TrC, LTS and TC) 508 respondents**

		Structure			Total
		TrC	TC	LTS	
Last work situation	Long term contract	9.5%	11.6%	2.0%	8.5%
	Short term contract	8.6%	5.3%	1.0%	6.5%
	Self-employed or professional work	4.8%	4.2%	-	3.7%
	Occasional worker	2.9%	4.2%	5.1%	3.5%
	Never employed	0.3%	2.1%	3.1%	1.2%
	Unemployed	52.1%	50.5%	62.2%	53.7%
	Permanent invalidity	5.4%	7.4%	-	4.7%
	Retired	12.4%	9.5%	26.5%	14.6%
	House work	1.3%	1.1%	-	1.0%
	Student	2.9%	4.2%	-	2.6%
Total		100.0%	100.0%	100.0%	100.0%

Most respondents reported they were unemployed at the time of interview (almost 5 out of 10 users). In fact the specific work categories with the largest number of respondents among TrC, LTS and TC users were

unemployed (53.7%) and retired (14.6%), followed by long term workers (8.5%) and short term workers (6.5%). 4.7% of users reported they were declared unable to work while 3.7% reported that they were self-employed. 3.5% were occasional workers while 2.6% were students. A small number of respondents reported that they had never been employed (1.2%) or were working at home .

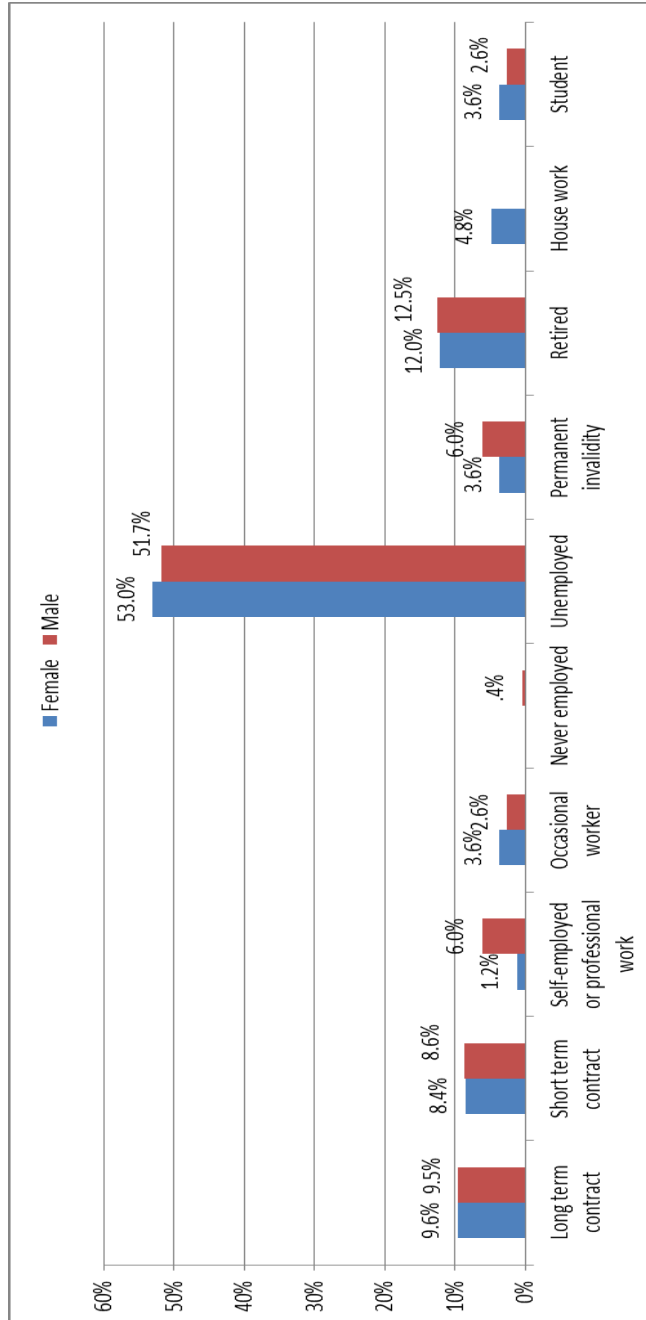
Figure 2.11 shows the distribution of the last employment situation for TrC users. Unemployed rates are high both for males and females (51.7% and 53% respectively) as well as rates of those retired from the job market (12% of women and 12.5% of men). Generally the gender distribution among the many employment categories doesn't have particular differences. We can affirm that the majority of TrC users are unemployed or retired.

Figure 2.12 shows a different situation for TC, the most significant disparity between women and men is in the long term contract category (5.9% vs 12.8% of men). Females are not represented at all in the categories of never employed and self-employed while they are more likely to have occasional jobs, short term work and permanent invalidity . Thus women in TC are less stable than men in their work condition.

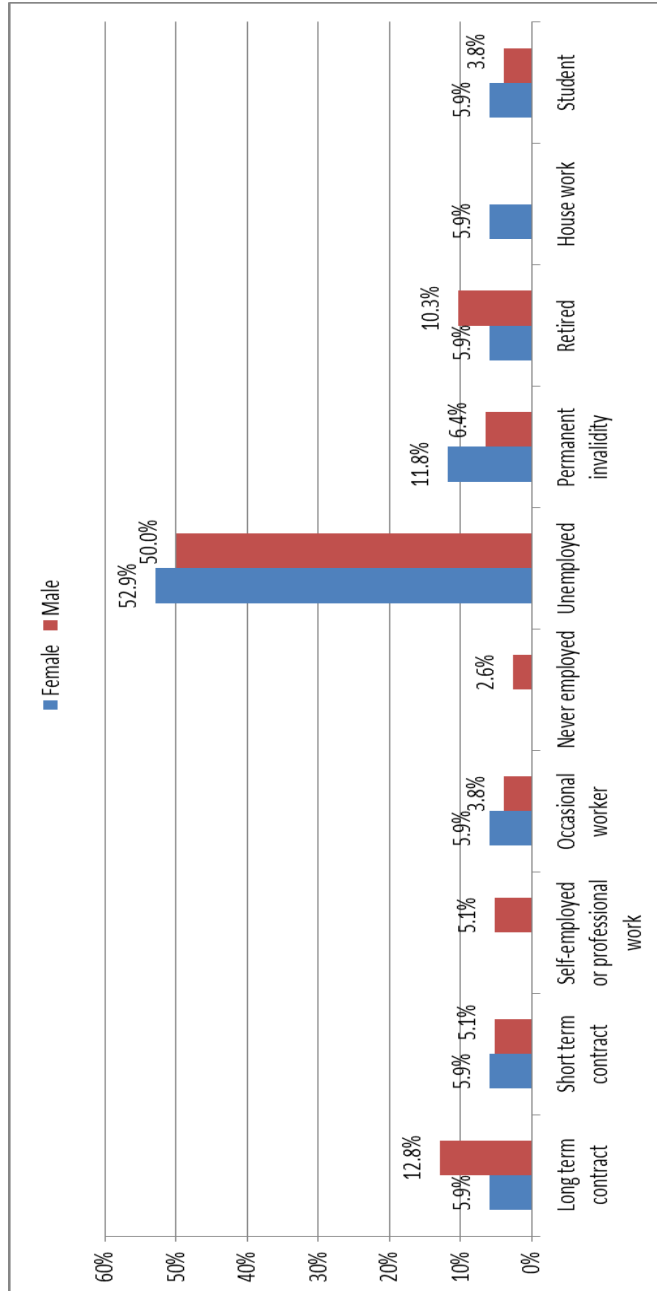
Figure 2.13, which refers to LTS, shows a split distribution between the unemployed and retirement categories. Females are a little bit more likely to be unemployed (66.7% vs 61.3% of men) and men are more likely to be retired (26.7% vs 23.8% of women). The rest of the sample in LTS is distributed among the others four work categories; women are not represented at all among short term workers and those who have never been employed. Notable is the absence of students and self-employed people among LTS patients. Generally, women seem to be more stable than men in LTS.



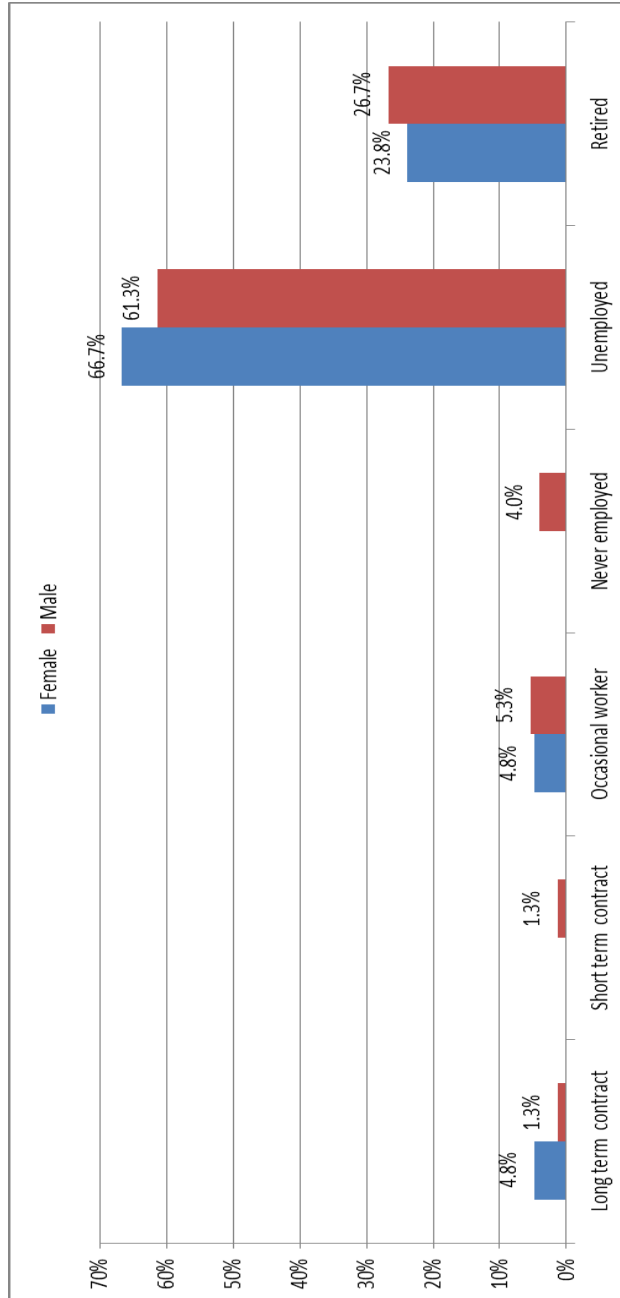
**Figure 2.11. last employment situation of TrC users by gender 315 respondents**



**Figure 2.12. last employment situation of TC users by gender 95 respondents**



**Figure 2.13. last employment situation of LTS users by gender 96 respondents**



**Table 2.7. last employment situation of TC and non-TC users 508 respondents**

		Therapeutic community		Total
		I've been / I'm in a therapeutic community	I've never been in a therapeutic community	
Work	Long term contract	7.8%	9.1%	8.5%
	Short term contract	5.7%	7.2%	6.5%
	Self-employed or professional work	3.7%	3.8%	3.7%
	Occasional worker	2.5%	4.5%	3.5%
	Never employed	1.2%	1.1%	1.2%
	Unemployed	53.3%	54.2%	53.7%
	Permanent invalidity	5.7%	3.8%	4.7%
	Retired	17.2%	12.1%	14.6%
	House work	0.8%	1.1%	1.0%
	Student	2.0%	3.0%	2.6%
Total		100.0%	100.0%	100.0%

Table 2.7 shows the different employment situation of respondents in relation to their contact with therapeutic communities. Users who have never been in therapeutic communities report higher percentages of users with long-term employment, but also higher rates of occasional work were reported from this kind of users (7.2%). Most retired and unemployed users had contact with TC.

Table 2.8 and 2.8 Bis show the last employment situation of users according to their contact with prison. Respondents who had never been in prison have the highest percentage for "long term contract" (12.1%) while those who have been incarcerated for both drug crimes and others are not represented at all in this category. Most of them are retired or unemployed (58.3% and 33.3% respectively). Those who have been incarcerated for crimes related to drugs also reported high percentages of unemployment (61.3%) and retirement (16.1%). Those who stayed in prison for crimes not related to drugs seem to be in a more stable work position.

**Table 2.8. last employment situation of users related to their contact with prison (column conditional distributions) 504 respondents**

		Prison				Total
		Never	For dealing	For other crimes	Both for dealing and other crimes	
work	Long term contract	12.1%	6.5%	3.1%	-	8.5%
	Short term contract	9.7%	-	2.5%	-	6.5%
	Self-employed or professional work	5.0%	-	1.2%	-	3.4%
	Occasional worker	3.4%	9.7%	3.1%	-	3.6%
	Never employed	0.7%	-	1.8%	8.3%	1.2%
	Unemployed	48.3%	61.3%	63.8%	33.3%	53.8%
	Permanent invalidity	6.4%	3.2%	2.5%	-	4.8%
	Retired	10.1%	16.1%	19.6%	58.3%	14.7%
	House work	0.7%	3.2%	1.2%	-	1.0%
	Student	3.7%	-	1.2%	-	2.6%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

**Table 2.8 Bis. last employment situation of users related to their contact with prison (row conditional distributions) 504 respondents**

		Prison				Total
		Never	For dealing	For other crimes	Both for dealing and other crimes	
work	Long term contract	83.7%	4.7%	11.6%	-	100.0%
	Short term contract	87.9%	-	12.1%	-	100.0%
	Self-employed or professional work	88.2%	-	11.8%	-	100.0%
	Occasional worker	55.6%	16.7%	27.8%	-	100.0%
	Never employed	33.3%	-	50.0%	16.7%	100.0%
	Unemployed	53.1%	7.0%	38.4%	1.5%	100.0%
	Permanent invalidity	79.2%	4.2%	16.7%	-	100.0%
	Retired	40.5%	6.8%	43.2%	9.5%	100.0%
	House work	40.0%	20.0%	40.0%	-	100.0%
	Student	84.6%	-	15.4%	-	100.0%
Total		59.1%	6.2%	32.3%	2.4%	100.0%

Table 2.9 reports the frequency of patients who received alternative sentences listing them according to their last working condition.

Users who have never made use of an alternative to prison present important rates whether in the category of long term workers (10.6%) or in the group of short term workers (7.3%). Those who made use of such alternative structures have higher percentages among those who are retired or unemployed.

**Table 2.9. last employment situation related to the use of alternatives to prison 476 respondents**

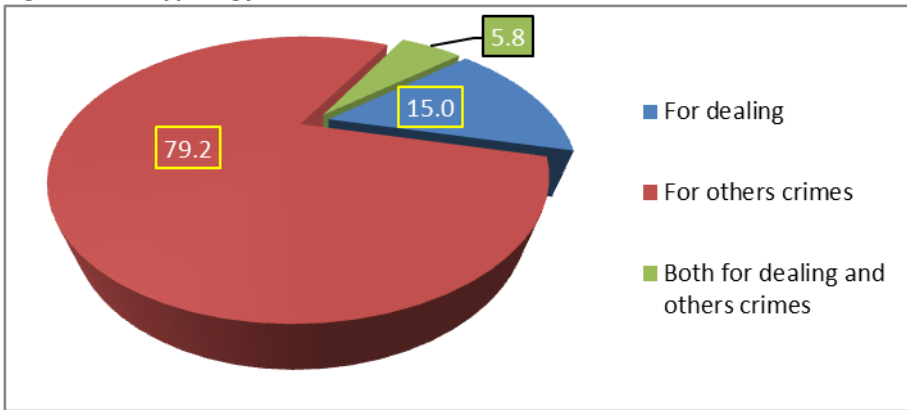
		Alternative sentences to prison		Total
		No	Yes	
work	Long term contract	10.6%	.9%	8.4%
	Short term contract	7.3%	4.6%	6.7%
	Self-employed or professional work	4.3%	0.9%	3.6%
	Occasional worker	4.1%	1.9%	3.6%
	Never employed	0.3%	4.6%	1.3%
	Unemployed	51.6%	59.3%	53.4%
	Permanent invalidity	5.7%	1.9%	4.8%
	Retired	12.5%	22.2%	14.7%
	House work	1.1%	0.9%	1.1%
	Student	2.4%	2.8%	2.5%
Total		100.0%	100.0%	100.0%

#### 2.4. Contact with prison

This sample contains people who had been convicted, 40.8% of the respondents have been incarcerated (Table 2.10) and more than 3/4 of them had been convicted for crimes not related to drugs (79.2% in Figure 2.14)

**Table 2.10. typology of crime committed 507 respondents**

Prison				
Never	For dealing	For other crimes	Both for dealing and other crimes	Total
59.2%	6.1%	32.3%	2.4%	100%

**Figure 2.14. typology of crime committed**



**Figure 2.15. typology of crime committed (TrC, TC or LTS)**

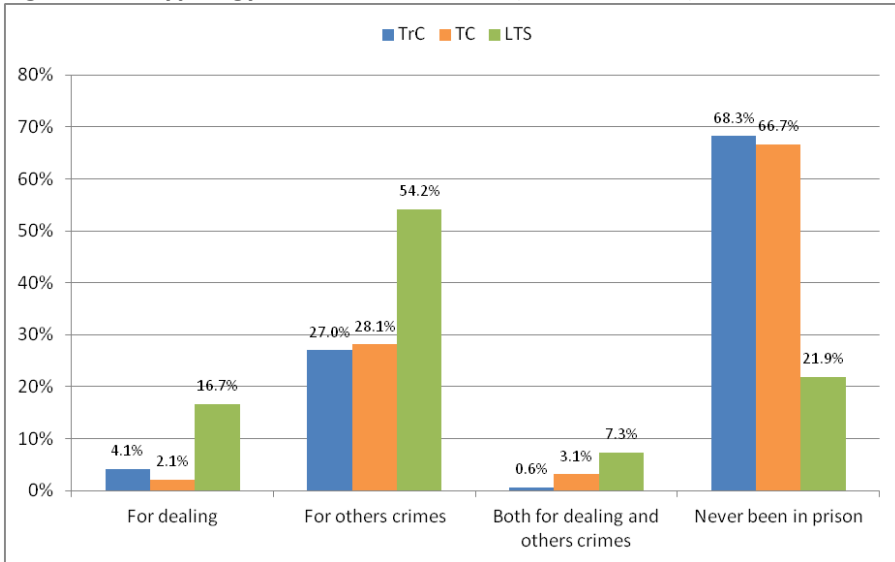
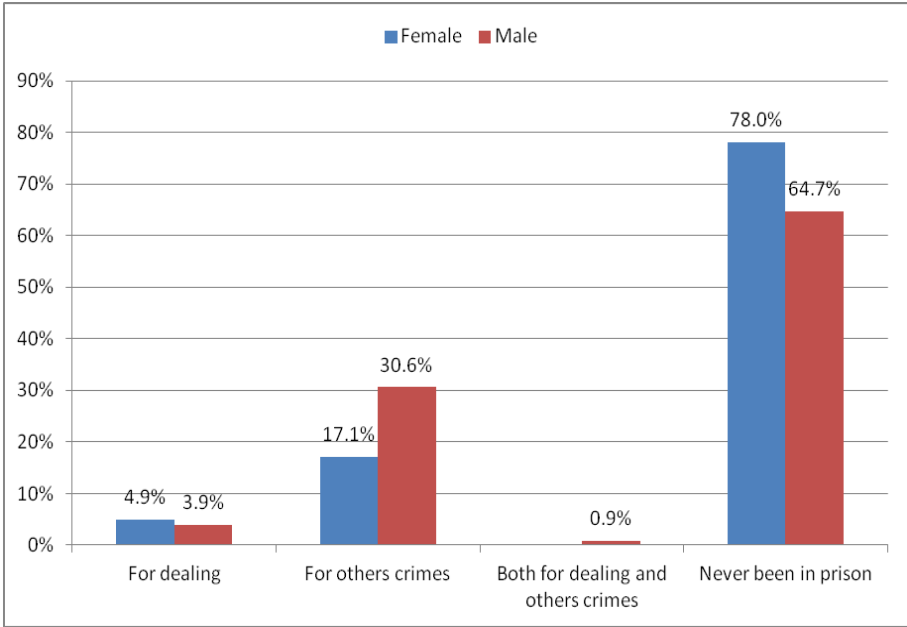


Figure 2.15 displays the prevalence for each specific typology of crime that was committed by LTS, TrC and TC respondents.

TrC and TC respondents report almost the same proportion of “never been in prison” as “imprisoned” while LTS users reported higher percentages (78.1%) among imprisoned people. LTS respondents also report higher proportion “for crimes not related to drugs” (54.2%).

**Figure 2.16. typology of crime committed by gender (TrC) 315 respondents**



When distinguishing by gender in each crime category we see that 78% of women in TrC have never been in prison, as opposed to just 64.7% men. A relatively high percentage of men have committed crimes not related to drugs (30.6%) while dealing is reported by women and men almost at the same level (4.9% and 3.9% respectively). Women are not represented at all in the category “both for dealing and other crimes” and men represent just 0.9% of this category.

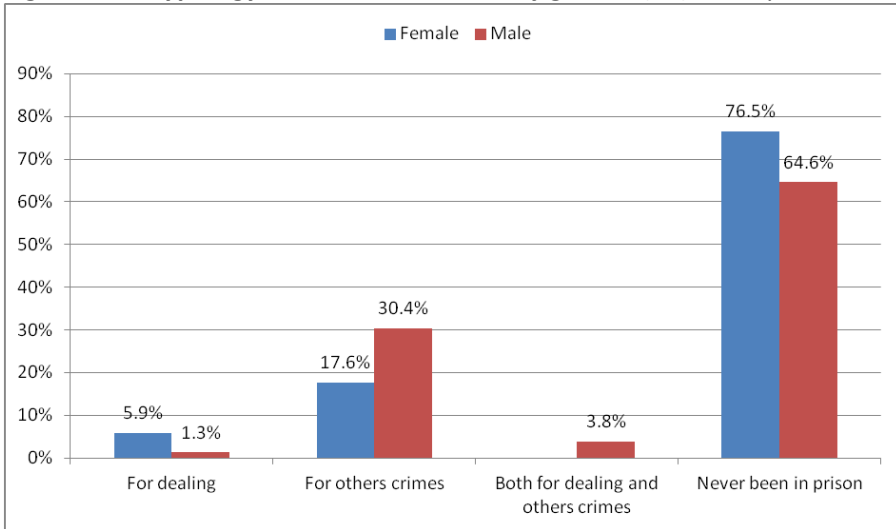
**Figure 2.17. typology of crime committed by gender (TC) 96 respondents**

Figure 2.17 shows the prevalence of male TC patients in every category of single crimes but not for dealing. The class with the highest frequency of men is “for others crimes” (30.4%), higher than the other class “for both dealing and other crimes” (3.8 %).

