Ethical Declaration against Substance Abuse

Social Services and
Policy Council

The Veneto Region

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(The European Study and Research Academy
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Introduction

In the context of the drug addiction prevention programme which the Veneto Region has been following innovatively and with determination for many years, seeking to protect future generations, we have felt it important to prepare this ethical declaration against substance abuse as a demonstration of our wish to propose a cultural model which is both effective and reflects the community spirit which is so much a part of the heritage of the Veneto region. The regional government has therefore unanimously resolved to issue an ethical declaration to which the competent social and health groups can refer when programming their work to combat the problem of drug addiction.

Dr. Giancarlo Galan
President of the Veneto Regional Government

Translation by: *William George*

Presentation

With this initiative the Veneto Regional government is the first in Italy to issue an "ethical declaration" against the abuse of drugs.

The importance of this fundamental step is easy to see if one considers the enormous number of confused ideas and intentions are around on the subject, some of which politically motivated.

With the aim of clearing up once and for all the position of the Regional government in this field there has been extensive internal debate, of both a scientific and moral nature, which has, with the contribution of numerous experts, led to the drafting of the various papers contained here.

It should be forcefully recalled that the use of psychoactive substances from the black market, exploiting younger and weaker members of our society, is assuming ever greater and more worrying proportions, especially if we consider the great spread over the past few years of new substances which are socially more readily accepted and frequently associated with the use of alcohol and psychoactive prescription drugs.

We must not therefore let our guard drop and our efforts in this field have to be given the highest priority.

This is particularly the case if we consider that the number of people who resort to psychoactive substances is much increased and this use is characterised by the contemporary intake of a variety of substances.

There is therefore a need to continue with the considerable and skilful efforts which the Veneto Region has in the past put into the fight against drug abuse and, specifically, by proposing an Ethical Declaration which aims to more clearly define the cultural and ethical stance which we would like to see underlying action programmes dealing with drug abuse, thus definitively getting away from the ambiguities spoken by those who erroneously consider the use of such substances harmless or to be tolerated.

For these reasons the Social Services and Policy Council, in collaboration with the European Study and Research Academy in preventive and community medicine (AKADEMEIA), has prepared an ethical declaration against the non-therapeutic use of narcotics and psychoactive substances.

The provision was approved in the Regional government assembly for the Veneto on 27th October 1998 and the declaration defines the general rights of the individual which are to be protected in relation to the abuse of drugs and the general policy principles to be followed in this area; three levels of strategy (reduction in demand, health care and rehabilitation, and the community and social and health organisations); and finally it sets forth guidelines for how it should be used in the social services area Plans.

The "ethical declaration" is essentially an instrument to increase public and

administrative awareness of the need to develop co-ordinated policies between different sectors for the promotion of public health, and in particular to get everyone to understand that drug abuse is always dangerous and harmful, including that of the so-called new drugs, soft drugs and alcohol.

All drugs kill people, if not physically they can morally and psychologically enslave people and so rob them of their freedom and essence.

Raffaele Zanon
Councillor for Social Services and Policy

Translation by: *William George*

Ethical declaration by the Veneto Region against the non-therapeutic use of narcotics and psychoactive substances

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The purpose of the ethical declaration

Foreword

The use of psychoactive substances from the black market which exploits the weaker or younger members of the community is assuming ever greater and more alarming proportions, especially when one considers the rapid spread there has been in recent years of new substances with rituals associated with their assumption which are socially more accepted and, very frequently, are combined with the use of alcohol and psychoactive drugs.

Furthermore the number of individuals who are addicted to heroin remains high and, on analysis, can be seen anything but reduced or on the way to being under control.

As a result the total amount of people using psychoactive substances is much increased today, frequently with one drug leading to another and various substances are often used contemporaneously.

These situations frequently lead to real dependence and a long litany of serious physical, mental and social consequences.

It is therefore necessary to continue to combat illicit drug use as the Veneto Region has done with considerable effort and good sense, by making an 'Ethical declaration' which has defined the cultural model which should form the basis of any action taken in relation to drug addiction.

There has been a dangerous 'normalisation' and passive social acceptance in the face of the enormous spread in substance abuse which has turned out to represent almost tolerance or resigned fatalism before a 'natural catastrophe' erroneously perceived to be inevitable. This state of affairs needs to be strongly resisted first and foremost by providing alternatives capable of promoting health and better life choices and of, at the same time, stimulating a calm and measured debate on the issues raised.