Females who have never been imprisoned are the majority (76.5% vs 64.6% of men) as well as those imprisoned for drug dealing (5.9% vs 1.3% of males).

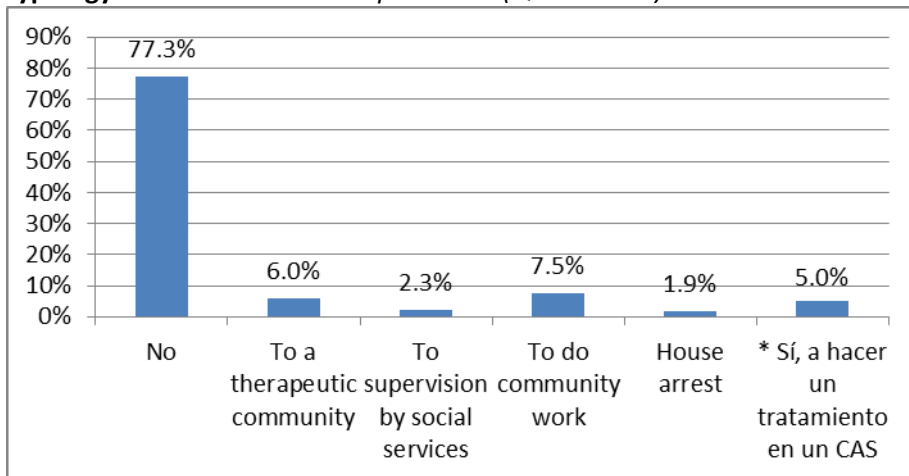


Looking at Table 2.11 a first analysis of the trend in each single row brings us to the conclusion that the first crime – in the case of prison - is “other crimes”; “dealing” is more important for the age group over 54, as well as for “both dealing and other crimes”.

## 2.5. Alternative Sentences

After having analyzed the respondents' relations with prison it is interesting to proceed elaborating the characteristics of users who received an alternative sentence.

**Figure 2.19. patients who got alternative sentence or not related to the typology of alternative 481 respondents. (Question 29)**



77.3% respondents couldn't obtain any sort of alternative to prison (Figure 2.19).

Community work is the most popular alternative, received by 7.5% of those who could skip prison followed by therapeutic community (6%). Those attending other alternatives to prison are very few. Next to TC we have the CAS service (5%). Supervision by social services was reported by 2.3% of users and house arrest by 1.9%.

**Figure 2.20. female patients who got alternative sentences related to the typology of alternative 14 respondents**

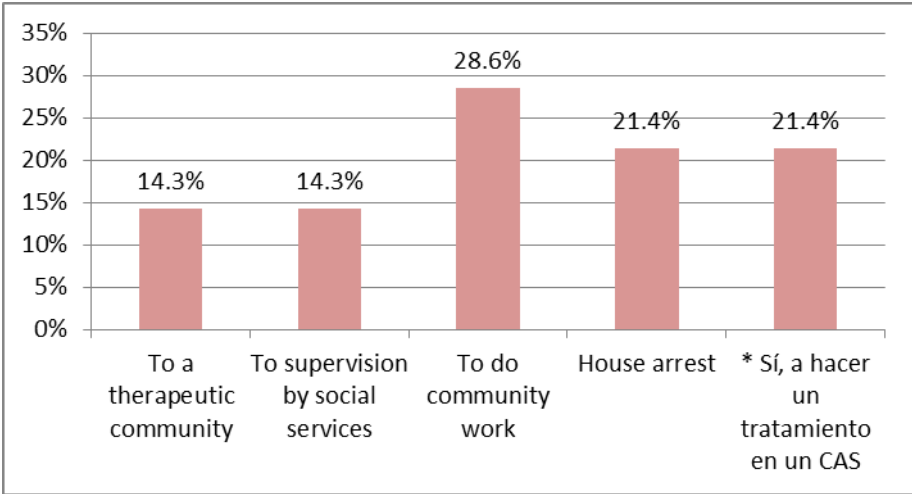
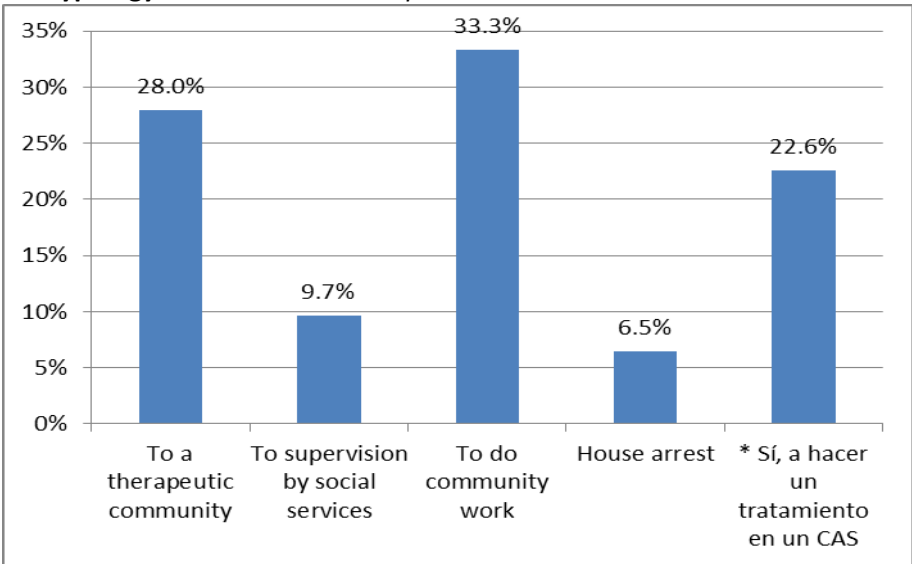


Figure 2.20 and 2.21 take into consideration only the users who benefited from alternative sentences, distinguishing them by gender.

In general, men report a higher percentage among all the types of alternative classes than women, except for house arrest and the supervision by social services.

**Figure 2.21. male patients who received alternative sentence related to the typology of alternative 93 respondents**

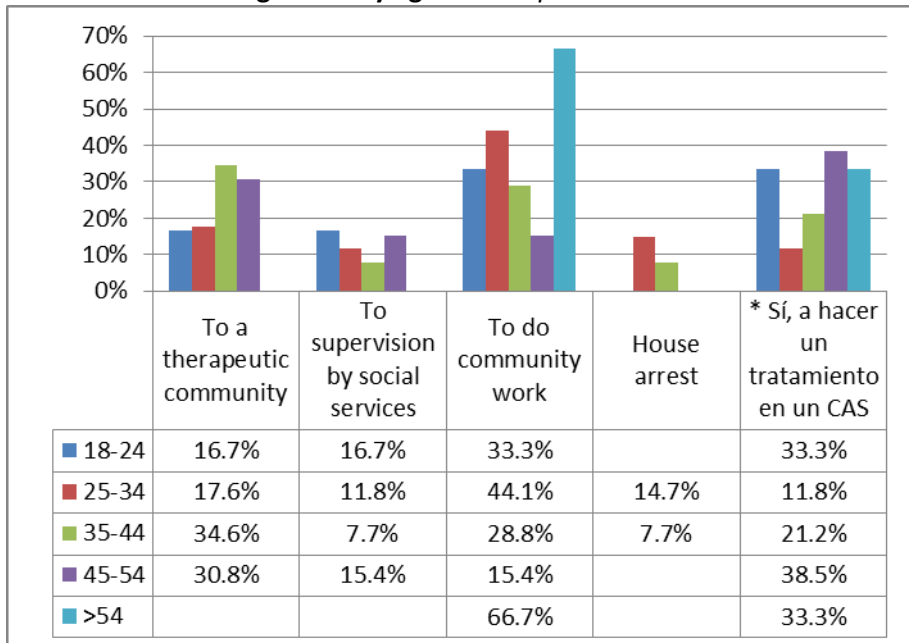


The most frequent alternative choice by both genders is community work (33.3% men and 28.6% women).

Women mostly reported house arrest and treatment with CAS services (21.4% for each services) as the most common alternative to prison sentencing. Therapeutic community is the second most frequently chosen alternative by men (28%). Following, we have CAS treatment and supervision by social services. Women's third most common alternatives are tied between the therapeutic community and supervision by social services (14.3%).

The data from figure 2.22 allows us to document how many alternative sentences users received in relation to their age. This distribution shows how the house arrest alternative is used only by users between 25 and 44 years old. Those older than 54 got mostly community work and CAS treatment. This latter alternative is common among users older than 45. Therapeutic community is attended mostly by the age groups 35-44 and 45-54 while young adults aged 18-24 tend to receive community work and CAS treatment as an alternative sentence.

**Figure 2.22. patients who got alternative sentence related to the number of alternative. Distinguished by age. 109 respondents**







# CHAPTER 3

## Consumption, Doses, Prices

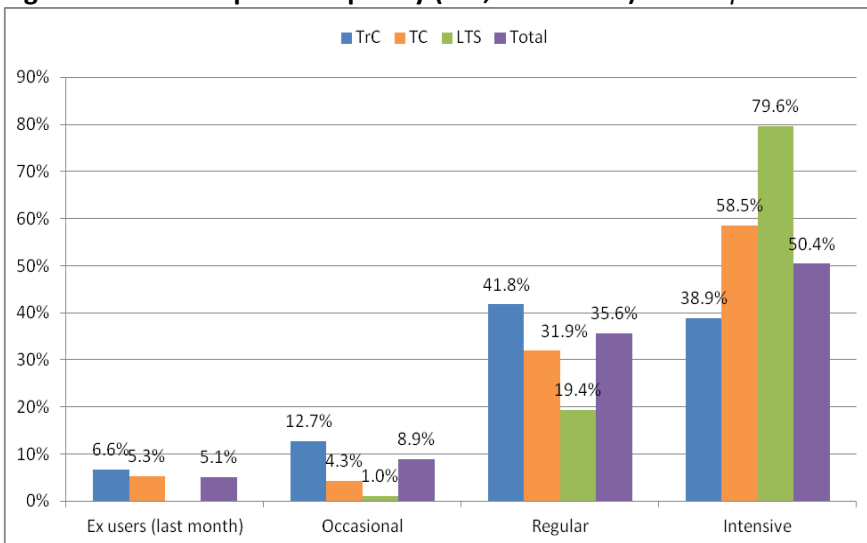
### 3.1. Drug Consumption

This chapter concerns consumption analysis in the last 30 days for LTS and TrC patients, in the case of TC patients it refers to the last month before entering the current therapeutic community.

Therefore it is possible to have 4 different categories: ex users, occasional users (1-5 times in the last 30 days), regulars (6 – 19 times) and intensives (20 times and more).

The last month is not always a month of high consumption because the patients could already be in treatment (for detoxification) before starting a treatment period in a TC or they could simply be reducing their normal consumption keeping in touch with a health care structure.

**Figure 3.1. consumption frequency (TrC, LTS and TC) 508 respondents**



Ex users or temporary “ex” users represent 5.1% of respondents and they are mostly from TrC and TC. Among “intensive” users the majority are from LTS (79.6%) with 58.5% from TC and 38.9% from TrC. For this latter category of users the most frequent value is in the consumption class “regular” (41.8%); among occasional consumers high rates are found in TrC (12.7%). Looking at the general distribution TrC users seem to be the most moderate consumers compared to TC and LTS. Rates of these two users’ categories are negligible in the consumption class “occasional”. LTS users are not represented in the consumption category “occasional”.

In Table 3.1 the rate of consumers is reported distinguished by gender and service .

**Table 3.1. consumption frequency of TrC. TC and LTS users distinguished by gender 508 respondents**

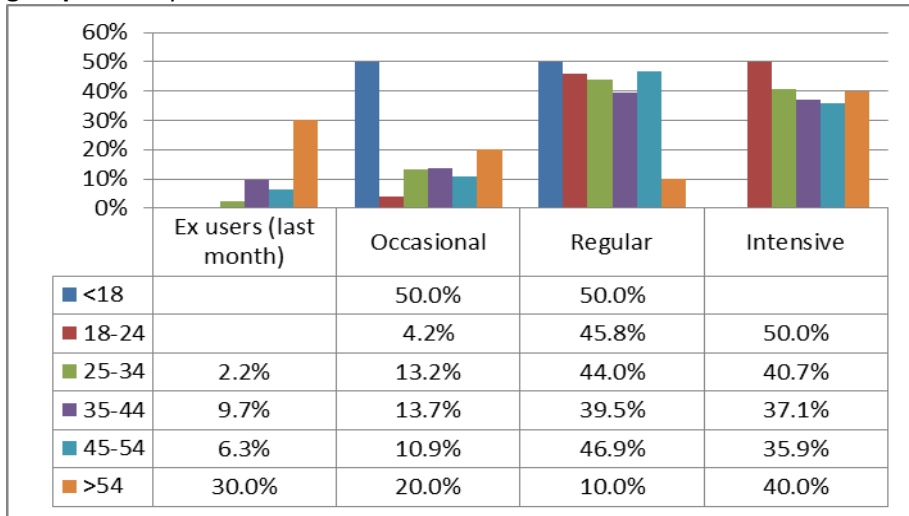
	TrC		TC		LTS	
	Female	Male	Female	Male	Female	Male
Ex users (last month)	6.9%	4.8%	6.5%	-	-	-
Occasional	11.7%	15.7%	5.2%	-		4.8%
Regular	42.0%	41.0%	31.2%	35.3%	14.7%	33.3%
Intensive	39.4%	38.6%	57.1%	64.7%	85.3%	61.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Among LTS patients, high rates of women were intensive consumers (85.3% vs 61.9% of men). In TrC services the modal value is regular consumers for both female and male (42% and 41% respectively) followed by intensives (39.4% and 38.6%) and occasional users. In TC women and men are mostly intensive and regular consumers. Here men are not represented at all in the consumption categories occasional and ex users while only very few women feature in these categories.

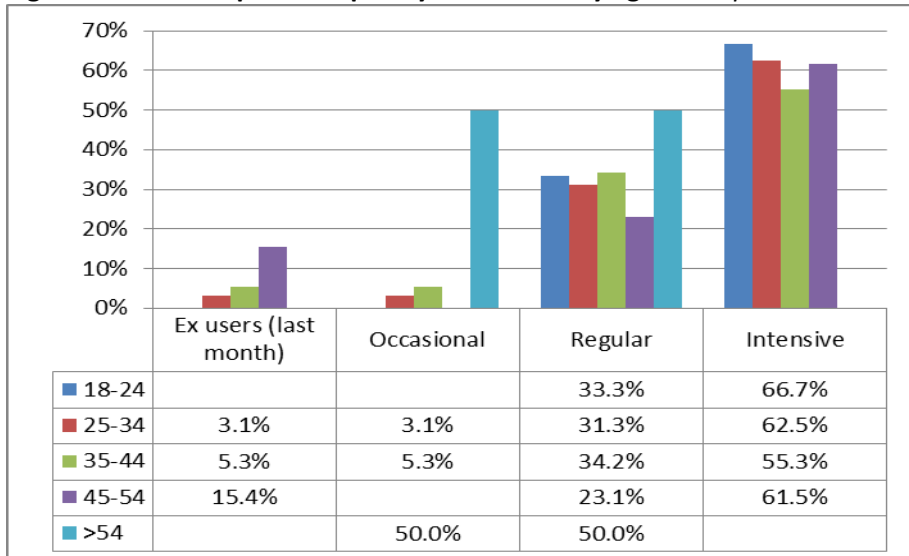
In figure 3.2, which refers to TrC users, the distribution of those younger than 18 is split between occasional and regular consumers. Also for young adults (18-24) the distribution is concentrated in two consumption classes ; regular and intensive.

Age classes between 25 and 54 present high rates among intensive and regular consumers. Rates in the others consumption categories are little. Those older than 54 are mostly intensive or ex users.

**Figure 3.2. consumption frequency of TrC patients related to their age group 315 respondents**

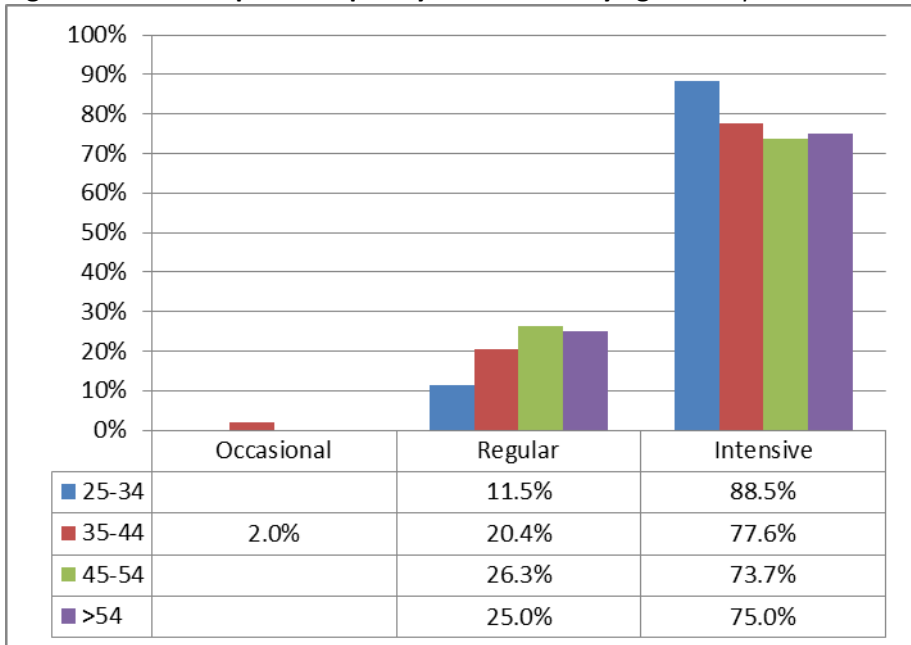


**Figure 3.3. consumption frequency of TC users by age 94 respondents**



As shown in figure 3.3 (which refers to TC patients) most young users aged 18-24 are intensive users (66.7% of the total of young users). The remaining 33.3% of these users reported regular consumption. The same trend is followed by those aged 25-54 years old. Compared to the younger group this group have notable rates among ex-users. Respondents older than 54 are fairly evenly spread among occasional and regular users.

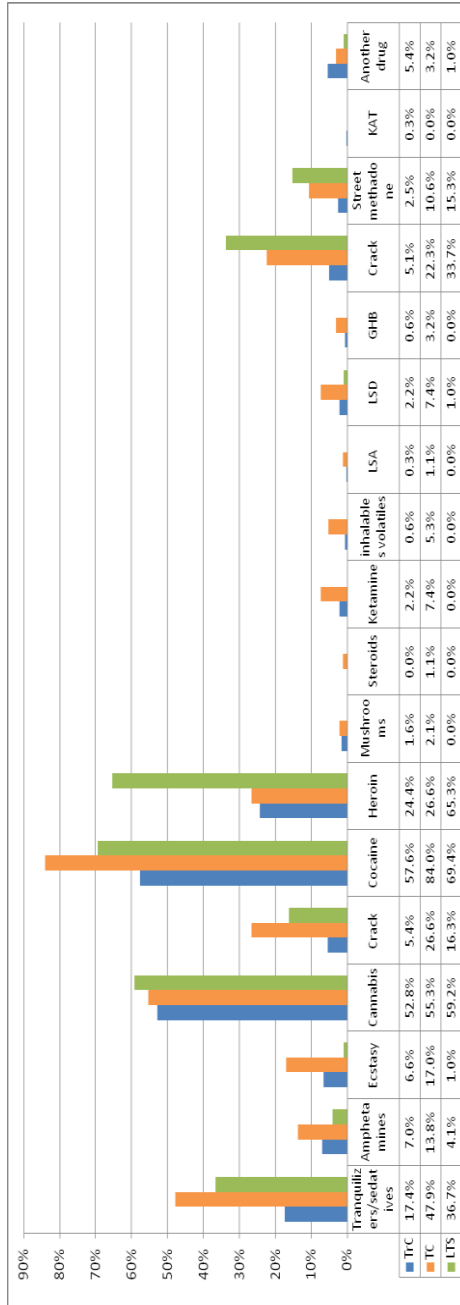
**Figure 3.4. consumption frequency of LTS users by age 98 respondents**



Trends are dissimilar across different services. In LTS almost all the younger users (25-34) are intensive consumers (88.5%). The most frequent value is "intensive" for all the age groups, but respondents exceeding 35 years in age increased in regular use. Occasional and ex users are not represented at all in LTS except in the age group 35-44 where 2% of users are occasional consumers.

In the following figures and tables we are going to analyze the consumption frequency of each kind of substance.

**Figure 3.5. last month's drug consumption (TrC, TC and LTS patients) 508 respondents**



Cocaine, cannabis, heroin and tranquillizers continue to be the most popular drugs (Figure 3.5). Cocaine was more appreciated by TC patients (84% of TC users vs 69.4% of LTS and 57.6% of TrC users) while heroin was favored by LTS patients (65%) followed by TC (26.6%) and TrC users (24.4%).

Percentages of cannabis users are spread among TrC, TC and LTS patients (52.8%, 55.3% and 59.2%). Consumption of tranquillizer and sedatives and crack is also relevant. These substances are taken most commonly by LTS users followed by TC and then by TrC users.

To be considered in descending order are: Street methadone, ecstasy, amphetamines, LSD and psychedelic mushrooms. These types of drug are used most often by TC users.

In distinguishing consumers by gender we can see some differences between men and women. Heroin is the drug most used by men (34.7% vs 26.4% of women), followed by cannabis (57.2% vs 45.5% of women). Cocaine, tranquillizers and sedatives and ecstasy are the drugs most used by women.

Men consume more crack, amphetamine, ketamine, ghb and LSD. "Other drugs" (which often means alcohol) are used mostly by men (4.7% vs 2.5%).

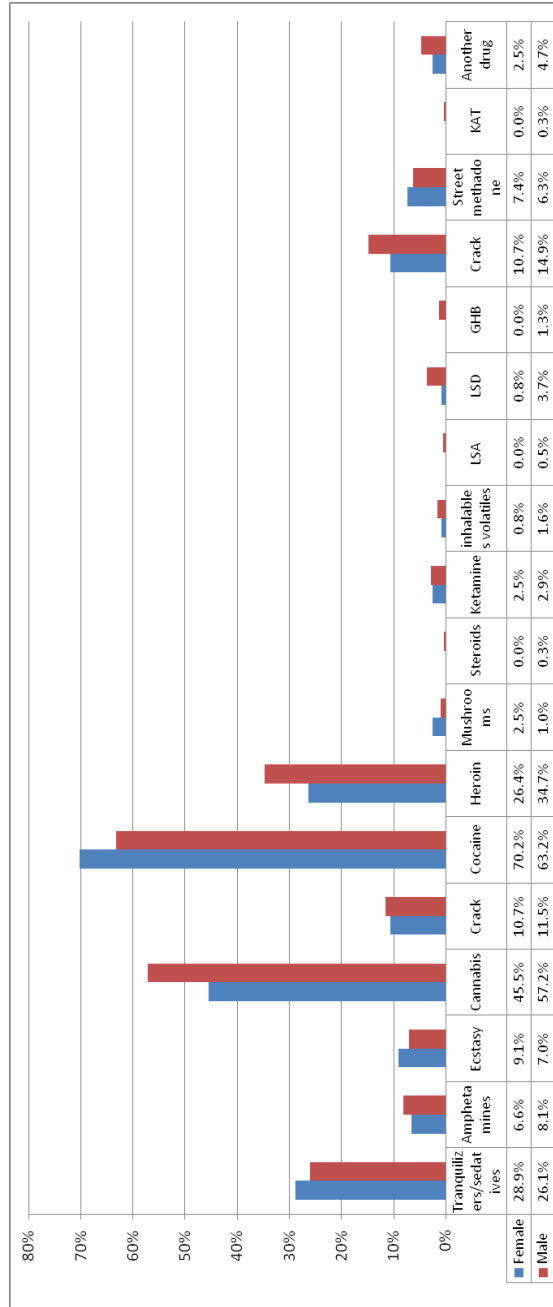
Another review can be undertaken distinguishing users by age and analyzing what different types of drug have been used by respondents during the last month of consumption.

Figure 3.7 reports the rates of drug consumption among TrC patients: young patients are the most important consumers of cannabis, ecstasy, crack and amphetamine. Relevant rates of younger drug consumption are found also in cocaine. This data is important in understanding how much poly-drug use is widespread among young adults.

Older patients (>54) are consumers of cannabis, cocaine and heroin. Except for these age groups at the two extremes, trends in consumption follows inverse or proportional relations depending on which type of drug we are talking about.

Cannabis, cocaine, ecstasy and amphetamine consumption follow an inverse correlation: as age increases, the prevalence of these drugs decrease. For tranquillizer, heroin and crack, as the age increases, the prevalence of these drugs increase as well.

**Figure 3.6. Frequency distribution of the last month's drug consumption by gender 503 respondents**



**Figure 3.7. frequency distribution of the most used drugs during the last month by age group - TrC 315 respondents**

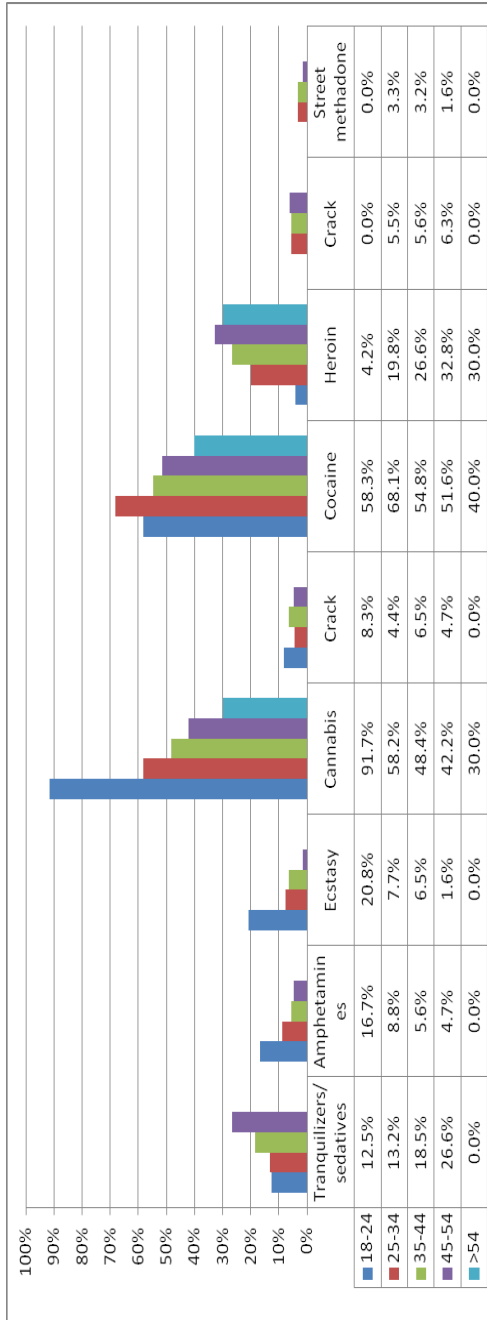






Figure 3.8 reports the rates of drug consumption among TC patients: young patients are the most important consumers of ecstasy, amphetamine and cannabis. High rates of consumption are found also for tranquillizers, crack, cocaine and heroin. Here the previous consideration that poly drug use is widespread among young adults is confirmed.

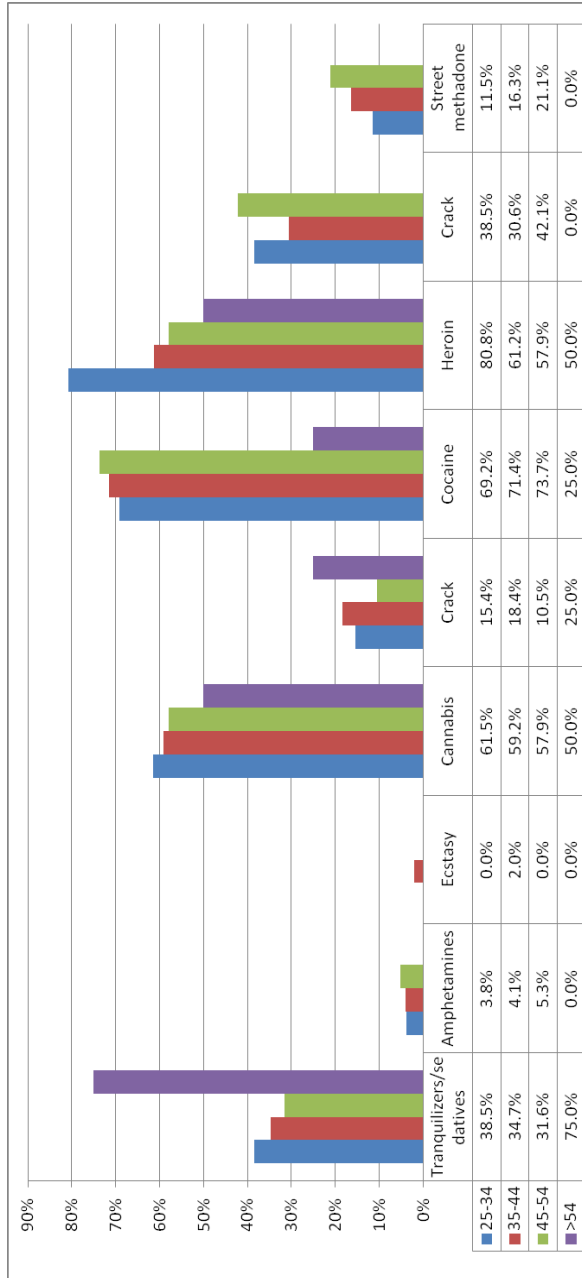
Users aged 25-34 and 35-44 years old are the most important consumers of cocaine, heroin, crack and tranquillizer. Generally they reported high rates of consumption for every type of drug.

Rates of consumption regarding users aged 45-54 are spread among all the drugs except amphetamine and consumption rates are not so high as those of other age groups.

Figure 3.9 speaks about drug consumption among LTS patients: young patients are again the most important consumers of cannabis and heroin but their consumption rates are high also for cocaine, crack and tranquillizer consumption. After young adults the most important consumers of cannabis and heroin are those aged 35-44 and 45-54. They are high consumers also of cocaine, crack and tranquillizer and sedatives but, for this last drug, older patients (>54) are the main consumers.

Concluding, the prevalence of cannabis, tranquillizer and heroin decrease, with an increase in age. The opposite trend is found with cocaine and street methadone prevalence.

**Figure 3.9. frequency distribution of the most used drugs during the last month by age group - LTS 98 respondents**



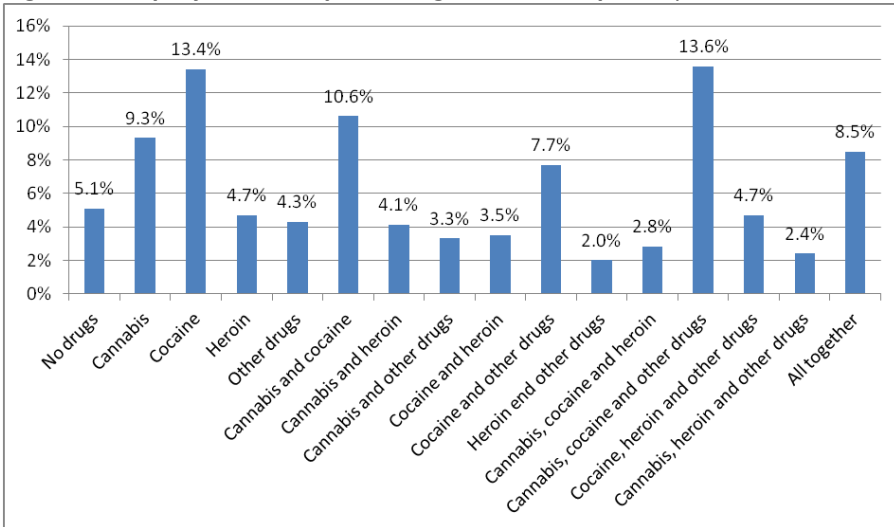
**Figure 3.10. poly-use, as a percentage of the sample respondents 513**

Figure 3.10 speaks about poly use. Only one drug consumed was indicated by 31.7% of respondents and among them only cocaine was used by 13.4%, only cannabis by 9.3% and only heroin by just 4.7%.

The prevalence of hard drugs mixed up with soft drugs is significant in this population.

Cocaine and cannabis together were also used by 39.2% respondents: just cocaine and cannabis 10.6%; cannabis and heroin 4.1%; cannabis, cocaine, and other drugs (\*) 13.6%; all together (\*\*) 8.5%.

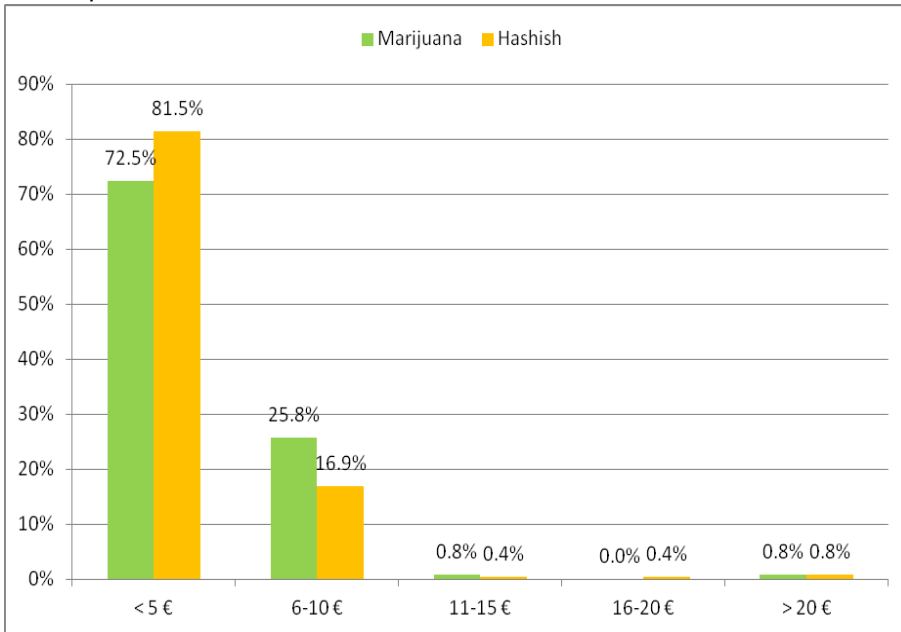
\*" Other drugs" means that at least one of the drugs listed other than the main three (cannabis, cocaine and heroin) is consumed.

\*\* All together includes consumers of cannabis, cocaine, heroin and at least one of the "other drugs".

### 3.2. Prices and substances

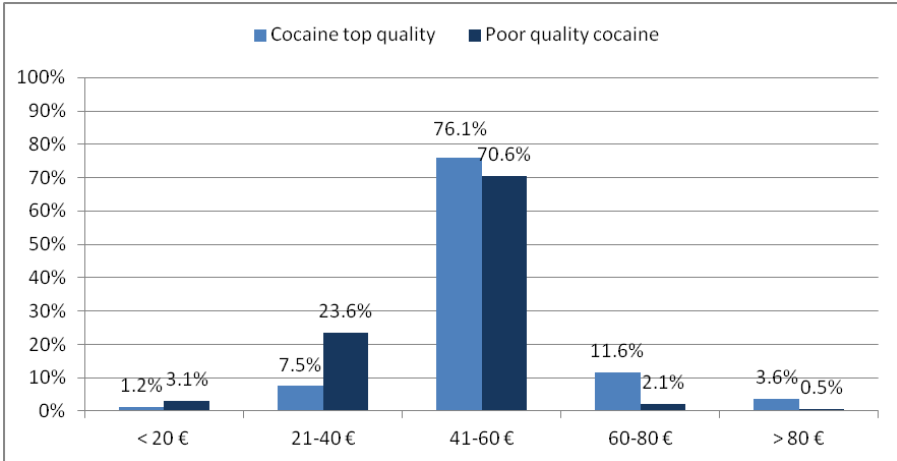
Information on drug prices comes from the answer to question number 23 of the questionnaire. Users were asked to indicate the latest known prices per dose, gram or pill of a list of 9 main drugs, with a specification in the case of heroin and cocaine of high or poor quality.

**Figure 3.11. price for 1 gram of marijuana and 1 gram of hashish 240 and 248 respondents**



The majority of respondents indicated the prices of marijuana and hashish at less than 5 €. A considerable percentage of users (25.8% for marijuana and 16.9% for hashish) reported a price between 6 and 10 €. A negligible number of users priced the two substances at over 11 € per 1 gram (under 1%). Thus marijuana and hashish prices are surely less than 10€ per 1 gram. Figure 3.12 shows the price difference between poor and top quality cocaine. Both qualities of cocaine were priced by most respondents at between 41 and 60€. Top quality cocaine distribution sees relevant percentages of users priced at over 60€ (15.2%) while for low quality cocaine 26.7% of users reported a price under under 40€. In conclusion the price of poor quality cocaine is certainly lower than 60 € per gram while a top quality cocaine price is between 60 and 80€ per gram.

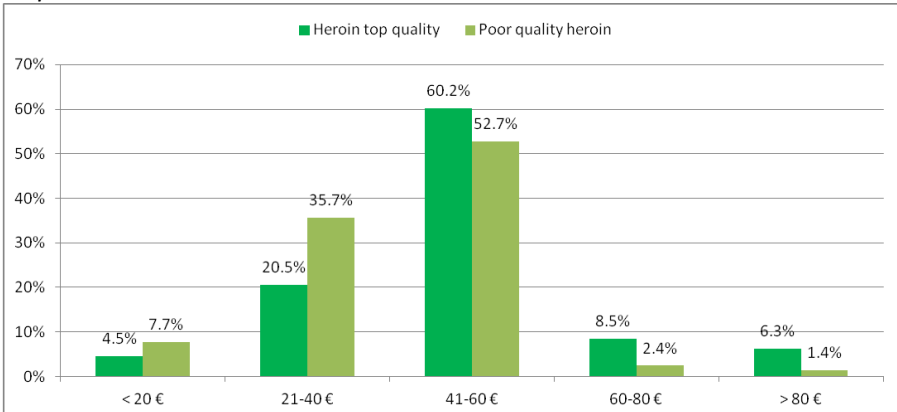
**Figure 3.12. price for 1 gram of top quality and poor cocaine 335 and 385 respondents**



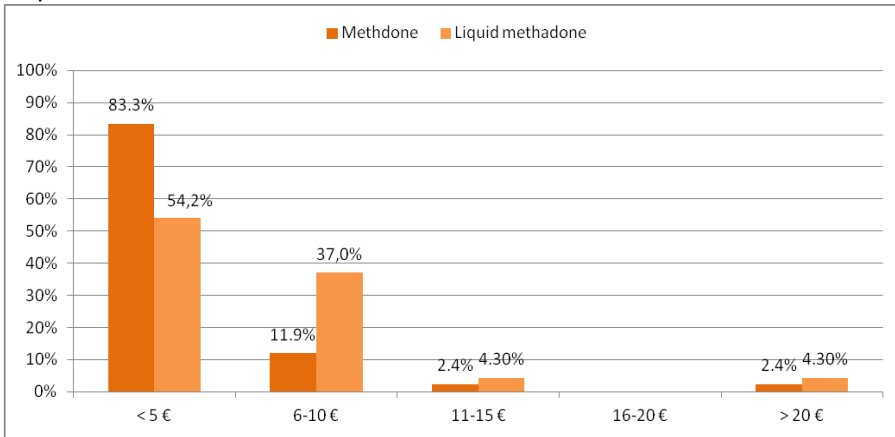
The modal value of poor and top quality heroin is within the class 41-60 € (52.7% and 50.2% respectively). Top quality heroin is indicated by 20.5% respondents in 21-40 € and by 8.5% in 60-80€.

Generally low quality heroin is costs less then 60€ while the quality cocaine is never less than 21€.

**Figure 3.13. price for 1 gram of top quality and poor heroin 176 and 207 respondents**

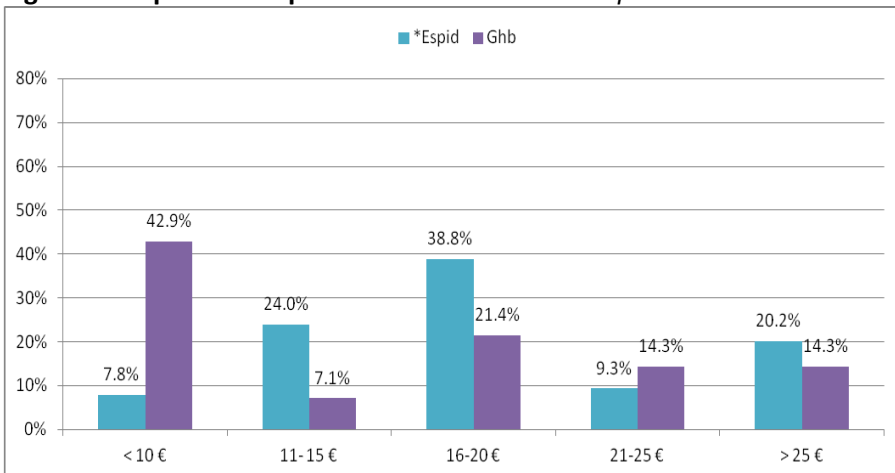


**Figure 3.14. price for Methadone and liquid methadone 42 and 46 respondents**



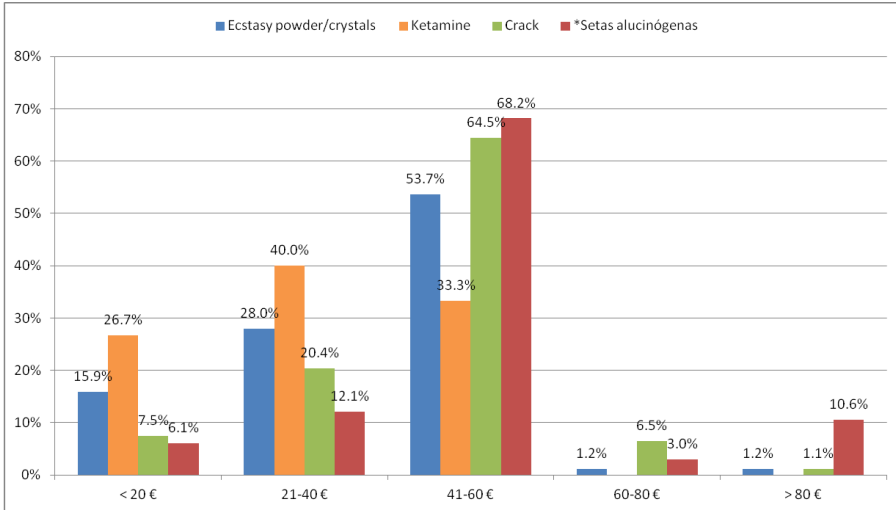
The overwhelming majority of interviewees (83.3%) said the price of methadone was under 5€ per 1 gram, followed those who said it usually cost 6-10€ (11.9%). Compared to methadone, liquid methadone is priced by 54.2% at under 5€ and by 41.3% at 6-15€.

**Figure 3.15. price for Espid and Ghb 129 and 14 respondents**



Espid and Ghb distribution is more varied. Most users priced Espid under 10€ while the majority of respondents said Ghb was between 16-20€. Relevant percentages of users reported a prices of Espid between 11-15€ (24%) and higher than 25€ (20.2%).

**Figure 3.16. price ecstasy powder/crystals, Ketamine, Crack and \*Setas alucinógenas 82, 45, 93, 66 respondents**



The prices of ketamine and ecstasy powder is never higher than 60€. The price of hallucinogens is reported by most of users as lower than 60€ but 13.6% priced it as higher than 61€. The trend for crack is the same as for hallucinogens but it possible to circumscribe the cost of this substance as around 41-60 €.