The world's social and health organizations orientation towards developing social consciousness founded on values

The world's great social and health organisations have been indicating the need for some time for governments to invest directly in its 'human capital' through the development of a social consciousness whose priorities include the promotion and protection of health and the acquisition and maintenance of healthy lifestyles. As already stated in the declarations of Copenhagen 1994 and Jakarta 1997, or even earlier in that of Alm-Ata of 1976 and Ottawa 1986 (backed by our own country), to obtain this it is necessary to strengthen the bonds of solidarity, individual equal rights to free choice, social democracy and above all the primacy of individual dignity. At the same time it is necessary to recognise the responsibility of the

institutions themselves to improve the proper working of organisations charged with the caring for people's health.

It is therefore vital, especially as far as the struggle against drug abuse is concerned, for governments to be committed at every level to putting into effect policies and programmes, in order to promote and protect public health, which are based on principles which ensure easy and general access to preventive information and care, widespread and high quality organisations for that purpose and finally, serious and constant assessment of the results and the costs and benefits of such work.

As a result health and social policies need to be seriously and scientifically monitored, especially as far as prevention is concerned, for results and costs. In this way an important ongoing selection process will be carried out in relation to any intervention and any action which is found to be quantitatively or qualitatively lacking, or is self absorbed and inefficient, will be eliminated while effective action will be further developed.

In carrying out such assessments due consideration must be given to 'intangible' factors such as well-being, mental tranquillity, emotional states, the dignity and decorum of the person and the intrinsic value of life, i.e. factors which cannot be simply itemised in a cost-benefit analysis, notwithstanding that such analyses are indispensable.

The current international situation in law. The UN Treaties

Since the beginning of the century the world's countries have wished to set up international bodies engaged in the pursuit of policies and national legislation to deal with the abuse of drugs. The aim has always been to lay down a common approach in law to deal with an international phenomenon and using as far as possible standardised and agreed upon measures of enforcement.

The present international legal framework stems primarily from three important United Nations treaties aimed at monitoring and controlling drug traffic; these are: The Narcotics Convention of 1961 (amended in 1972), the Convention on psychotropic drugs of 1971 and the Convention against the illicit trafficking in narcotics and psychotropic substances of 1988.

The fundamental objective of the first two treaties consists in the limitation of the use of listed drugs for authorised scientific and medical purposes. The third treaty is aimed at combating illegal drug trafficking and strengthening international co-operation on that front. All fifteen nations in the European Union have ratified the first two conventions and have, together with the European Community, signed the third.

In the light of the above it is clear that any action will have a real impact in national and regional terms only if, alongside international co-ordination, there is successful implementation of policy on an interdepartmental basis, and this with clearly defined objectives and proper scientific assessment of results on the risk factors and factors crucial to individual health.

It is therefore preferable to abandon dangerous all comprising and universal approaches because of their lack of concrete application and because they are almost always little more than declarations of intent based on ide-

ological expectations and the need for to create self-referent consensus with little relevance to real effects on the population.

The main aims of the ethical declaration

On the basis of the above assessment it is therefore considered essential to explain and enshrine these concepts in an ethical Declaration which can act as a reference point and be of specific use to operators in this sector, insofar as it is necessary to further co-ordinate and harness the will of the carers for the obtaining of certain important goals in the struggle against the drug problem.

To summarise, it is thought necessary to:

a) Increase the awareness of individuals and administrators of the need to develop interdepartmental policies and specific programmes able to promote healthy living and at the same time actively work against the abuse of all kinds of psychoactive substances ('drugs', alcohol and tobacco included).
b) Make as much objective information as possible available to the public on preventive action and on the risks connected to certain lifestyles as a result of the abuse of psychoactive substances.
c) Provide people with drug problems, or people who are at high risk, equal and early access to the health and social services and ensure suitable infrastructures for prevention and assistance.
d) Constantly assess the impact of policies aimed at promoting good health (with particular regard to the measures adopted to reduce or combat non therapeutic use of drugs), as well as those dealing with the care and rehabilitation of individuals who have problems.
e) Encourage the development of and research into new forms of prevention, cure and rehabilitation.
f) Ensure that there is adequate and permanent financial provision for these initiatives and specific systems for the struggle against drug abuse and its consequences.