Further analysis can be conducted drawing from data surveyed separately in occasional, regular and intensive consumers noticeably. The aim is to obtain an estimate of prices from those who had more recent experience.



**Table 3.2. estimated price for 1 gram of marijuana expressed by cannabis consumers according to their consumption frequency**

		< 5 €	6-10 €	11-15€	16-20€	> 20 €	Total
<b>Cannabis consumers</b>	Occasional	72.7%	27.3%	-	-	-	100.0%
	Regular	79.6%	18.5%	1.9%	-	-	100.0%
	Intensive	71.4%	26.1%	.8%	-	1.7%	100.0%

Table 3.2 displays estimated prices the users gave to marijuana according with their consumption habits.

Most respondents, whether they are occasional, regular or intensive marijuana users, estimated marijuana prices at less than 5€. A considerable number of occasional and intensive consumers declared a price of between 6-10 €. Negligible rates of both occasional, regular and intensive users reported prices higher than 11€.

Hashish distribution is similar to the previous pattern for marijuana, just a little bit considered it to be less expensive.

**Table 3.3. Estimated price for 1 gram of hashish expressed by cannabis consumers according to their frequency of consumption**

		< 5 €	6-10 €	11-15€	16-20€	> 20 €	Total
<b>Cannabis consumers</b>	Occasional	77.8%	22.2%	-	-	-	100.0%
	Regular	83.7%	14.0%	-	2.3%	-	100.0%
	Intensive	82.4%	15.4%	.7%	-	1.5%	100.0%

**Table 3.4. Estimated price for top quality cocaine and poor cocaine per 1 gram, expressed by consumers of these substances according to their consumption frequency**

			< 20 €	21-40 €	41-60 €	60-80 €	> 80 €	Total
<b>Cocaine and heroin consumers</b>	Top quality Cocaine	Occasional	-	-	100.0%	-	-	100.00%
		Regular	2.6%	1.3%	75.6%	15.4%	5.1%	100.00%
	Poor cocaine	Intensive	-	8.6%	78.1%	9.9%	3.3%	100.00%
		Occasional	-	15.0%	80.0%	5.0%	-	100.00%
		Regular	3.4%	17.2%	74.7%	3.4%	1.1%	100.00%
		Intensive	1.7%	26.9%	69.7%	1.1%	.6%	100.00%

Table 3.4 depicts prices of poor and top quality cocaine expressed by those who were consumers of these two types of substances. Analysis was undertaken distinguishing users according to their frequency of consumption .

The price for poor cocaine is between 41-60€. Levels of occasional, regular and intensive consumers are concentrated in the price classes between 21 and 60 € per gram.

Data about top quality cocaine shows a similar distribution as with poor quality cocaine. Considerable percentages of intensive users priced it within 21-40€ and 60-80€. In conclusion, top quality cocaine prices are usually between 21-80€ while poor quality cocaine prices are around 21-60€. The data in figure 3.12 confirms this.

Confirmation comes also from data about heroin prices given by consumers. Percentages are variously spread among price classes thus an exact estimation can't be undertaken. Though it is clear that the price of poor heroin is less than 60 € per gram while top quality heroin is less than 80€.

**Table 3.5. estimated price for top quality heroin and poor heron per 1 gram. expressed by consumers of these substances according to their consumption frequency**

		< 20 €	21-40 €	41-60 €	60-80 €	> 80 €	Total	
<b>Cocaine and heroin consumers</b>	Top quality heroin	Occasional	50.0%	-	50.0%	-	-	100.00%
		Regular	5.9%	11.8%	76.5%	5.9%	-	100.00%
		Intensive	3.4%	20.7%	59.8%	8.0%	8.0%	100.00%
	Poor heroin	Occasional	25.0%	12.5%	62.5%	-	-	100.00%
		Regular	-	38.5%	61.5%	-	-	100.00%
		Intensive	3.9%	39.2%	52.0%	2.9%	2.0%	100.00%

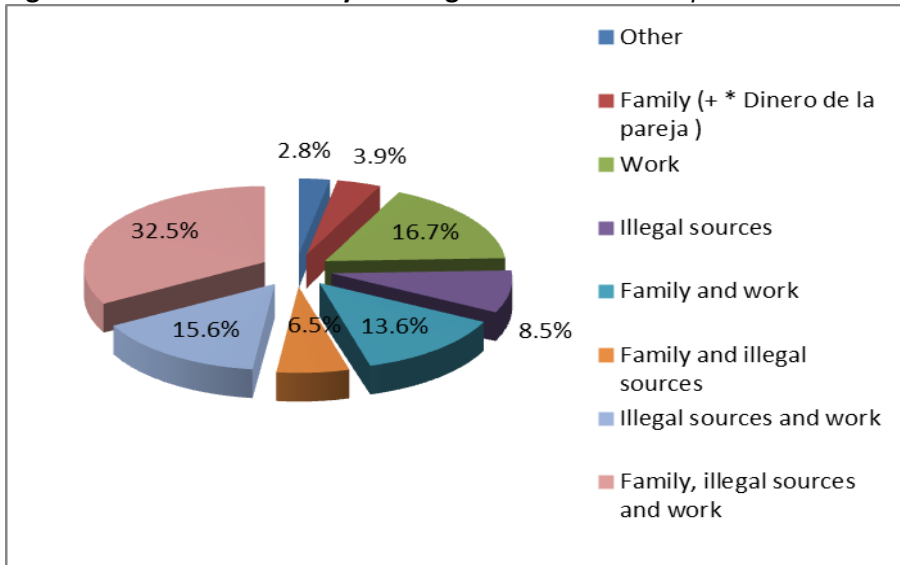


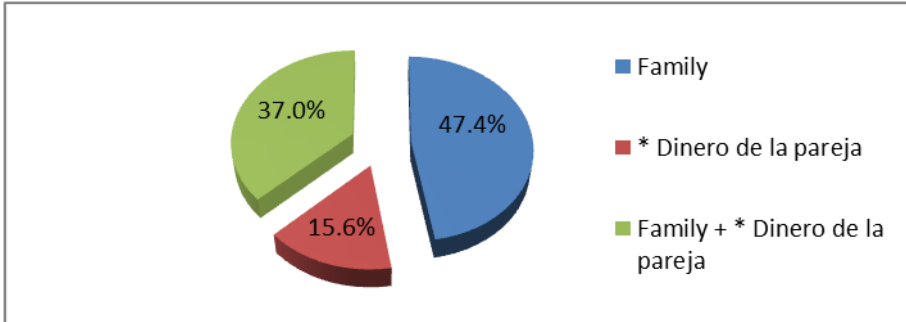
# CHAPTER 4

## Legal and Illegal Sources of Revenue

This chapter aims at identifying the sources of income (legal and illegal) through which users obtain the money to buy drugs. The issue of income sources is strongly correlated with the question of the funding of the illicit drugs market. There are three main sources of revenue that users invest in drugs purchases: money from family, work and illegal activities. The question “How did you usually get money to buy drug(s)?” could be answered choosing more than one answer. That has allowed the aggregation of the respondents into eight categories in which all the three main sources identified are combined.

**Figure 4.1. sources of money for drug consumers 360 respondents**



**Figure 4.2. sources of money from family (specification)<sup>3</sup>**

Families have a powerful prevalence as income for drugs addicts. “Family” alone is the income source of 3.9% of users. 13.6% collected money from family and work salary while 6.5% obtained money from family and illicit activities. 32.5% respondents drew from family savings, nearly always in conjunction with other sources. That could mean that money from the family is not enough in itself to maintain the level of consumption for most users, so they necessarily have to draw from other sources.

Work is an important source of income to buy drugs for 16.7% of users.

It is important to highlight that the main source after “family support” is “illegal activities”: 8.5% of respondents could reckon just on crimes without drawing from other sources.

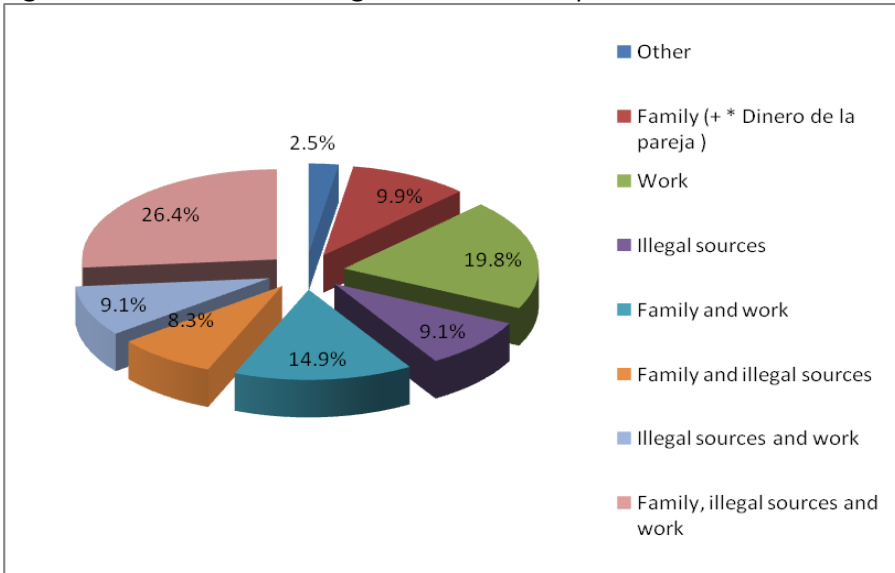
Although over one-quarter of the respondents (32.5%) use the three income sources all together to get money to spend in the drug market 15.6% use two income sources “illegal activities” and “work”; 6.5% “family” and “illegal activities” (Figure 4.1).

The income sources of women are different from those of men: family is more important for women (Figure 4.3) than for men. The pie chart in Figure 4.4 (for men) displays a split distribution among four main categories (family, work and illegal activities: 28.3%; illegal activities 21.9%; work and illegal activities 17.1% and work 14.7%) while distribution for women is apportioned among all income groups with an important concentration (38.2%) for “family, work and illegal activities” together.

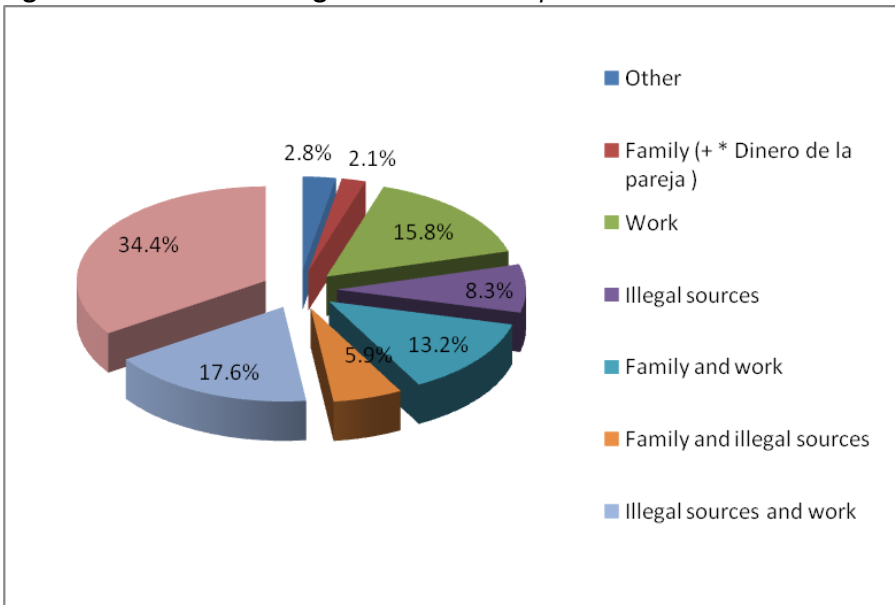
<sup>3</sup> This figure (4.2) shows also the contribution of “la pareja” (the partner), which is not as important as the contribution of the strictly family. This specification only is present in the Spanish questionnaire. In the other questionnaires the partner’s contribution is implicitly included in the family one.

Further, 19% of women reported income from illegal activities, 12.7% reported work and illegal activities, 8.8% reported family and illegal sources and 7.8% family and work, only 5.9% (vs 14.7 of men) from work.

**Figure 4.3. women's income generation 121 respondents**



**Figure 4.4. men's income generation 387 respondents**



Other important features can be observed in relation to the age of respondents.

Young adults aged 18-24 (Figure 4.5) received revenue mostly from “family, illegal activities and work” (33.3%) and from “family and illegal activities” (18.2%). Family as the only one source of money is reported by 9.1% of young adults while family combined with work is an important income for 12.1% of them.

Looking at the 25-34 age group “family, illegal activities and work” was still the modal value (40%); work (15.3%) and illegal activities combined with work (13.3%) become more important than for the younger group; illegal activities as the only one source of income slightly decreases with respect to the younger group (7.3%).

The age groups between 25-54 are the most likely to rely on work only or on work combined with family resources. Users over 55 tend to obtain resources mostly from illegal activities combined with work or from other sources of income which are not specified.

As age increases, respondents are more distributed among classes of combined sources of income except for respondents beyond the age of 55 years. For these users there is a level concentration in the income category “other”. Users over 55 are also the most likely, after young adults, to rely on family resources as the only one source of money to finance their addiction.

The survey also allows a deeper analysis concerning the main illegal activities: dealing, prostitution and theft/robbery. In order to better understand the phenomenon we built seven different clusters containing one or more of the above-mentioned activities in accordance with the multiple or single choices of respondents.



Figure 4.5. sources of money by age 512 respondents

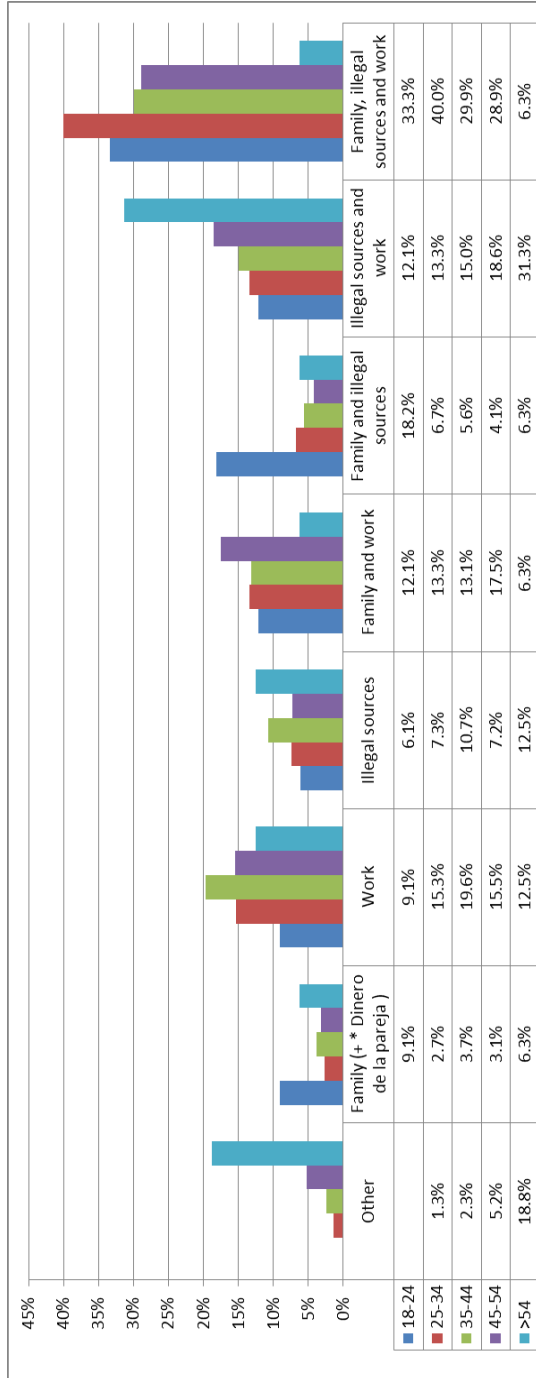
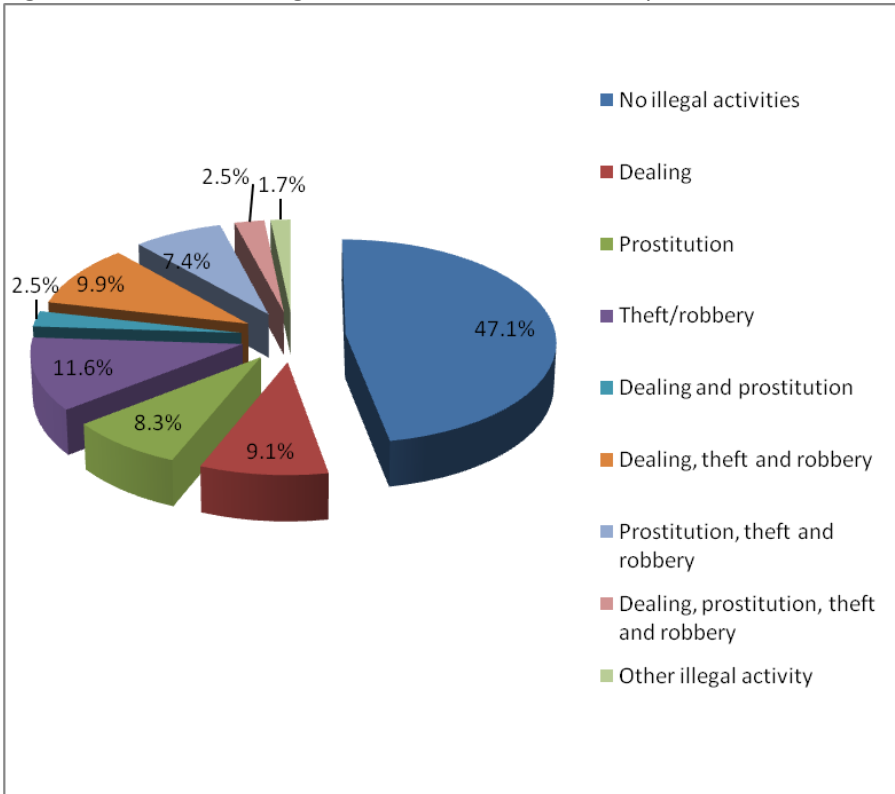
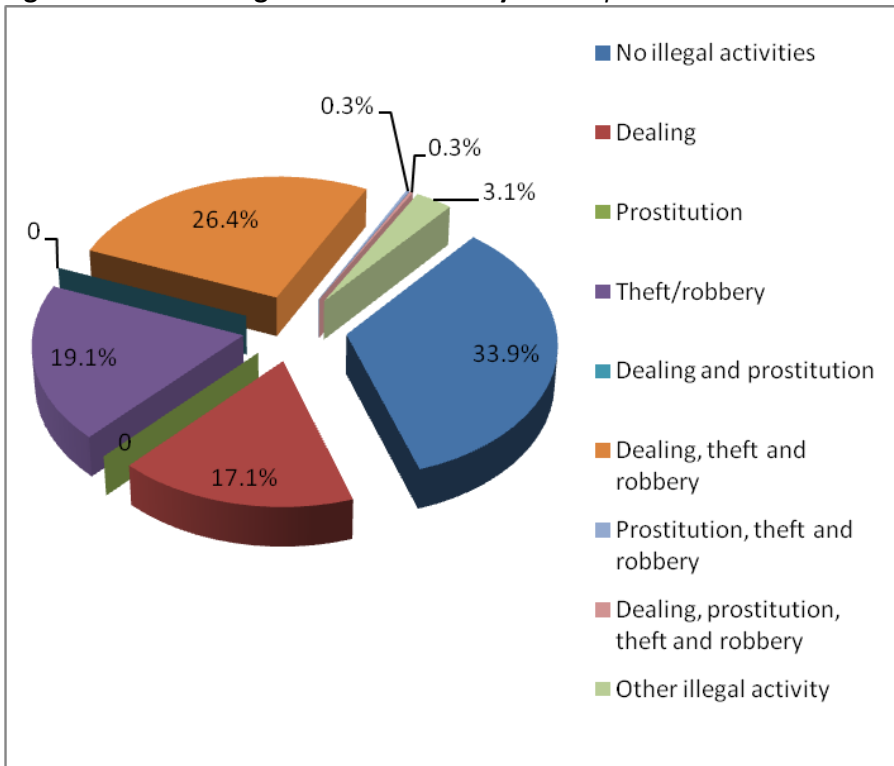


Figure 4.6 displays illegal sources of funding for women. The main illegal source of revenue is “theft and robbery” (11.6%), while 4.9% of respondents combine this activity with dealing, 9.1% cite selling drugs as the main source and 8.3% can count only on prostitution. Prostitution combined with theft and robbery is the only illegal activity for 7.4% of women while only prostitution is the main activity for 2.5% of women.

**Figure 4.6. women’s illegal sources of income 121 respondents**



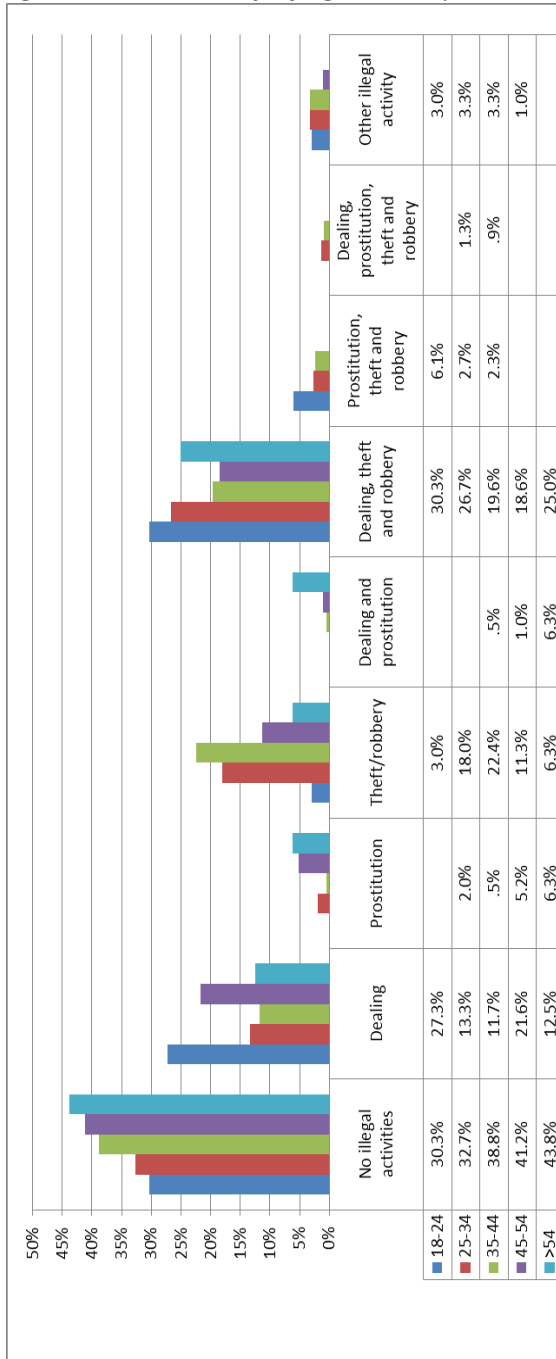
**Figure 4.7. men's illegal sources of money 387 respondents**



The illegal activities of men are more concentrated in three categories: “dealing, theft and robbery” (26.4%); “dealing” (17.1%); “theft and robbery” (19.1%).

Prostitution was declared by 3.4% men (summing up only prostitution and dealing and prostitution).

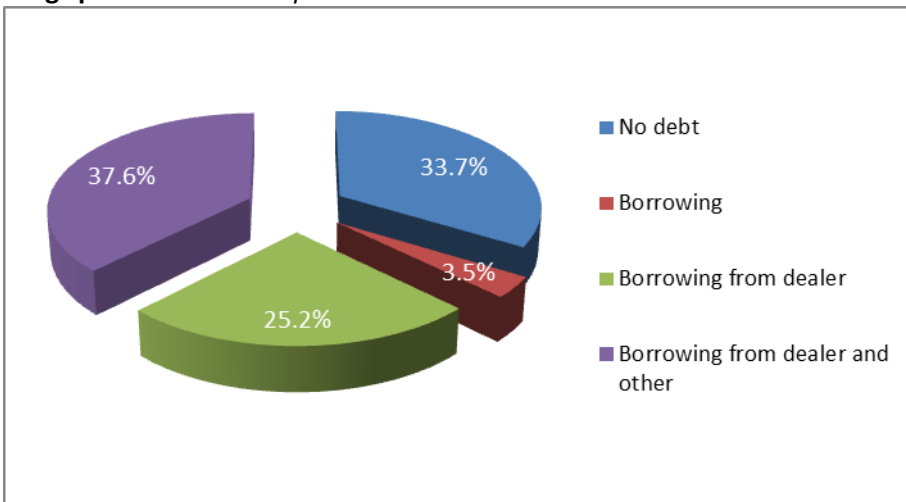
Figure 4.8. Illegal source of money by age 512 respondents



Drug dealing, on the individual level, and combined with theft and robbery are among the main activities used as an illegal income source to purchase drugs. That applies to all of the age groups. Drug dealing is still more widespread among the younger generation, especially combined with theft and robbery and prostitution activities.

Prostitution combined with drug dealing is more frequent among adults over 54 years old.

**Figure 4.9. distribution of respondents who contracted a debt or not for drugs purchases 508 respondents**



Among those who borrowed money to buy drugs, 37.6% had borrowed both from dealers directly and from other subjects, 25.2% reported to have borrowed money just from a dealer and the rest only from other subjects (3.5%). Over one quarter of respondents (33.7%) have never received a loan to buy drugs.

**Figure 4.10. Distribution of respondents who contracted a debt or not for drugs purchase by gender 508 respondents**

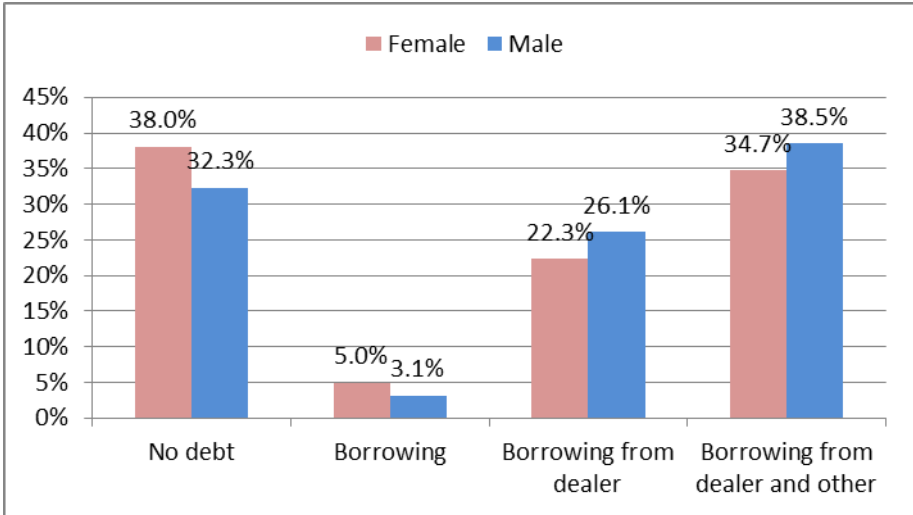
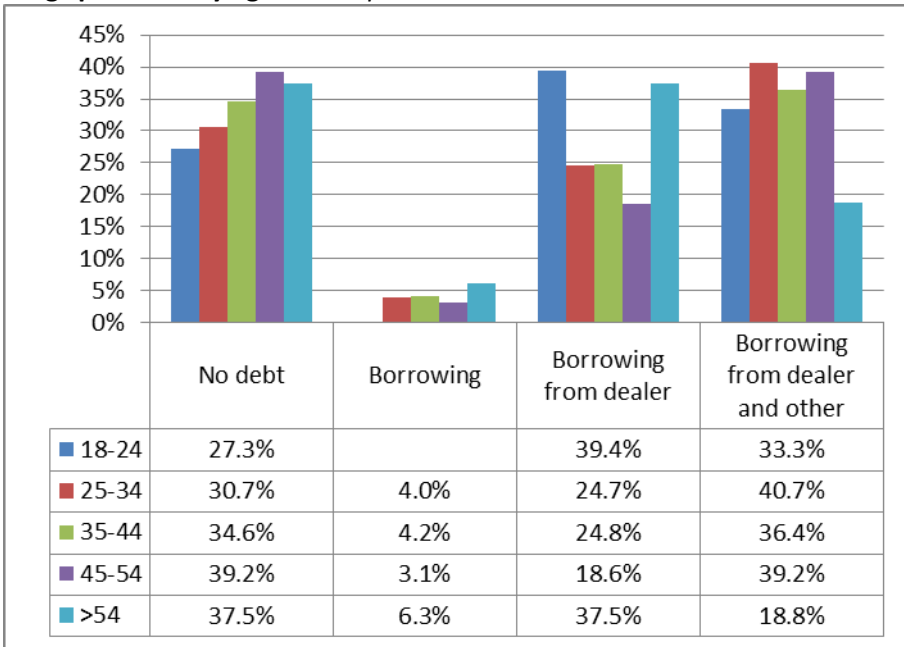


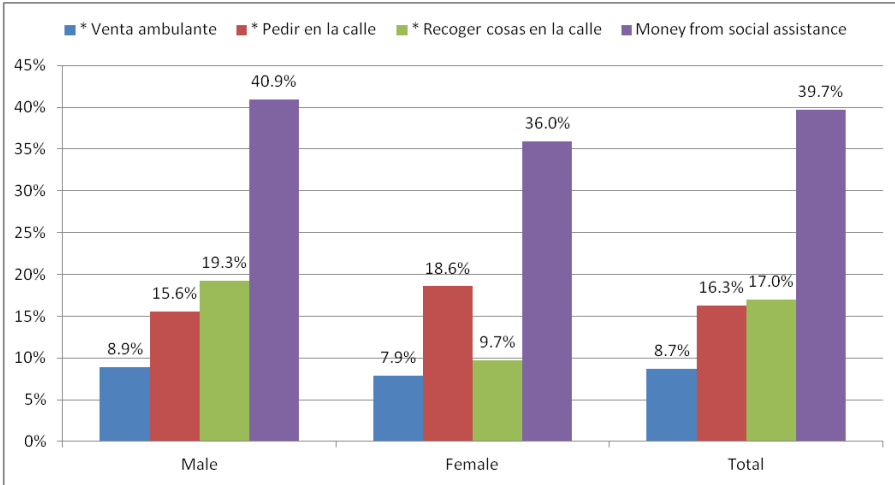
Figure 4.10 displays users' distribution by gender and the means of borrowing money to purchase drugs. The data shows a not irrelevant difference between male and female rates of borrowing. Men borrow from dealers more often than women and also borrow more from people other than dealers. Women are the majority among those who used to borrow from other subjects only. Men had incurred more debt than women.

**Figure 4.11. distribution of respondents who contracted a debt or not for drugs purchase by age 510 respondents**



The older the users are the more they are to ask for a loan to finance their addiction (Figure 4.11). The youngest and the oldest users tend to borrow from a dealer more than those aged 25-54. This large group of people (25 – 54 years old) are most likely to borrow money from a dealer and from sources other than a dealer.

**Figure 4.12. Sistribution of respondents who used contributions from social assistance to buy drug by gender**



A final analysis can be undertaken focusing upon those who used the contributions from social assistance to spend on illicit drugs. They represent 39.7% of the whole sample and they are mostly male (40.9% of the whole male sample). Women are 36% of the whole female sample. Other sources of income include peddling, used in equal measure by men and women, asking for charity in the street and begging. These last means of obtaining money are most commonly used by men.





# CHAPTER 5

## Evaluation of Services

Patient satisfaction is the major indicator of the quality of services provided by a health facility. In this chapter the aim is to assess the level of patient satisfaction within the various aspects of the health care.

### **5.1. Satisfaction with Services**

Respondents were asked about the usefulness of assistance received during their treatment program in care facilities. The usefulness of services has been expressed through a utility score ranging from 1 to 5, where 1 represents the minimum benefit and 5 the maximum one. Services under assessment are: psychological assistance, medical assistance, the chance of sharing experiences with others, getting back to living in regards of communal rules, access to drug substitutes and assistance in job hunting.

**Figure 5.1. average rate of patient satisfaction for health care services**  
 502, 491, 493, 488, 478, 490 respondents

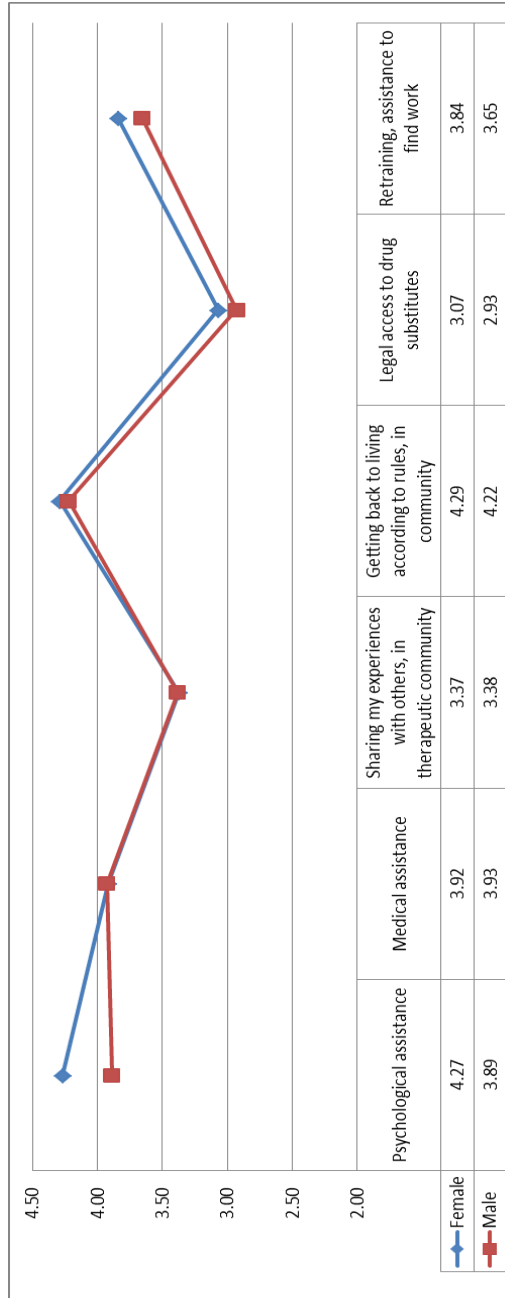


Figure 5.1 shows the average satisfaction expressed by women and men. On average women evaluated all services with almost the same trend in ranking. The only considerable difference between the genders is in the evaluation of psychological assistance: men rank it higher than women.

Table 5.1 gives more details about the distribution of these evaluations. All the services are ranked with an intermediate score between 3 and 4 points. Percentages of those giving the highest or the lower rates are little. The most frequent value for all the mentioned services is “4” follow by “3” and then “2”. “5” – the highest level – is not very often seen used in this survey .

**Table 5.1. evaluation of services usefulness [1= lowest rating \_ 5 = highest rating] 506. 494. 496. 491. 481. 493 respondents**

	<i>Psychological assistance</i>	<i>Medical assistance</i>	<i>Sharing my experiences with others. in therapeutic community</i>	<i>Getting back to living according to rules. in community</i>	<i>Legal access to drug substitutes</i>	<i>Retraining. assistance to find work</i>
Values						
1	8.5%	8.3%	19%	7.3%	38.7%	19.7%
2	4.9%	6.9%	9.5%	4.3%	5.8%	5.3%
3	16.2%	15.8%	18.3%	8.8%	10.2%	11.0%
4	21.5%	22.1%	20.4%	15.9%	11.2%	12.8%
5	48.8%	47.0%	32.9%	63.7%	34.1%	51.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Further analysis can be conducted distinguishing users between those who have never entered a therapeutic community and those who have been patients in these structures at least once in their life.

**Table 5.2: evaluation of service usefulness by TC patients. at least in the past [1= lowest rating \_ 5= highest rating] 240. 235.238. 234. 228. 235. respondents**

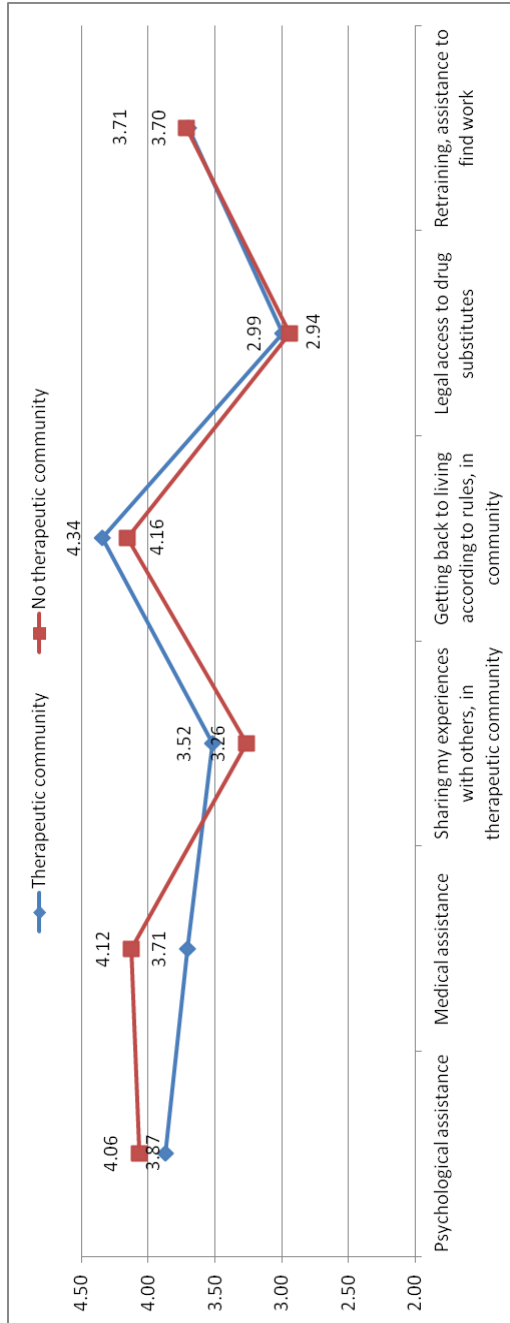
	<i>Psychological assistance</i>	<i>Medical assistance</i>	<i>Sharing my experiences with others. in therapeutic community</i>	<i>Getting back to living according to rules. in community</i>	<i>Legal access to drug substitutes</i>	<i>Retraining. assistance to find work</i>
Values						
1	9.2%	9.8%	16.0%	4.3%	36.8%	16.6%
2	7.5%	9.4%	8.0%	6.0%	7.0%	6.4%
3	14.6%	18.7%	17.6%	7.3%	9.6%	15.3%
4	24.6%	24.7%	24.8%	16.2%	13.2%	13.6%
5	44.2%	37.4%	33.6%	66.2%	33.3%	48.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Getting back to living according to rules within the community (66.2%), psychological assistance (44.2%) and social and work reinstatement assistance (48.1%) receive the highest percentage on the maximum utility score (5 points). Just about 15% of users evaluated the utility of these services to be lower than 2 points.

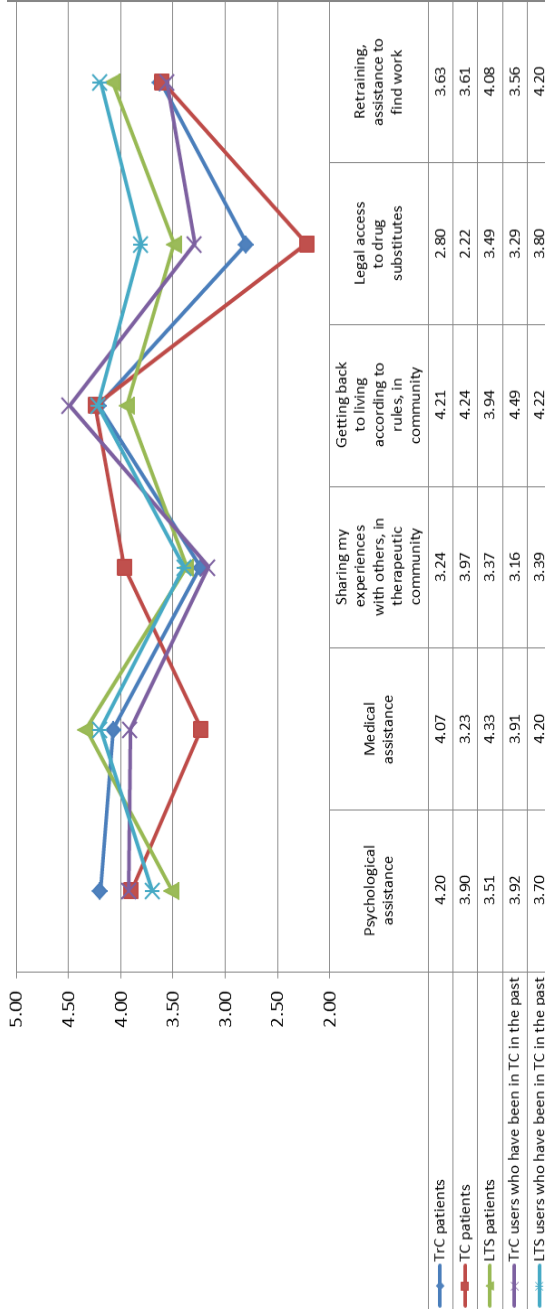
“Legal access to drug substitutes” is a particular services offered in LTS, it received a low score among TC residents; 43.8% of them evaluated this service at under 2 points but 46% gave it between 4 and 5 points. The best rated services are those proper to the therapeutic community: “sharing experience with others” and “getting back to live according to rules”. The first services were also negatively evaluated (1 point) by 16% of TC users. Also the never-been- in-TC assigned high satisfaction rates to those services proper to therapeutic communities. 61.5% of them evaluated ‘getting back to living according to rules’ with 5 points and 32.2% gave the maximum score to ‘sharing the experiences with others’. This latter service received also a negative evaluation from 21.7% of users. Two other services are negatively evaluated by non-TC users: they are ‘legal access to drug substitutes’ (considered the worst services also by TC users) and ‘retraining services’ (22.5% gave 1 points). This latter service is also positively evaluated by 54.3% of TC users, making it one of the most useful services for those who have never been in TC.



Figure 5.2. average evaluations according to enrollment in TC [1= lowest rating\_ 5 = highest rating]



**Figure 5.4. comparison of the evaluations by TC patients, LTS users, TrC users, LTS users been in TC, TrC users been in TC regarding the utility of services [1= lowest rating \_ 5= highest rating]**



Comparing differences in patient characteristics and average utility scoring among the 5 patient groups reported in figure 5.3, we can see that the lowest evaluation for psycho-social treatments is given by LTS patients who probably have never experienced these kinds of treatments before. The most useful service for LTS patients is medical assistance (4.33) followed by retraining (4.08). All the other services were evaluated at under 4 as an average score. Users from LTS who have also been in TC ranked services in a similar way to LTS patients. They evaluated “getting back to living according with rules” and the “legal access to drug substitutes” as the best services.