Finally, it is clear that in order to realise these aims, those people who find themselves in different ways in the front lines should be involved from the outset. This involvement is required in the formulation cultural reference models, the promotion of health and the battle against the non-therapeutic use of drugs. Encouragement to participate in the process should be given to: politicians, administrators, the public, specific public and private organisations, voluntary groups and the social groups which are directly affected.

In order to provide general policy guidelines also for regional planning it is important to make explicit and share some fundamental principles and strategies of action which the Veneto Region considers should drive the new approach to the fight against drug abuse. It is clear that the points indicated here are simply ethical guidelines which apply on a general basis and have no legislative function as such.

Court of human rights

Here below is the court of basic human rights to assure people of an effective policy against psycoactive substances which respect themselves and their personal choice.

ETHICAL DECLARATION BY THE VENETO REGION AGAINST THE NON THERAPEUTIC USE OF PSYCHOACTIVE SUBSTANCES

COURT OF HUMAN RIGHTS

1) Everyone has the right to the benefits of social action aimed at protecting health, the family, the community, and the workplace from accidents, violence and other harm (including contagious diseases) which may result from the use of psychoactive substances.

2) Everyone has the right to receive, from first infancy, correct and impartial information and education on the negative effects which may be caused by the taking of psychoactive substances.

3) All children and adolescents have the right to grow up in an environment which is protected from the negative consequences of incitement to use psychoactive substances and from their consumption which is a result, at times, of widespread and deliberate underestimation of the associated risks.

4) All those who take psychoactive substances in a harmful way, non-therapeutically, or in a way which is subject to risk, as well as their families, have the right to support and early and readily available treatment and care, (with a free choice of the place and kind of treatment), aimed at rehabilitating the person by helping him give up the drugs and getting him back into leading a meaningful and independent life. All user also have the right to access to effective information and services to prevent the onset of diseases related to the use of psychoactive substances as well as other serious social and environmental consequences such as a life of crime or prostitution.

5) Everyon has the right to be protected from pressures, whether direct or indirect and whether individual or social, to use psychoactive substances. It is also everyone's right to be supported in a life or sobriety and non-consumption of drugs.

6) Everyone has the right to express, make the most of and preserve their intellectual, working and human potential in a context of liberty and independence from the negative effects of non-therapeutic use of psychoactive substances.

7) Everyon has the right to expect that the state's efforts to combat the illegal drugs market does not make use of strategies which could expose them to health risks.

8) Everyone has the right to decide on their own behaviour and lifestyle in a dignified context of reciprocal and binding respect for the rights and freedom of others.

General principles for action

The non-therapeutic use of psychoactive substances

The activity of promotion and protection of good health must have as its target 'narcotics and other psychoactive substances', i.e. any substance (legal or illegal) which can interfere with the neurological and mental processes and which presents a potential risk of non-therapeutic use and/or dependence.

'Non-therapeutic use' means use of substances for 'purposes which cannot be properly understood as therapeutic', i.e. a drug is used therapeutically only in the following circumstances:

a) where there is a disease or some form of ill health which has been correctly diagnosed and which requires pharmacological treatment;
b) Where there is a specific and authorised prescription for the drugs;
c) Where the substance is used at dosages, in ways and for time periods which are in line with what has been established by scientific research as 'effective and tolerable' in the treatment of the individual's particular illness.

The danger of psychoactive substances to health

There are many psychoactive substances and some of these also find uses in the treatment of illness but those which concern us only those which are dangerous to the health of the individual or the persons around him.

Such danger is found where, following the use of the substance, at least one of the following situations arises:

a) Effects which interfere with neurobiological and psychological gratification mechanisms, alertness, self-control or judgement, or the reduction, even temporary, in the mental and physical performance of the person.
b) Acute or chronic toxicity, with particular regard to the nervous system.
c) The possible development in the individual of a perception of 'normality' or 'being up-to-it' or 'in control' only in the presence of the effects of the substance which may lead to compulsive periodic intake of the substance and/or addiction.
d) The possible conditioning of the individual to follow life styles which may lead him, even temporarily, to act indecorously, lose his dignity, fail to express his abilities as a person, socially and in his work and to act responsibly in relation to others (such as his children, family etc.).
e) The individual's use of the substance primarily or exclusively in order to attain an altered mental state, or altered perceptions or consciousness while underestimating the risks and nor seeking therapeutic benefits.

Among these substances which must be included are those which are commonly called 'drugs' i.e. cannabis, cocaine, heroin, ecstasy, amphetamines, hallucinogens etc, as well as a range of pharmacological products with neuro-psychological and behavioural effects such as sedatives, hyp-

notic drugs in general and alcoholic drinks in all their forms and strengths.

The behaviour involved in the consumption of such substances which can be regarded as satisfying the expression 'the non-therapeutic use of narcotic and psychoactive substances' includes the taking 'for fun', recreational assumption, compulsive taking and so on.

It should be made clear that the non-therapeutic use of substances does not always involve dependence but if dependency is present there is true 'addiction', i.e. depending on the type of substance, the way it is taken and the effects of withdrawal of the substance, a mental or physical or mental and physical state of negative dependence which is certainly in any case to be avoided.

General principles

1) It is a matter of extreme importance to find and share a strategy which can be easily and widely communicated and which is aimed at combating the non-therapeutic use of drugs. The strategy should be based on principles and methods which promote the voluntary adoption of healthy lifestyles backed up by an understanding of the need to look after one's health and the integrity of the person as a whole.

2) As a result any strategy or action promoting health must be clearly directed at the individual, considered biologically, psychologically and socially.

3) The bodies and associations concerned must therefore be assured flexibility in the way they adopt the organisational and care models suggested in this paper, while acknowledging their right/duty to carry out their specific functions.

4) Each individual must be assured his inviolable right and freedom to decide on his own behaviour and lifestyle while at all time respecting the rights and freedoms of others. Thus, while recognising the need for clear laws on the production and use of psychoactive substances, it is fervently hoped that there shall be at the same time the development of policies aimed at leading the individual to adopt, as far as possible voluntarily, healthy patterns of behaviour. The policies in question must therefore be oriented, first and foremost, at promoting cultural models based not simply on liberalisation, or on prohibition, but on providing incentives to adhere to positive social values, responsible behaviour and, as far as possible, these should be freely chosen. This has to be achieved by the growth of a responsible and mature awareness of the need to protect one's own health and that of others, as well as an understanding of the grave risk of harmful consequences of substance abuse. This awareness should also bring with it the need to get involved socially in first person, through one's own behaviour, in seeking to stop the negative and dangerous process of 'normalising' the use of psychoactive substances, without however discriminating against those who are engaged in the use of these. In this context it should be made clear that a healthy lifestyle, to be pursued socially and individually, is one which does not

involve the non-therapeutic use of drugs and that any such use should be viewed as a 'negative exception' to sober behaviour which should thus be seen as the 'positive norm'. To clarify and delineate the problems related to drug use it is necessary to introduce a common and more precise language which more closely corresponds to the psychological, physiological and social phenomena which are consequential to the introduction of psychoactive substances into the organism. This consideration is also relevant to giving proper and coherent analysis of the conduct of persons who use, in different ways, a variety of psychoactive substances with different pharmacological characteristics and effects.

5) The fact must also be taken in to account that there is considerable variability in individuals' reactions to substances, particularly as regards their psychological effects and resulting behaviour and both in the short term and the long term. The effects are therefore not predictable for all people. It is not therefore possible to adopt a superficial stereotype of the effects of substances when the same dose and method of assumption may have no effect on some people and cause permanent damage to others. It should also be recalled that there is a significant number of young people who, owing to their particular psychophysical makeup or social conditions, are particularly vulnerable and may become permanently involved in the use of psychoactive substances frequently resulting in dependency with all the personal and social problems entailed. On the other hand the use of such substances by others of the same age seems to be controlled, with no evident social problems, albeit with powerful effects on their mental and neurobiological functioning and therefore with an impairment of their ability to perform tasks etc.

6) As far as prevention is concerned, it is essential to recall that there is now an abundance of evidence that there are population bands which, due to the makeup of the individual and/or social causes or individual biology, are at greater risk if they come in contact with drugs of becoming dependent or engaging in frequent usage, with serious repercussions for individual health and on the social situation. In terms therefore of general public health policy, action must be specifically programmed to safeguard, respect and protect these high risk and therefore needy population bands.

7) Scientific research has shown us that adopting preventive behaviour also depends on the degree of awareness of the risks, the individual's self control, the ability to identify and avoid dangerous situations in advance and on the motivation to maintain such behaviour. It has also been shown that these factors can be influenced by information campaigns and particularly through education. There are other factors which condition the behaviour of the individual which depend on the social and cultural models of the peer groups. These are equally able to provide an incentive to the individual to engage in dangerous behaviour as they can reduce the propensity to behaviour which is at risk. It has also been observed that most young people pay attention to information which points out the risks of harm resulting from drug use, while some display

no particular response to the information and others still (a small group) may be stimulated by the idea of rebellion. It can be seen therefore that there is also a range of responses to the provision of information itself, which nevertheless remains a valid option as regards the majority of young people and is useful particularly if started at elementary school as part of early and wide-ranging education for healthy living.