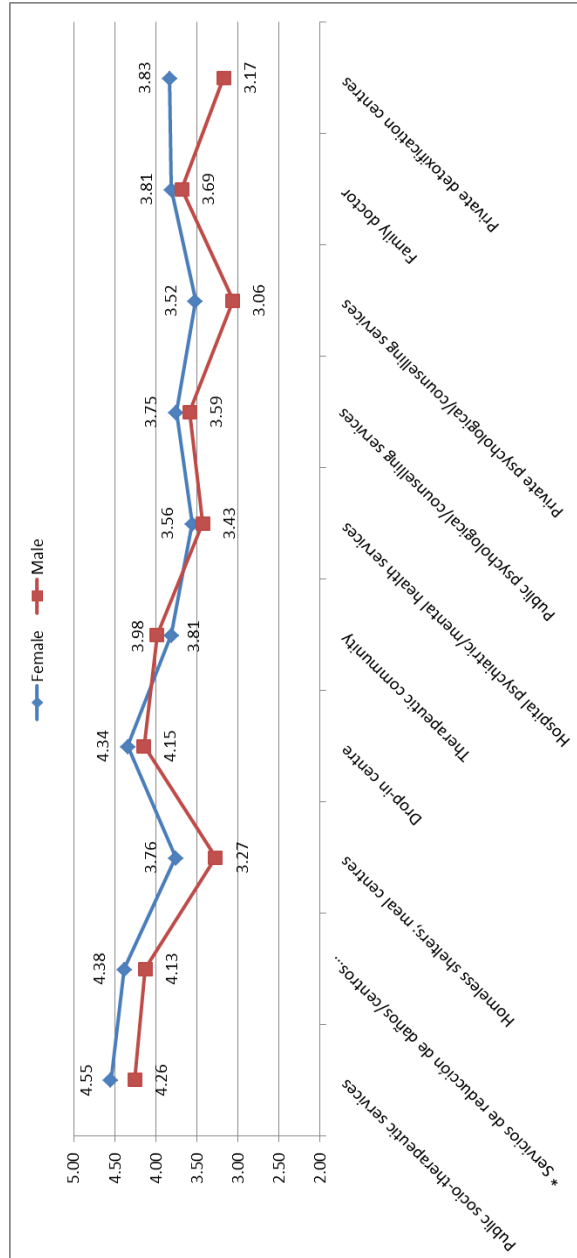
TC patients assigned lowest rates to “legal access to drug substitutes” and to “medical assistance”. The most useful services for TC patients are “sharing experiences with others in TC” (3.97) and the “getting back to live according with rules” (4.24). “Psychological assistance” and “retraining” are well evaluated.

Users who have been both in TC and TrC follow the lines of those who have just just been in TrC. They gave a lower rating to “sharing experiences with others” rather than those who have experienced only TC. Medical assistance and legal access to drug substitutes are evaluated better by those who have experimented with both TC and TrC.



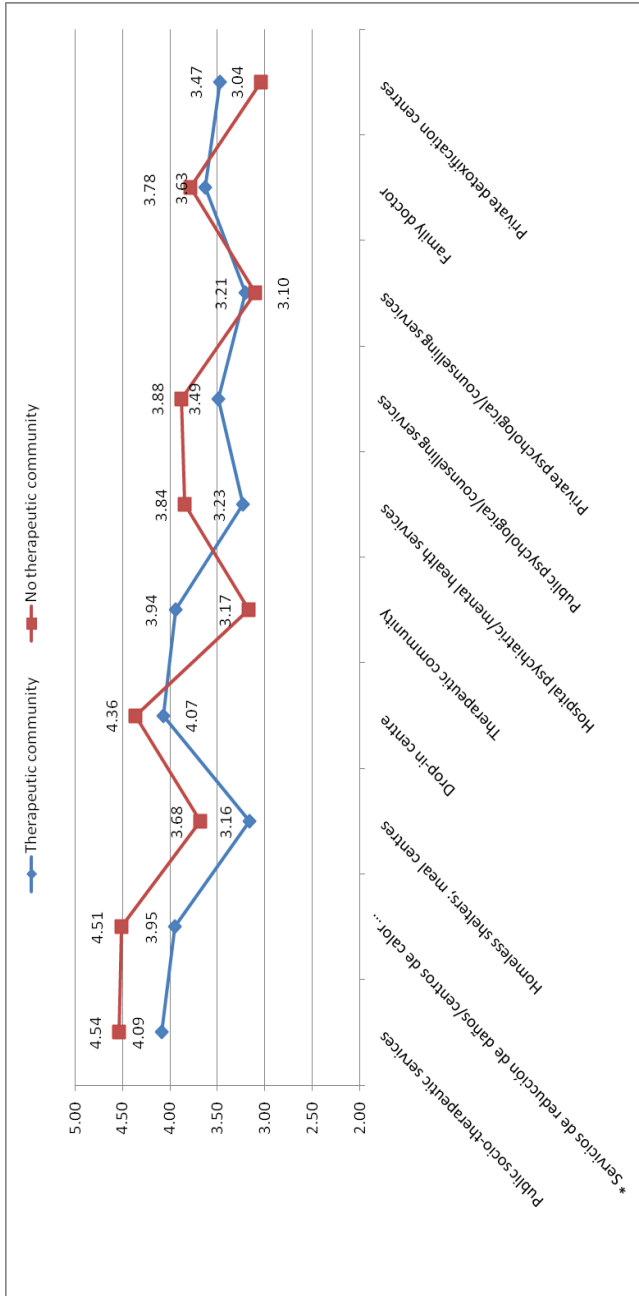
## 5.2. Satisfaction with Institutes

**Figure 5.4. average rate of patient satisfaction by typology of institute**  
 Female min. 24, max 115 respondents; male min. 69, max 364 respondents





**Figure 5.5. difference between TC and non-TC users services evaluations [1 = poor 5 = excellent].**



**Table 5.5. evaluation of institute by TC patients [1= lowest rating \_ 5= highest rating]**

	Public socio-therapeutic services	* Servicios de reducción de daños/centros de calor café	Homeless shelters; meal centres	Drop-in centre	Therapeutic community	Hospital psychiatric/mental health services	Public psychological/counselling services	Private psychological/counselling services	Family doctor	Private detoxification centres
Values										
1	5.2%	7.7%	24.0%	8.4%	8.6%	21.1%	12.5%	16.4%	12.7%	16.7%
2	7.3%	7.7%	13.3%	7.4%	7.3%	11.6%	14.4%	17.9%	9.4%	13.6%
3	12.4%	14.3%	17.3%	8.4%	12.4%	17.9%	16.3%	16.4%	19.3%	12.1%
4	23.6%	23.1%	13.3%	20.0%	24.5%	22.1%	25.0%	26.9%	18.9%	21.2%
5	51.5%	47.3%	32.0%	55.8%	47.2%	27.4%	31.7%	22.4%	39.6%	36.4%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Tables 5.5 and 5.6 make a comparison between quality evaluation expressed by users who have tried therapeutic community services and by those who have never made use of such facilities. As we saw in figure 5.5 , those who have never been in a therapeutic community gave a very negative evaluation of private detoxification centers and a neutral evaluation of therapeutic community services.

**Table 5.6. evaluation of institutes by non-TC patients [1= lowest rating \_ 5= highest rating]**

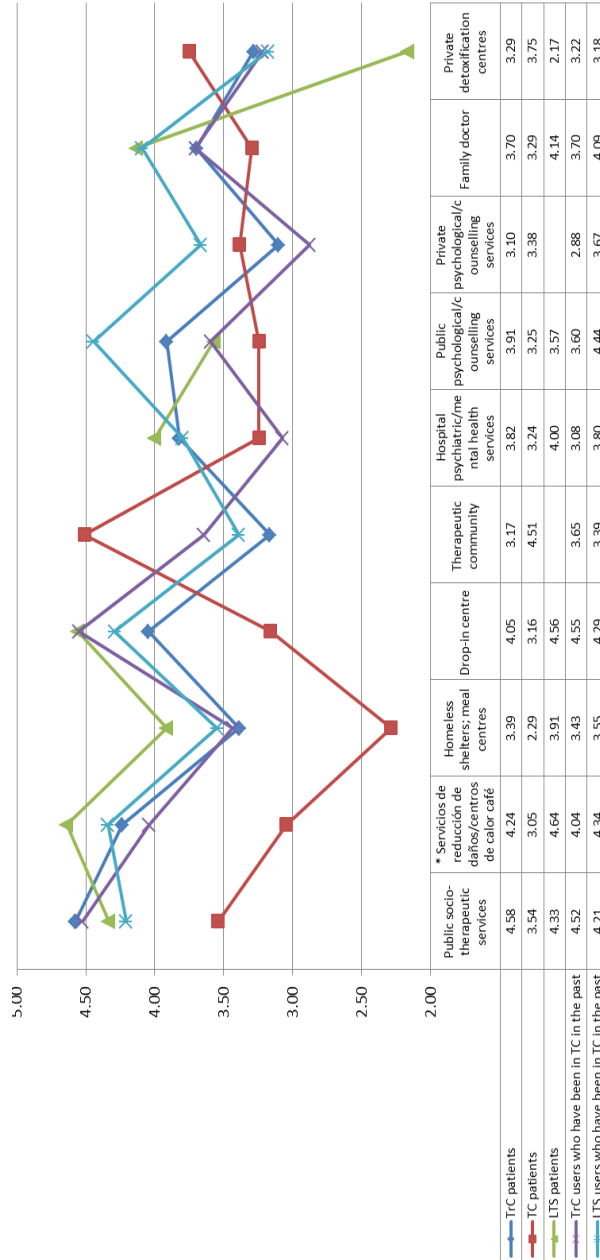
	Public socio-therapeutic services	* Servicios de reducción de daños/centros de calor café	Homeless shelters; meal centres	Drop-in centre	Therapeutic community	Hospital psychiatric/mental health services	Public psychological/counseling services	Private psychological/counseling services	Family doctor	Private detoxification centres
Values										
1	0.8%	1.5%	12.2%	3.6%	16.7%	10.3%	6.2%	17.9%	11.3%	25.9%
2	2.0%	4.4%	4.9%	5.5%	-	5.2%	6.2%	20.5%	6.1%	18.5%
3	7.2%	4.4%	24.4%	9.1%	50.0%	15.5%	23.1%	15.4%	20.0%	14.8%
4	22.8%	20.6%	19.5%	14.5%	16.7%	27.6%	23.1%	25.6%	18.3%	7.4%
5	67.2%	69.1%	39.0%	67.3%	16.7%	41.4%	41.5%	20.5%	44.3%	33.3%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

For those who have never-been-in- TC the best quality services are provided by public structures such as socio-therapeutic services, services for harm reduction and drop in services: more than 6 users out of 10 gave the maximum quality score to these three facilities. For the patients of therapeutic communities the best quality service providers are considered to be the public socio-therapeutic services and drop in centers. TC users tend to give an evaluation of between 4 and 5 points to the services compared to non-TC users who mostly gave the maximum score.

TC users were unsatisfied with psychiatric hospitals and homeless centers about 30% of them scored the quality of this public service at between 1 and 2 points. Although a considerable percentage evaluated them as a positive service, users who had never been in TC expressed a positive evaluation for hospital services.

Both TC and non-TC users prefer public psychological services rather than the private ones, which were evaluated at between 1 and 2 points by a relevant number of users.

**Figure 5.6. Mean of the evaluations by TC patients, LTS users, TrC users, LTS users who have also been in TC and TcR users who have also been in TC regarding the quality of services [1= lowest rating \_ 5= highest rating]**



In figure 5.6 we isolated from LTS users those subjects who had attended a TC structure in the past and from TC users those who had attended TrC a in the past.

The valuation line that most deviates from the others is that of TC patients. Compared to other user groups they have a lower consideration of homeless centers (2.29), public socio-therapeutic services (3.54%), harm reduction centers, drop in centers, public psychological centers and family doctors. Furthermore, TC patients evaluated therapeutic communities (4.51) and private detoxification services (3.75) with a higher score compared to other patient groups.

As shown in figure 5.6 - except for TC patients - evaluation of all of the services follow almost the same trend for the others 4 kind of users. LTS patients represent a nonconforming case in the evaluation of private detoxification centers. They perceive it as a very bad service, giving it an average of 2 points. On the contrary the whole population from LTS gave the maximum score to harm reduction centers. LTS users have also the best consideration of mental health services and homeless centers.

To summarise TrC patients have a lower consideration of therapeutic communities. For the other services they tend to follow the assessment line of TrC users who have been in TC in the past with some little differences in their evaluation of mental health services and public psychological centers (rated higher by TrC, but not by TrC who had also been in TC).

Among those patients who have attended both LTS and TC structures, LTS services were perceived negatively compared to the feedback provided by attendees of solely LTS services.

Among those patients who have attended both LTS and TC structures, LTS services have been perceived more negatively than by attendees of solely LTS services.





## APPENDIX 1 – Question 8: drugs used along three periods.

During the first year of use - After three years of use - Last time

Question 8 is the first multiple question of the questionnaire. It was asked which drugs have been used in three different periods and how much in each period.

The question aimed to investigate doses taken and tolerance.

*The descriptive analysis.*

Almost every respondent answered this question, but just around 2/3 of the respondents declared the daily doses for each period and for some drugs. The maximum number of respondents had been reached within the 1<sup>st</sup> year of use in the case of cannabis (74%).

The case of cannabis is quite interesting because the number of respondents decreases across the three periods (at 59.8% in the most recent time period) and this confirms that cannabis is a drug for beginners and is less appreciated among intensive users of hard drugs. Heroin (35%) increases 3 points after three years and remains stable in the most recent period. Cocaine (58 %) reaches 66% after three years and in the most recent period; Kibret goes from 15.7% to 19% in the most recent period; Crack (19%) follows the same trend as Cocaine and Tranquillizers (without prescription) remaining stable along the three period with 19%.

Around 20% of respondents had been collected for Ecstasy and Amphetamines (first year of use) but these drugs see their users decreasing down to around 15% in the last period.

Looking at the different distributions for Heroin, Cocaine and Cannabis – that are not presented at the moment, because a deeper analysis has been required - there are slight differences among the three periods, the modal values are almost the same for Cocaine and Heroin, Cannabis has a modal value for the most recent period at just one joint (20.8%) on the contrary the modal value of “after three years” is 10 joints (11.7%) , that confirms the view of cannabis as a “drug for beginners”, of course who continues to use cannabis increase the daily quantity .

- *A better description of tolerance.*

To give a better description of tolerance three new variables can be introduced.

Given X= doses used in the first year; Y= doses used in the third year; Z= most recent doses:

$(A1) = (Y-X)/X * 100$  measures if the consumption is increased or decreased between the first and the third year;

$(A2) = (Z-Y)/Y * 100$  measures if the consumption is increased or decreased between the third year and most recent use;

$(A3) = (Z-X)/X * 100$  measures if the consumption is increased or decreased between the first and most recent use.

The comparison between A1, A2, A3 is an attempt to gain a clear idea of the tolerance level induced by the use of each drug.

Cannabis seems to generate a low degree of tolerance or a greater possibility of being substituted; Heroin, Kobret and Cocaine, on the contrary, seem to generate the most important degree of tolerance.

## APPENDIX 2 – Question 26: How many doses sold weekly?

This question was been answered by 493 respondents, 96% of the sample, and 52% of them reported to have never sold drugs. It is assumed (but just for statistical convenience) that non-respondents have never sold drugs and this assumption can be considered a good proxy of the real situation, therefore - in keeping with the methodology adopted for other countries - those who have “never-sold-drugs” comprise 54% of the sample.

Almost all the dealers sell at least 2 types of drugs; the most commonly sold drugs are: Cocaine (by the 31% of the respondents); Heroin (by 15%); Cannabis (by 25%). The other drugs are less available to be sold by our respondents: Ecstasy (by 8%); Crack (by 2%); LSD (by 4%); Amphetamine (by 7%). In the following table A2.1 doses and respective percentages of dealers of the main drugs are listed.

In the table A2.1, a very simple classification for dealers is proposed, in order to highlight how important the single dealer is within the market.

**Table A2.1. weekly doses sold by dealer respondents 493 respondents**

		Ecstasy		Cannabis		Cocaine		Heroin	
<b>dealers</b>	% on dealers population		16.2%		53%		64%		31%
	% on sample population		8%		24%		30%		14%
<b>small dealers</b>	doses	% dealers	doses	% dealers	doses	% dealers	doses	% dealers	
	3	0.4%	1	0.4%	2	0.8%	1	0.4%	
	10	0.8%	3	0.8%	3	1.7%	2	0.8%	
	15	0.4%	5	0.8%	5	1.3%	3	1.3%	
	20	0.8%	10	2.1%	6	0.4%	4	0.8%	
	25	0.8%	12	0.4%	7	0.8%	5	1.3%	
	40	0.4%	20	0.4%	8	0.4%	6	0.8%	
			25	3.0%	10	7.6%	7	0.4%	
			30	0.4%	12	0.4%	10	3.0%	
					13	0.4%	12	0.4%	
					15	5.5%	14	0.4%	
					18	0.8%	15	1.7%	
					19	0.4%	18	0.4%	
					20	7.2%	20	4.2%	
					25	3.4%	25	1.7%	
					30	4.2%	30	1.3%	
	<b>Sub-total</b>	<b>3.6%</b>		<b>8.3%</b>		<b>35.6%</b>		<b>19.1%</b>	

Street dealers		50	0.8%	50	4.7%	35	0.4%	35	0.8%
		100	3.8%	60	0.4%	40	1.3%	40	1.3%
				75	0.4%	50	6.4%	50	1.3%
				100	6.4%	60	1.3%	100	1.7%
				120	0.4%	70	0.4%		
				125	0.4%	80	0.8%		
				150	2.1%	100	3.8%		
		<b>Sub-total</b>		<b>4.6%</b>		<b>14.8%</b>		<b>14.4%</b>	
expert dealers		200	2.1%	200	3.8%	120	0.4%	120	0.4%
		300	1.7%	250	8.1%	150	0.4%	150	0.8%
		800	0.4%	300	1.3%	175	0.4%	175	0.4%
		1000	1.7%	350	0.4%	200	1.7%	200	1.7%
		2000	1.3%	400	0.4%	250	0.8%	250	1.3%
		4000	0.4%	500	4.2%	300	0.4%	350	0.4%
		70000	0.4%	600	0.4%	350	0.4%	500	0.4%
				700	0.4%	400	0.4%	600	0.4%
				753	0.4%	500	3.0%	1000	0.8%
				800	0.8%	1000	3.4%		
				1000	3.0%	1500	0.4%		
				1500	0.4%	2000	0.4%		
				1530	0.4%	2500	0.4%		
				1750	0.4%	5000	0.8%		
				2000	0.4%	7000	0.4%		
				3000	0.4%	2000000	0.4%		
				3500	0.4%				
				5000	1.7%				
				10000	0.4%				
				100000	0.8%				
			2000000	0.4%					
	<b>Subtotal</b>		<b>8.0%</b>		<b>29.9%</b>		<b>14.4%</b>		<b>6.8%</b>

Specialization in the market is also another factor and poly dealing is described in Table A2.2.

**Table A2.2. composition of the dealers market by number of substances sold. Frequencies of the respondents.**

Sold substances	% on sample population
Never sold	54.39%
Only cannabis	6.24%
Only cocaine	7.41%
Only heroin	4.29%
Only methadone	0.00%
Only other substances	2.34%
Cannabis and cocaine	4.29%
Cannabis and heroin	0.58%
Cannabis and methadone	0.00%
Cannabis and other substances	1.75%
Cocaine and Heroin	2.34%
Cocaine and methadone	0.2%
Heroin and methadone	0.2%
Heroin and other substances	0.58%
Three or more substances	11.89%
Total	100.00%



### APPENDIX 3 – Question 38: The characteristics of users older than 25 years of age

This multiple question was the most complex, it was successful considering also the position at the bottom of the questionnaire.

At least 2 out of 3 of the possible respondents for this question (> 25 years old) answered all the details of this complex question.

Also for this question it was necessary to generate new variables for a simple description of the data.

6	<b>Civil status - parameters</b>
	Single 1
	Married /living together with a partner 2
	Divorced/widow 3
	NO ANSWER 5
First position	Age of first use
Second	25 years old
Third	35
Fourth	Now

88% of the respondents are single at the age of first use; at the age of 25 48% are still single, while the married respondents reach the higher percentage of 49%; at the age of 35 a consistent percentage of divorced respondents (15.7%) appears. In the current status married respondents comprise only 25%, while 18% are divorced and 57% single.

#### Children

At the ages of 25 and 35, 29% and 33% live with their children; currently only 21% do it.

#### 7 How do you live? And where?

On 8.5% of the respondents (9.9% of males and 3.9% of females) always live with their parents in the 4 periods. 5.2% of the sample (5.6% of males and 3.9% of females) lived with parents when they started taking drugs and then with a partner, 4.3% of the sample (4.8% of males and 2.6% of females) lived with his parents at the beginning of the drug use , with a partner at 25 years old and 35 years old and then return to live with their parents.

## 8 Employment

18.6% of respondents (17.6% of males and 20.7% of females) were students at age 25; 11.9% of respondents (14% of males and 6.9% of females) were student up to 25 years of age and then unemployed, 3.6% of the respondents (2.9% of males and 5.2 % of females).

18.6% of the respondents are students throughout the period (17.6% of males and 20.7% of females). Only 1.5% of respondents had a stable job for throughout the period (2.2% of males). 3.1% of respondents were self-employed (2.9% of males and 3.4% of the females). 3.1% of respondents have a part-time throughout the period (3.7% of males and 1, 7% of females). 3.6% of respondents had a fixed-term contract for the period (3.7% of males and 3.4% of females).



## APPENDIX 4 – Main parameters of the sample

Age by gender	Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
Males	37.93	8.40	37	32	43.25	17	71
Females	37.57	9.02	38	32	44	17	59

First use by gender		Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
First use drugs	Males	14.02	2.62	14	13	15	7	26
	Females	15	3.29	14	13	16	10	28
First use hard drugs	Males	16.74	3.61	16	15	18	9	41
	Females	17.79	4.45	17	15.25	18	12	36
First time selling drugs	Males	19.46	5.22	18	16	22	8	45
	Females	20.19	4.92	19	17	22.75	14	39
Latency	Males	2.72	2.82	2	1	4	0	26
	Females	2.79	3.26	2	1	3	0	15

Prices	Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
Marijuana	4.15	1.97	5	2.5	5	0.1	7
Hashish	4.04	2.62	3	2	5	0.1	10
Cocaine	50.28	9.76	50	3	10	15	70
Eroine	49.54	12.95	45	45	55	22.5	95
Amphetamine	8.78	7.99	6	42.5	55	1	30

Age at services first contact	Mean	Standard deviation	Median	1st quartile	3rd quartile	Min	Max
Street centers	37.05	22.84	29.5	23.5	39.5	19	50
Public therapeutic centers	33.85	23.43	23.5	22	33.25	19	50
Therapeutic communities	31.25	17.83	25.5	22.5	34.25	18	52
Private detoxification centers	31.15	18.04	26	22	34.75	10	51





# PART 6

## Albanian Pilot Survey

Julia Sallaku

Sampling design, data collection, data entry and analysis have been conducted by the Easy and Faster s.r.l. working group coordinated by Roberto Ricci and composed of: Francesco Fabi, Umberto Ialiccio, Claudia Musella and Claudia Restelli.