8) It must be understood and explained that the individual's responsibility for his non-therapeutic use of psychoactive substances is not only in relation to his own health by also in relation to the risks and harm which can result for others. The behaviour is not therefore circumscribed as a solely individual matter. It should be emphasised that personal freedom ends where it comes into conflict with the freedom and rights of others.

9) We must include among the person responsibilities also those which derive from the fact that the non-therapeutic use of drugs can provide a role model for others (and particularly in the parent-child relationship). It has been proved that such behaviour encourages others (especially vulnerable) to follow suit and take drugs. Such behaviour may also help to maintain cultural models of negative behaviour which are capable of conditioning other individuals to adopt lifestyles which are dangerous to their health. Concrete social behaviour which can be described as 'mutually helpful' should be encouraged in each individual, i.e. behaviour which is visible and promotes, maintains and extends as widely as possible, explicit and clear models proposing lifestyles which exclude recourse to the non-therapeutic use of any psychoactive substances.

10) No person who makes non-therapeutic use drugs should however be discriminated against or attacked for this reason. Indeed every effort should be made to provide opportunities and structures able to give real help so that the person can solve his problems and/or reduce the incidence of related diseases. Any sick person should thus be offered, in a professional way and on a basis of equality of treatment with any other form of disease, the necessary health and social care and all the therapeutic options available. At the same time the individual's choices must be respected while also encouraging him to make informed choices in an effort to lead him back to leading a full and normal life.

11) Finally it should be underlined that it is considered of fundamental importance to greatly increase all efforts to combat the recycling of the huge quantities of money involved in the illegal drugs market. We do not however share the view that this black market should be attacked using solutions based on the illusion of causing prices to fall, (with falls in costs for users and falls in profits for dealers), through a 'legal' supply which would be in competition with the present illegal market. Such a course of action does not stand up to ethical examination when we consider that it conflicts with the general principle that the social and health services' remit is to truly and coherently promote and protect public health. The supposed advantages of such a course in terms of controlling

the illegal market could not be balanced by the disadvantages and risks of resulting damage to individuals (particularly pre-disposed individuals) by the increased availability of psychoactive substances. There would also be incalculable damage as a result of the recognition of the state in its laws of a cultural and social model which accepts the use of such substances as the norm and as such regards this use as being socially acceptable. It cannot be ethically acceptable that in order to combat crime and solve public order problems the public are exposed to serious social and health risks. A civilised society cannot pay the price of law and order with the health of a group of its youth, particularly a group which needs special help as it is the most vulnerable. In general terms then two distinct problems need to be identified and dealt with by the employment of distinct plans and policies. One the promotion of public health and two the control and repression of the illegal drugs market. On the other hand it is equally unacceptable to pursue a simple policy of prohibition without at the same time putting into effect concrete and effective primary and secondary measures of promoting responsibility and at the same time ongoing police activity to control money-laundering. There is not doubt that the large amounts of capital from the drugs trade and the dealer networks could be monitored with the systems which are already in place, given effective policies. It is not necessary to make the public pay the unacceptably high price in the fight against crime of increasing the 'health risk' factor by making the substances which are the subject of abuse more easily available.

Intervention strategies

Intervention strategies must focus attention on three levels of action contemporaneously:

Level I - On persons at potentially high risk, on families and on demand for psychoactive substances.

Level II - On persons who already have a problem, expressed or not, of non-therapeutic use and/dependence on such substances.

Level III - On the community and governing bodies.

The main strategies can be summarised for each level as follows:

Level I: the reduction in demand

1) The drawing up of intervention programmes with the general aim of encouraging and promoting the acquisition of knowledge, awareness and sense of responsibility towards the individual's own health and that of others, in a context of voluntary, reasoned and free behaviour, if possible self-determined.

2) Giving full, constant and objective information on the risks and of possible harm which can be caused by the non-therapeutic use of drugs to

the individual's physical and mental health, to the family and to the community. At the same time to also give information on effective measures which can be taken to prevent or reduce the possible negative effects from the use of such substances, including large-scale educational programmes aimed especially at adolescents.