# INTRODUCTION

This pilot survey is a first attempt for evaluating the situation in a country in fast developing towards an open market economy, coming from a closed economy.

Data collection has been possible thanks a cooperation between the University of Tirana and the University of Rome Tor Vergata. The methodology of this research is based on a surveying unit composed of those who approached the socio-sanitary structures to confront their drug addiction in a therapeutic community.

These patients have usually gained an adequate consciousness of their condition. When they meet the health care structures, they have entered into the critical stage of addiction and the desire to get out of this severe condition is strong.

Therefore they have used for a certain long period and probably they are not the best representatives of the current situation of the users, but they are good representatives of the evolution of the market in the last period.

The drug market doesn't yet seem as developed as it is in Italy or in Spain or in Portugal looking at the findings of the survey. Only 35% of the respondents took his first drug in the adolescence, in every country the majority of the drug users takes his first drug during the adolescence; it is important to analyze also a survey on school-aged population for being sure of the findings of this survey, because the market can be evolved in the last 2 or 3 years with younger drug users.

The sample is composed by 23 respondents.

This report concerns:

- Characteristics of drug users, age first use;
- Education, work, contact with law enforcement;
- Consumption, doses and prices of drugs in the market;
- Services evaluation.

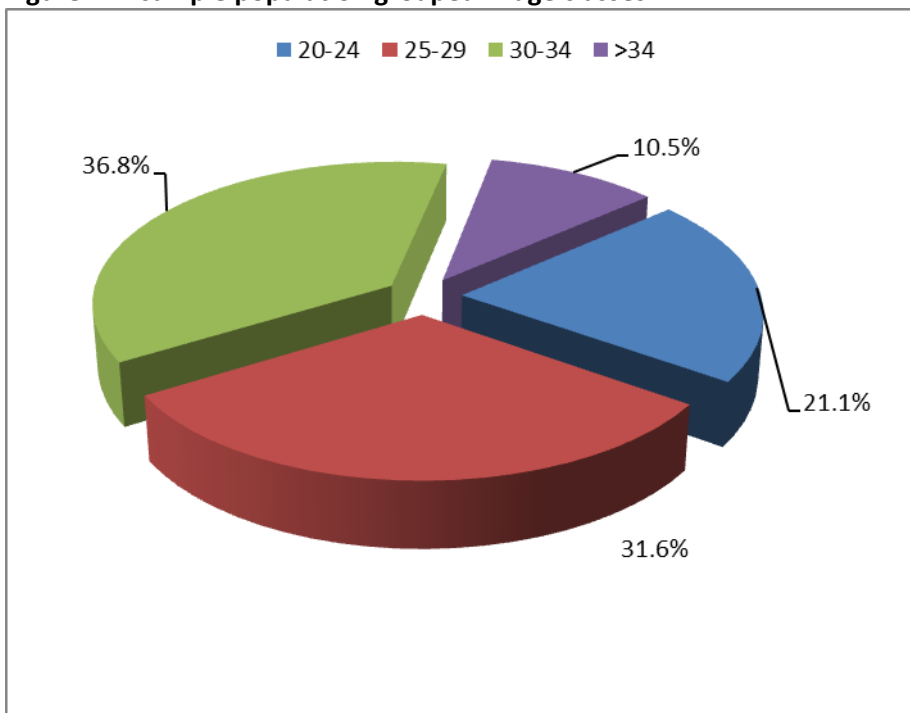


# CHAPTER 1

## Characteristics of users

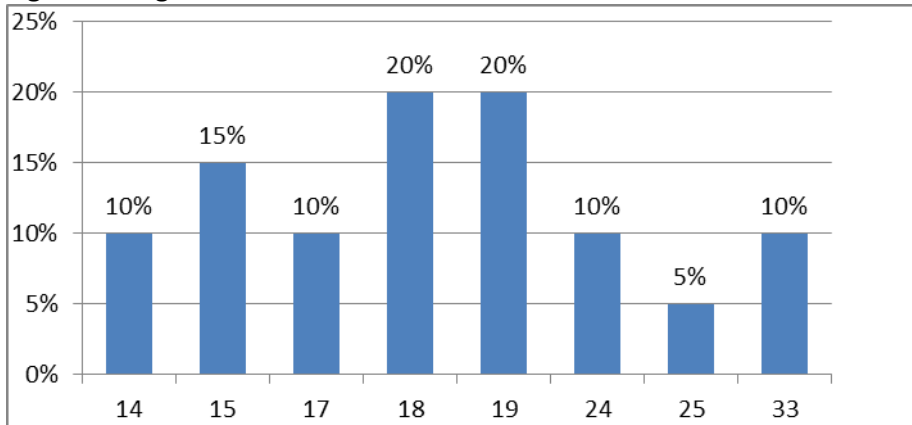
The age distribution of the sample is different from the ones of the other countries: the average age is just 30.2 years and there are only two respondents in the age classes > 34 (Figure 1.1 and Table 1.1.).

**Figure 1.1. sample population grouped in age classes**



**Table 1.1. age of respondents**

		Frequency	Percentage	Valid percentage
Years	20	1	4.3%	5.3%
	21	1	4.3%	5.3%
	24	2	8.7%	10.5%
	25	1	4.3%	5.3%
	27	2	8.7%	10.5%
	28	1	4.3%	5.3%
	29	2	8.7%	10.5%
	30	1	4.3%	5.3%
	31	1	4.3%	5.3%
	32	2	8.7%	10.5%
	33	1	4.3%	5.3%
	34	2	8.7%	10.5%
	45	1	4.3%	5.3%
	50	1	4.3%	5.3%
	Total	19	82.6%	100.0
Missing	0	4	17.4%	
Total		23	100.0%	

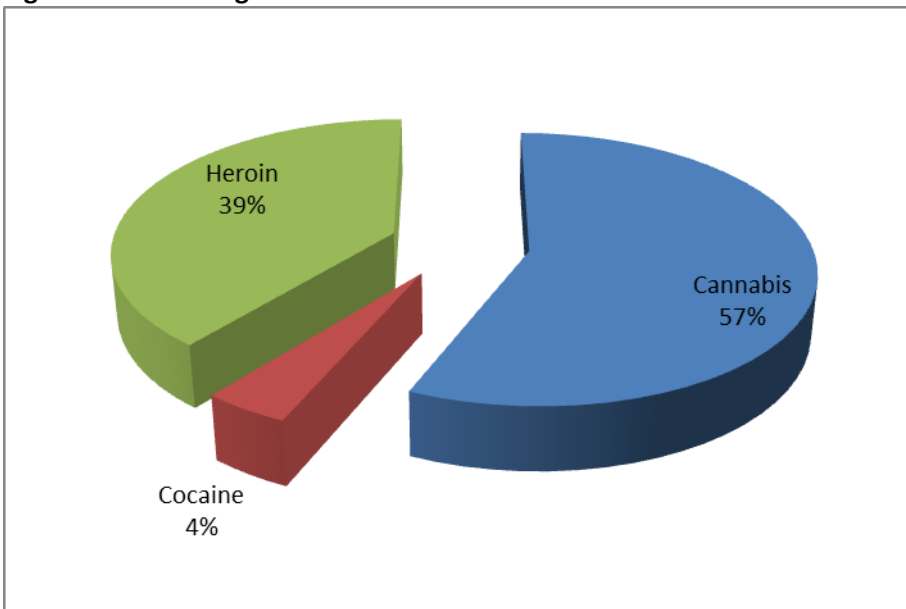
**Figure 1.2. age at first use**



The first important consideration is that the large majority of respondents didn't take their first drug during adolescence (Figure 1.2) with the average age of first use being 19.7 years. This is in contrast to all other countries studied.

When we state that from the evidence only 35% of the respondents took the first drug during the adolescence, we should also recall a strong connection with the dominant age in the survey (36.8% aged 30-34). Before the 1990 most of the Albanians didn't even know about the existence of the drugs. So it was very difficult for these age size to try any kind of illicit drug during this period. ( So impossible for them to try it during the adolescence ). Also after the 1990 most of the people in Albania were very poor and the first who tried the drug were those " richer than the others ", who in fact were a very low percentage of the population

**Figure 1.3. first drug used**



Heroin is very important as a first drug (Figure 1.3), 39% of the respondents take heroin and their first use is delayed in comparison with other countries.

During the '90 the most common drug used first was heroin, cannabis was mostly seen used in the late '90. Probably these were they years where the drug produced in Lazarat started to be sold in the national market as well. So after the '90 cannabis started to be used more widely.

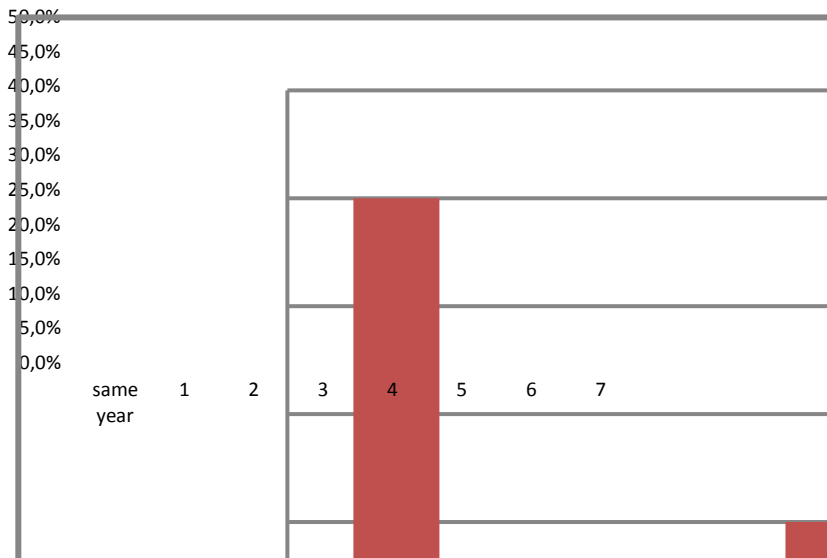
**Table 1.2. first drug used and age at onset**

		Which of the following drugs was the first one you ever used?		Total
		Cannabis	Heroin	
What was your age at 1st use drug(s)	14	15.4%		10.0%
	15	23.1%		15.0%
	17	7.7%	14.3%	10.0%
	18	30.8%		20.0%
	19	23.1%	14.3%	20.0%
	24		28.6%	10.0%
	25		14.3%	5.0%
	33		28.6%	10.0%
Total		100.0%	100.0%	100.0%

Table 1.2. shows clearly that cannabis is the first drug used during adolescence and heroin is the first drug after that period, probably the availability of cannabis has not been so large in the past as it is now because a slight prevalence of cannabis can be observed as the first drug among the youngest respondents (Table 1.3.).

**Table 1.3. first drug used and age at onset**

		Which of the following drugs was the first one you ever used?		Total
		Cannabis	Heroin	
Age	20	7.7%		5.3%
	21		16.7%	5.3%
	24	15.4%		10.5%
	25	7.7%		5.3%
	27	15.4%		10.5%
	28		16.7%	5.3%
	29	15.4%		10.5%
	30		16.7%	5.3%
	31	7.7%		5.3%
	32	15.4%		10.5%
	33		16.7%	5.3%
	34	15.4%		10.5%
	45		16.7%	5.3%
	50		16.7%	5.3%
Total		100.0%	100.0%	100.0%

**Table 1.4. latency period of the gateway from soft drugs to hard drugs**

-The distribution of the latency period of the gateway from cannabis to hard drugs is similar to other countries, with the exception of the high percentage of “same year” (Figure 1.4), that is a consequence of the high prevalence of heroin also as first drug used.

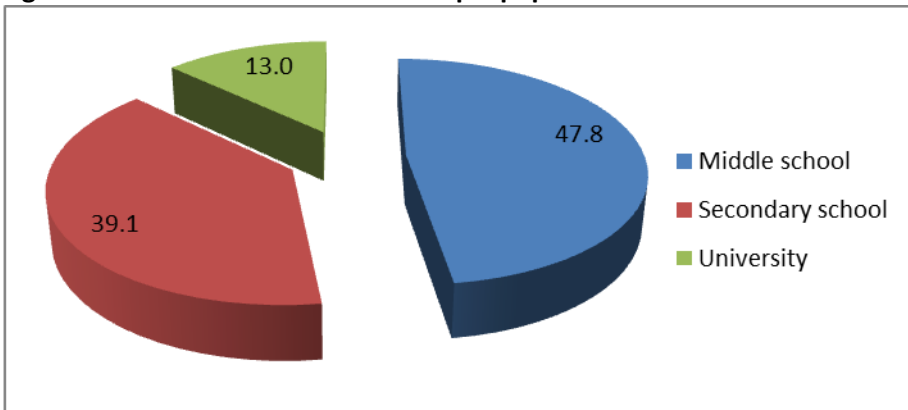
## CHAPTER 2

### Lifestyle: Education, Work and Contacts with Prison

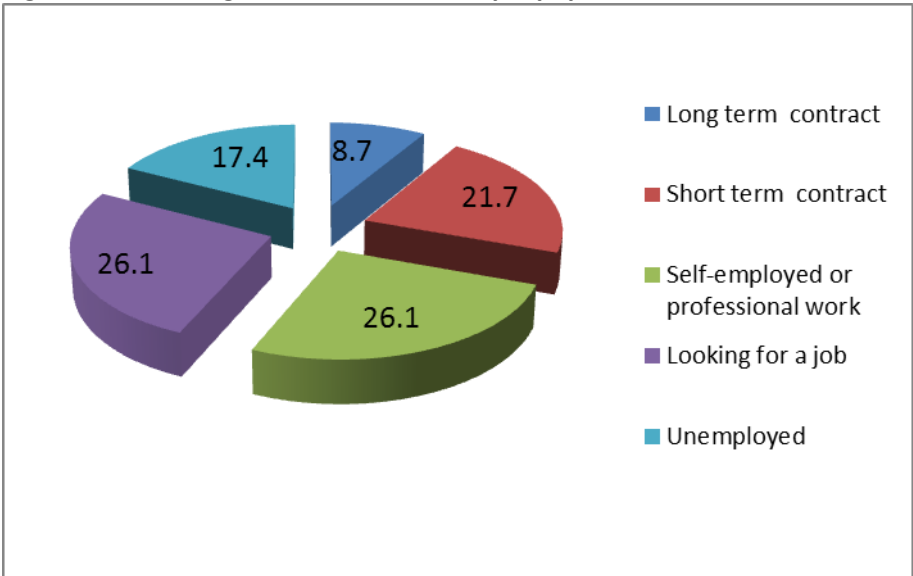
Figure 2.1, 2.2, 2.3 and 2.4 describe educational level, working condition, place for drug consumption and contact with prison.

There are just a few dealers in the population of our sample and the large majority of respondents had consumed drugs in the street, parks or alone at home. The lifestyle of drug users in Albania is similar to other countries.

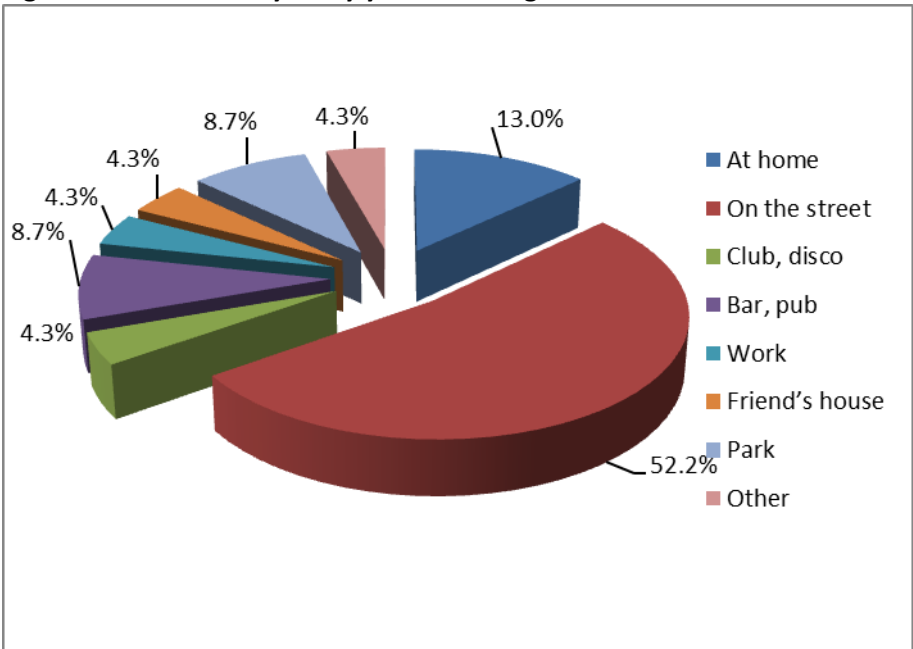
**Figure 2.1. education level in the sample population**

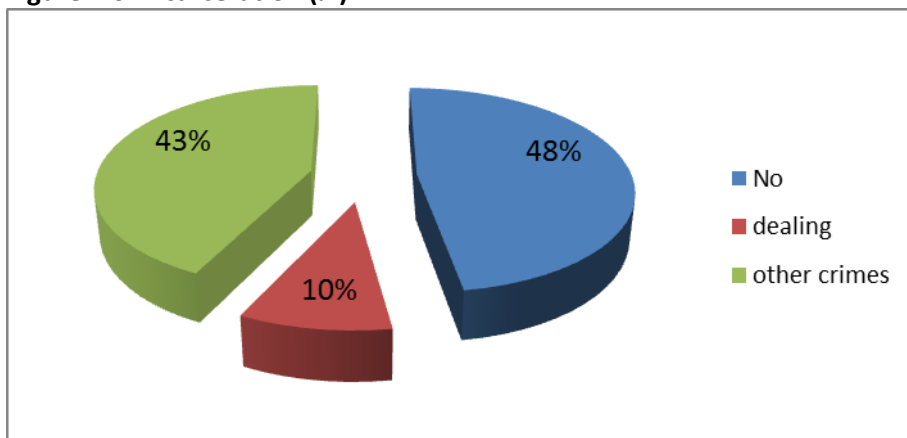


**Figure 2.2. working condition in the sample population**



**Figure 2.3. Where did you try your first drug?**



**Figure 2.6. incarceration (%)**





## CHAPTER 3

# Consumption

The main difference in the Albanian market is the great importance of heroin and tranquillizers. Heroin is a drug for an expert drug abuser; tranquillizers are used as drug substitutes in the case of unavailability and normally they are a drug used by poor drug abusers.

The Albanian market doesn't offer many alternatives; many drugs on the list in the questionnaire are not used at all (amphetamines, crack, ketamine). It seems a poor market, maybe it could be a “developing market” with a likely increase of cannabis and cocaine.

The features of this market are closer to the Czech drug market than the Italian one, but it is likely to change in the near future because the age of first use may decrease and, in this case, the starting point we are witnessing could move towards a very dangerous evolution.

**Table 3.1. last month's drug consumption**

<b>Tranquilizers/sedatives</b>	58.3%
<b>Amphetamines</b>	0.0%
<b>Ecstasy</b>	11.1%
<b>Cannabis</b>	50.0%
<b>Crack</b>	0.0%
<b>Cocaine</b>	45.5%
<b>Heroin</b>	73.3%
<b>Assentium</b>	12.5%
<b>Kobret</b>	11.1%

**Table 3.2. Frequency of use for the most popular drugs**

	<b>Tranquilizers/sedatives</b>	<b>Cannabis</b>	<b>Cocaine</b>	<b>Heroin</b>
<b>Didn't use it</b>	41.7%	50.0%	54.5%	26.7%
<b>1-2</b>	16.7%	16.7%	18.2%	20.0%
<b>3-5</b>	8.3%	8.3%	18.2%	6.7%
<b>6-9</b>	8.3%	8.3%	-	6.7%
<b>10-19</b>	-	-	9.1%	-
<b>20-30</b>	8.3%	-	-	20.0%
<b>&gt;30</b>	16.7%	16.7%	-	20.0%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

Table 3.1 and 3.2 describe clearly a market where heroin and tranquilizers are the most used drugs, with still occasional use of cocaine.

# CHAPTER 4

## Evaluation of Services

Evaluations of services (1 to 5; where 1 is the lowest score) are almost around the same levels in all the countries of this survey and it is interesting to make a comparison between this survey and the Italian survey.

**Figure 4.1. average rate of patient satisfaction for health care services**

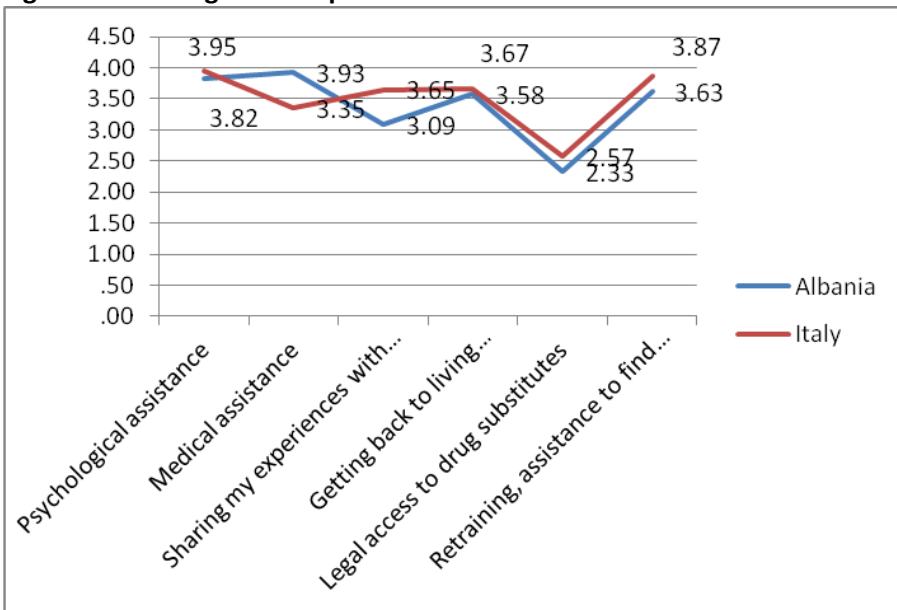
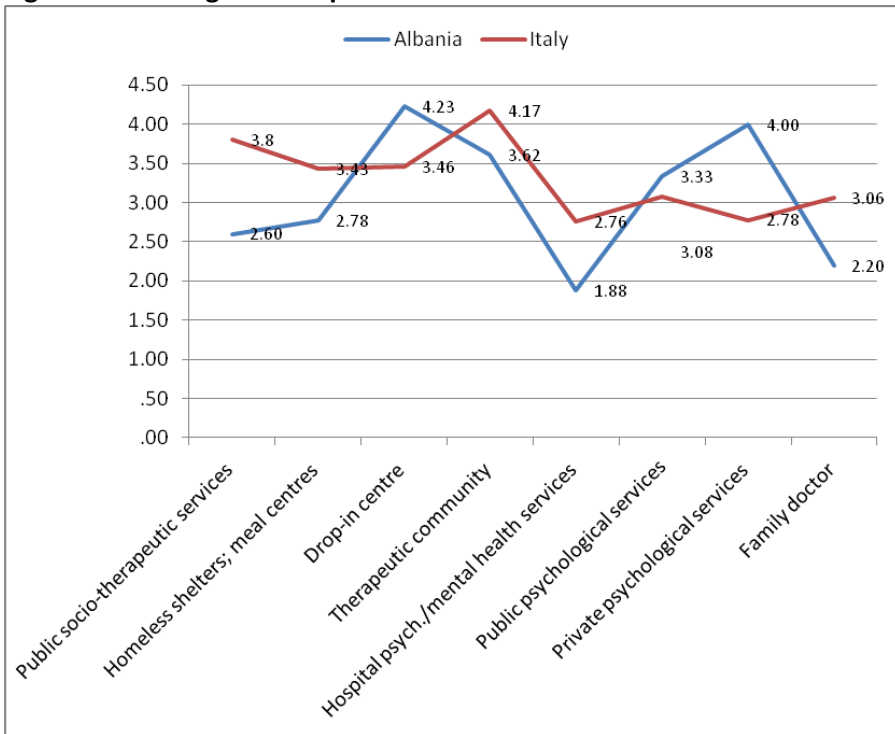


Figure 4.1. shows that satisfaction for the care provided in the therapeutic community is around the same as in Italy. Satisfaction with institutions is not always high; probably improvements are necessary for the “public socio-therapeutic services”, the “ mental health centers” and the family doctor.

Figure 4.2 shows low scores for public services, on the contrary they seem to be enthusiastic for “private psychological services” and “drop in” services. These services have obtained higher scores than in Italy though probably it is not because they are excellent, but, rather, is a logical consequence of the comparison between public and private services and a clear preference for the latter.

**Figure 4.2. average rate of patient satisfaction for institutions**



# CONCLUSION AND EXECUTIVE SUMMARY

## **General purpose**

An investigation on therapeutic communities and on low threshold services has been conducted in order to fill the gap in data on the lifestyle of drug consumers; this lack of knowledge is in spite of the gravity of the problem that has involved institutions at a national and international level. Evidence based knowledge of many important aspects for the definition of a drug policy is insufficient. The most reliable, complete, available and comparable information in many countries comes from investigations into the students of senior schools<sup>4</sup>, when drug consumers begin their first use of drugs - for the most part cannabis - at least in Italy<sup>5</sup> and in Europe in general.

How does one arrive from there to take heroin or cocaine? What is the evolution from occasional, recreational or weekend use to intense use and the use of hard drugs?

These questions are hard to resolve only by investigating the behaviour of students. In fact a problem drug user rarely follows the rhythms of school and often fails to complete studies and is therefore absent from the largest studies in Europe and the USA.

Even studies into the general population are insufficient because it is too difficult to study problematic users, so the users which are studied tend to

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<sup>4</sup> ESPAD in the European countries (<http://www.espad.org> ) and Monitoring the Future in US (<http://www.monitoringthefuture.org> ).

<sup>5</sup> Fabi F, Ricci R, Rossi C, " Segmentazione e valutazione del mercato dal lato della domanda", in Rey G.M., Rossi C., Zuliani A. eds. (2011), "Il mercato delle droghe: dimensione, protagonisti, politiche", Marsilio editori, Venezia..

be within groups that are atypical in terms of drug use. Besides this the low level of response to such surveys results in a further devaluation of their perceived value.

From this point the idea to conduct an investigation of the people that frequent therapeutic communities and low threshold services is justified in that in this way it is possible to find consumers that after a life of consumption have reached the decision to stop taking drugs, or have at least decided to reduce the harm caused by drugs.

Whilst studies of students revolve around first experimentation, this study addresses the end of this course rather than the first problems encountered with health and the justice system.

The strict collaboration between the public infrastructure and the therapeutic community, during the process of detoxification and reintegration, makes an investigation of therapeutic communities and low threshold services (for those who don't want to stop using drugs but have need of medical and paramedical assistance) ideal in Italy.

After the survey of 2010 conducted in Italy, thanks to European funding, in 2012 a study of 4 European countries - Italy, Czech Republic, Italy, Portugal and Spain - was conducted. In Spain that investigation was undertaken in Catalonia.

A small study conducted on a country that in the '90s emerged from totalitarianism - namely Albania - is also of interest because it is an almost completely new market and to this end represents an opportunity to observe the phenomenon of drug use from the start and to propose policies which have proved to be most effective in other countries.

The principle themes approached are: the characteristics of the consumer, in terms of culture and work; their contact with prison and the justice system; drugs consumed; sources of funding, the cost of drugs and finally an evaluation of services and institutions that deal with those drug users who request help.

### **Characteristics of the Consumer**

The consumer does not seem to have particular characteristics in the first stages of experimentation. Level of schooling mirrors on average that of the population in general with a slightly lower attendance at secondary school motivated by the difficulties that begin at the end of adolescence. The age of first use starts generally before the age of 18 in the four countries studied, with the major percentage being between 13 and 16 years of age (except for Albania where the market for illegal drug use did not exist before 1990).

Users become identifiable only after a certain period of time for the economic, before the social degradation which accompanies the drug addict. The predisposition to partake in criminal activities, even at a low level, renders them progressively isolated, exposed to accidents and dangers and makes them the object of stigmatization on the part of public opinion which sees the drug user and a danger to collective productivity, as will be made clear.

### **Contact with the Justice System**

Our respondents have been on the most part arrested for crimes other than drug selling. It is opportune to repeat here Table 1.2.6 (pag. 20, Part 1), to better illustrate this point.

This can be partly explained in the difficulty in pursuing every small drug seller while it is much easier to arrest crimes committed against property or the person, particularly if they are committed under a state of inebriation.

**Table 1.2.6. arrest and incarceration across the different countries (%)**

		Italy	Czech Republic	Portugal	Spain
<b>Arrested</b>	<b>Never</b>	38.6%	38.0%	40.9%	39.5%
	<b>For dealing</b>	17.1%	4.9%	17.2%	8.6%
	<b>For other crimes</b>	30.0%	54.2%	36.7%	47.0%
	<b>Both for dealing and other crimes</b>	14.3%	2.8%	5.3%	4.9%
	<b>Total</b>	100.0%	100.0%	100.0%	100.0%
<b>Incarcerated</b>	<b>Never</b>	42.9%	64.8%	57.2%	59.2%
	<b>For dealing</b>	13.8%	4.2%	14.1%	6.1%
	<b>For other crimes</b>	29.5%	30.3%	26.6%	32.3%
	<b>Both for dealing and other crimes</b>	13.8%	0.7%	2.1%	2.4%
	<b>Total</b>	100.0%	100.0%	100.0%	100.0%

## Consumers

A problem user users predominantly hard drugs. Soft drugs such as cannabis are considered low level drugs and their use lowers over time, as opposed to the pattern with substances such as cocaine, heroin and pervitin (in the Czech Republic).

The market is diversified both in terms of prices and available quantities. Portugal and Catalonia have cheaper cocaine, while in Czech Republic pervitin is the principal substance for the problematic consumer; in Czech Republic 67% of users started with cannabis, while in Italy, Spain and Portugal between 70% and 80% of problematic consumers have begun drug use with cannabis.

Also the home production of cannabis begins to have effects, yet is not a major element relevant to problematic users.

## Sources of Finance

From questions on sources of finance one can obtain a level field of comparison between the four countries on the progressive degradation of problematic users.



The family - generally the closest relative or partner - is one of the principle sources of funding to sustain drug use in all of the countries studied. Over time family links deteriorate and the consumer becomes ever more isolated (with higher levels of divorce and separation from a partner) and falls prey to the criminal circuit where they obtain their drugs. Work is predominantly occasional and with the passage of time the user has always less possibility of being active in the job market.

**Table 1.4.1. sources of money for drug consumers**

	Italy	Czech Republic	Portugal	Spain
<b>Other</b>	1.3%	4.3%	3.1%	2.8%
<b>Family</b>	2.2%	2.9%	5.3%	3.9%
<b>Work</b>	13.4%	7.2%	22.2%	16.7%
<b>Illegal sources</b>	21.5%	14.4%	14.2%	8.5%
<b>Family and work</b>	9.1%	12.9%	11.9%	13.6%
<b>Family and illegal sources</b>	6.2%	17.3%	5.6%	6.5%
<b>Illegal sources and work</b>	16.5%	5.8%	16.4%	15.6%
<b>Family. illegal sources and work</b>	29.8%	35.3%	21.4%	32.5%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

**Table 1.4.2. illegal sources of money**

	Italy	Czech Republic	Portugal	Spain
<b>No illegal activities</b>	26.0%	27.3%	42.8%	37.0%
<b>Dealing</b>	21.2%	9.4%	16.7%	15.2%
<b>Prostitution</b>	0.9%	2.2%	2.8%	2.0%
<b>Theft/robbery</b>	18.9%	26.6%	13.6%	17.3%
<b>Dealing and prostitution</b>	1.0%	1.4%	0.6%	0.6%
<b>Dealing. theft and robbery</b>	23.6%	26.6%	15.3%	22.4%
<b>Prostitution. theft and robbery</b>	0.7%	0.7%	1.4%	2.0%
<b>Dealing. prostitution. theft and robbery</b>	2.3%	3.6%	3.1%	.8%
<b>Other illegal activity</b>	5.3%	2.2%	3.9%	2.8%
<b>Total</b>	100.0%	100.0%	100.0%	100.0%

It is worth taking the two above tables into account in order to underline how illegal activity is important to a problematic user. particularly in Italy and the Czech Republic where nearly 3/4 of respondents financed their use with illegal activity while in Spain and Portugal around 3/5 reported the same thing.

Still on this subject. one can note that the sale of illegal substances is very important for problem users. more or less at the same level as for other crimes (with the exception of the Czech Republic). But as we have previously noted. far less people are arrested and imprisoned for drug use than for other crimes.

### **Evaluation of Services**

The survey contained questions on satisfaction with services available for those wishing to stop drug use or to reduce harmful effects and levels of use. which were positive particularly with regard to psychological assistance and rehabilitation for reentry into work.

Services for the supply of alternative drugs (such as methadone) and basic medical assistance received the lowest scores.

The principle objective aimed at with these questions was to permit these patients to express their opinion beyond the comments usually made of a statistical nature collected by workers in the health care sector.

## The Questionnaire

**University of Rome "Tor Vergata" - Centre for Biostatistics and  
Bioinformatics**

**Istituto da Droga e da Toxicodipendencia - Lisboa**

**Istitut de recerca de l'Hospital del Mar - Barcelona**

**Addiktologie - Charles University. Prague**

**EU Project JUST/2010/DPIP/AG 1410**

**New Methodological Tools for Policy and Programme Evaluation**

### Questionnaire for the survey on Communities and Low Threshold Services

**1. Gender**

Male  Female

**2. Year of birth (yyyy) [ \_ | \_ ] [ \_ | \_ ]**

**3. What is your country of origin? \_\_\_\_\_**

**4. What is your highest level of education completed?**

No level completed   
 Primary school (grades 1-5)   
 Middle school (grades 6-8)   
 Secondary school (grades 9-13)   
 University   
 Other (e.g. technical school) (specify) \_\_\_\_\_

**5. What is the highest level of education of your parents?**

	Father	Mother
No level completed	<input type="checkbox"/>	<input type="checkbox"/>
Primary school (grades 1-5)	<input type="checkbox"/>	<input type="checkbox"/>
Middle school (grades 6-8)	<input type="checkbox"/>	<input type="checkbox"/>

- Secondary school (grades 9-13)
- University
- Other (e.g. technical school)
- (specify) \_\_\_\_\_ (specify) \_\_\_\_\_

**6. What about your employment situation? (one answer. two if you are a student)**

- I'm a student
- I'm working with a long term contract
- I'm working with a short term contract
- Self-employed or professional work
- Occasional work only
- I have never been employed

**7. Which of the following drugs was the first one you ever used? (One answer only)**

**(in each countries some drug could be added : see pervitin)**

- Tranquilizers/sedatives (without medical prescription)
- Amphetamines
- Ecstasy (MDMA. XTC. etc...)
- Cannabis (marijuana. hash. ganja)
- Crack
- Cocaine
- Heroin
- Psychedelic mushrooms
- Steroids
- Ketamine
- Smart drugs
- LSA (Hawaiian seeds)
- LSD
- GHB (liquid ecstasy)
- Kobret
- Street methadone
- Another drug (specify) \_\_\_\_\_

8. Please could you check which of the following drugs you used and how much. if you can remember the quantity?

	During the first year of use	After three years of use	Last time
<b>Amphetamines</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr pills/day	----	----	----
<b>Tranquilizers/sedatives</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr pills/day	----	----	----
<b>Ecstasy</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr doses/day	----	----	----
<b>Cannabis (marijuana. hash)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr joints/day	----	----	----
<b>Freebase (Crack)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr doses/day	----	----	----
<b>Cocaine</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr strips/day	----	----	----
<b>Heroin</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr doses/day	----	----	----
<b>Psychedelic mushrooms</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr/day	----	----	----
<b>Ketamine</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr pills/day	----	----	----
<b>LSD</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr doses/day	----	----	----
<b>GHB (liquid ecstasy)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr doses/day	----	----	----
<b>Kobret</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr doses/day	----	----	----
<b>Street methadone (without prescription)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr cl/day	----	----	----
<b>Other drugs (specify)_____</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nr doses/day	----	----	----

**9. What was your age at:**1<sup>st</sup> use drug(s) \_\_\_\_\_1<sup>st</sup> use cocaine/heroin or other hard drugs (LSD. ecstasy...)

(if it applies) \_\_\_\_\_

1<sup>st</sup> time you sell drugs (if it applies) \_\_\_\_\_**10. Can you please mark all years of age in which you have used drugs. since the age of your first use? Do not mark years in which you have abstained for 6 months or longer**

<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>25</b>	<b>26</b>	<b>27</b>	<b>28</b>	<b>29</b>	<b>30</b>	<b>31</b>	<b>32</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>33</b>	<b>34</b>	<b>35</b>	<b>36</b>	<b>37</b>	<b>38</b>	<b>39</b>	<b>40</b>	<b>41</b>	<b>42</b>	<b>43</b>	<b>44</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>45</b>	<b>46</b>	<b>47</b>	<b>48</b>	<b>49</b>	<b>50</b>	<b>51</b>	<b>52</b>	<b>53</b>	<b>54</b>	<b>55</b>	<b>56</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**11. What were your reasons for first trying drugs? (Not more than three answers)**

- For fun/entertainment
- To be alternative
- For self-hurt
- My friends were doing it
- My girlfriend/boyfriend was doing it
- There was a lot at school
- There was a lot where I worked
- To perform better
- To calm down. relax
- To make new friends
- To escape my problems. my life
- Curiosity
- Other(please specify) \_\_\_\_\_

**12. Where were you when you first tried the drug?**

- At home
- On the street
- Social centre / Squat
- Prison
- Club. disco. bar. pub
- Rave
- School
- Work
- Friend's house
- Gym
- Park
- Parish recreation hall
- Stadium/arena
- Cinema
- Other (please specify) -----

**13. What was the occasion?**

- An ordinary day
- At a private party
- During vacation
- Public event (concert. festival. parade. etc.)
- Other (please specify)

**14. Whom were you with?**

- Alone
- Friends
- Classmates
- Girlfriend/boyfriend
- Acquaintances
- Relatives
- Other

**15. When you tried the drug for the first time did you consider the risks involved?****(One answer only)**

- I only thought of a brief loss of self-control
- I thought of addiction but I didn't see it as possible
- Overall. I thought that benefits outweighed the risks
- No I didn't





**19. Over the last month that you used drugs, could you say what was the typical quality?**

**(Please answer on every line)**

**Didn't use it top- quality medium-high poor**

Ecstasy

Cannabis (marijuana, hashish)

Crack

Cocaine

Heroin

**20. Over the last month that you used drugs, did you also use one of the following:**

**(Please answer on every line)**

**regularly sometimes never**

Alcohol

Tranquilizers

Sleeping medication

Steroids

**21. Who supplies/supplied you with the drugs you often use/used?**

**(One answer per line)**

never bought offered

Friend

Acquaintance

By Internet

An occasional dealer

My regular dealer

Schoolmate or work-mate

Other (please specify

.....)

**22. Where did/do you get drugs? (One answer per line)**

usually sometimes never

At home

Dealer's house

Street

Social centre/squat

Club/disco/bar/pub

Rave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prison	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cinema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gym	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Park	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parish hall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stadium/arena	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)_____			

**23. Could you please indicate the most recent prices you know. per dose/gram/ pill and if you is used to buy it or not (Please answer on every line)**

		Never bought
Ecstasy (1 pill) (MDMA)	_____ €	<input type="checkbox"/>
Ecstasy powder/crystals (1gr)	_____ €	<input type="checkbox"/>
Amphetamine (1 dose)	_____ €	<input type="checkbox"/>
Ketamine (1 dose)	_____ €	<input type="checkbox"/>
Marijuana (1 gram)	_____ €	<input type="checkbox"/>
Hashish (1 gram)	_____ €	<input type="checkbox"/>
Crack (1 gram)	_____ €	<input type="checkbox"/>
Cocaine top-quality (1 gram)	_____ €	<input type="checkbox"/>
Cocaine below top-quality (1 gram)	_____ €	<input type="checkbox"/>
Heroin top-quality (1 gram)	_____ €	<input type="checkbox"/>
Heroin below top-quality (1 gram)	_____ €	<input type="checkbox"/>
Kobret (1 gram)	_____ €	<input type="checkbox"/>

**24. How did you get usually money to buy the drug(s)? (Please. answer on every line)**

	Always	Often	Sometimes	Never
Money from my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostitution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theft/robbery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other illegal activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money from social assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Borrowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Borrowing from dealer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**25. Did a dealer ever suggest you to sell drugs?**

Yes. often Yes. sometimes Never

**26. If you were ever a dealer. how many deals of the following drugs did you make in a typical week?**

- Amphetamines
- Pharmaceuticals
- Ecstasy
- Cannabis (marijuana. hashish)
- Crack
- Cocaine
- Heroin
- Mushrooms
- Ketamine
- LSD
- GHB (liquid ecstasy)
- Kobret
- Other drugs (please specify) .....
- Never been a dealer

**27. Since your first drug use. have you been charged or cautioned for any legal offence?**

- No
- Yes. for dealing/illegal sale of drugs
- Yes. for other offences

**28. Have you ever been sentenced to prison**

- No
- Yes. for dealing/illegal sale of drugs
- Yes. for other offences

**29. Have you ever received an alternative sentence?**

- No
- Yes. to a therapeutic community
- Yes. to supervision by social services
- Yes. to do community work
- Yes. house arrest (where applied)

**30. How often have you tried to stop using drugs?**More than once Once Never **31 . How old were you when you had the first contact with:****never**Government Youth shelter \_\_\_\_\_ Low threshold services \_ \_\_\_\_\_ Public therapeutic service (Ser.T. In Italy) \_\_\_\_\_ Therapeutic Communities \_\_\_\_\_ Private detoxification centres \_\_\_\_\_ **32 . How long have you been in charge of:**

	<b>Over 2 years</b>	<b>Between 1 and 2 years</b>	<b>Less than 1 year</b>	<b>never</b>
Government Youth shelter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public therapeutic service (Ser.T. In Italy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic Communities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private detoxification centres	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**33. How many times have you been in a therapeutic community?***If you have not been. please. go to the following question*

\_\_\_\_\_

**34. Why did you choose to enter a therapeutic community?*****If you didn't, please, go to the following question***

- It was my decision
- It was the only way to stay away from drugs and from bad companies
- I was convinced by the medical services I was using
- I was convinced by my relatives/ my friends
- I was forced but not convinced
- I thought it was better for me to stay in a community rather than in prison
- Other (specify) \_\_\_\_\_

**35. Why are you using or did you use low threshold services?*****If you didn't, please, go to the following question***

- I lived on the street and I had nowhere to go
- wanted to take a break from a critical situation/moment
- I wanted to quit and I thought it was useful to contact this kind of services
- Other (specify) \_\_\_\_\_

**36. What do you think are the most useful kinds of assistance to you?  
(Please answer 1 for least as far as 5 for most useful)**

- |  | 1                        | 2                        | 3                        | 4                        | 5                        |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Psychological/psychiatric assistance                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Medical assistance   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sharing my experiences with others. in therapeutic community | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Getting back to living according to rules. in community      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Legal access to drug substitutes                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Retraining. assistance to find work                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**37. How would you rate any services you have personally used (Please answer 1 for least as far as 5 for most useful. 0 if not experienced).**

	0	1	2	3	4	5
Public socio-therapeutic services (Ser.T. in Italy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low threshold services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homeless shelters; meal centres	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drop-in centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital psychiatric/mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public psychological/counselling services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private psychological/counselling services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private detoxification centres	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**38. if your age is at least 25 years. could you please provide some information in the following temporal references?**

	When you started using drugs	Around 25 years old	Around 35 years old	Currently
What was/is your civil status?				
Single	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Married /living together with a partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Divorced/widow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Did/do you have children living with you?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Where and how did/do you live?**

Alone in my own dwelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With parents or other relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With my wife. partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With friends/acquaintances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hotel /hostel /pension/squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shelter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital. therapeutic facility. nursing home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jail. prison or other correctional facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**What was/is your  
employment situation?**

Full-time steady job

   Self-employed or professional  
work   

Part-time job

Short-term contract

   Unemployed. searching for  
work   

I have never been employed

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