3) The structuring of public and private places and the workplace is such a way as to safeguard, as far as possible, against the circulation of drugs while protecting them from accidents, violence and other negative consequences which may result from the non-therapeutic use of such substances.

4) To enforce the law and encourage preventive action such as avoiding driving or working under the influence of psychoactive substances.

5) Promoting good health through the control of availability and access to psychoactive substances, in particular to the young population, by means of stricter control of medical prescriptions for those substances which are legal (when necessary) and a series of actions taken against the production and distribution of illegal substances.

6) The enforcement of strict control measures over direct or indirect advertising of psychoactive substances to ensure that no form of advertising may specifically target young people or connect such substances with events or stereotypically youthful behaviour presented as 'positive or trendy'.

7) The encouragement of a greater sense of ethical responsibility, as well as responsibility in law, in those operating in the market or trade of legal psychoactive substances.

8) Ensuring that there are strict controls on the prescriptions for and supply of psychoactive substances on the part of doctors and pharmacists.

Level II: cure and rehabilitation

1) To ensure that those persons engaged in non-therapeutic use of substances, whether or not they are addicted, have access to early and effective support services, treatment and rehabilitation carried out by well trained and authorised personnel.

2) To ensure that there are programmes which have as their priority contact with the individual, and encourage him to permanently give up the use of psychoactive substances (without prejudice to their receiving social and health service attention). The aim of such programmes being to lead the person back to a full a independent life (even if this only be achievable in the long term).

3) The recognition of 'substance dependence' as an 'illness' which can be treated, is curable, chronic (though subject to remission in the great ma-

jority of cases) and where the patient frequently relapses. Such addiction is accompanied by serious prejudice to the addict's social situation and requires specific forms of assistance, preventive treatment in relation to related diseases and rehabilitation. These on the basis of the patient's voluntary co-operation with overall approach which is centred around the person, professionally and scientifically carried out and free from moral prejudice or discriminatory attitudes.

4) Recognition, particularly in the case of addicts who inject, that early intervention is a priority matter in order to deal with the emergency situation related to widespread disease which may be fatal and/or serious social deviance (such as prostitution and crime) which are associated with such addiction. Such early intervention is necessary to avoid possible death, or serious disease or social deviance with permanent consequences which could compromise any future attempts at rehabilitation.

5) To commit to a campaign to change the punishments for crimes connected with non-therapeutic use of psychoactive substances (excluding trafficking and dealing) where possible, to activities which are genuinely rehabilitative in nature and which are socially useful and encourage the person to regain his social and psychological position, avoiding the instrument of imprisonment.

6) The promotion, through agreements and initiatives with labour organisations and employers, of the return to the working and social environment of persons with addiction problems, creating suitable forms of protected work and ensuring that there is social service support for them and their families.

7) In the context of the various therapy and rehabilitation programmes and as they are running, it is also fundamental to reconstruct and develop social networks able to provide a greater chance of successful rehabilitation by encouraging the person and supporting his long term participation in cultural, recreational and sports activities and social commitment.

Level III: community and social and health services organisations

1) The formulation and issuing of structured programmes aimed at promoting shared cultural models which are explicitly against the non-therapeutic use of psychoactive substances and in favour of healthy living, while proposing ways in which the person can fulfil himself and become individually and socially responsible.

2) Through the direct involvement of the mass media and opinion leaders, to help the growth in the community of the will to concern itself with problems associated with the use of psychoactive substances. Also to promote the training of operators in the various sectors involved, i.e. health and social departments and also education and the judiciary, and at the same time to strengthen and develop the central role of the com-

munity in the forming and spreading of cultural models based on drug free living.

3) To require that the organisations which dedicate themselves to activities of preventive health or assistance of drug addicts clearly define their objectives and report their results, using a pragmatic and scientific approach. To further require that progress is monitored and that periodic updating of programmes is carried out, based on constant assessment of the results obtained in relation to:
   - A fall in demand
   - The move away from or suspension of the use of substances
   - The increase or maintenance of the addict's overall performance as a human being
   - The improvement of the quality of living
   - The fall in the incidence of pathology in medical terms and in psychological and social terms (prostitution, crime etc.)

4) To get the competent public authorities (health authorities, municipal and regional authorities etc.) to commit themselves effectively to combating the drug problem, and to providing adequate and continuous annual funding as well as identifying truly assessable intervention programmes which can be agreed upon by the various departments etc. involved, organising valid consultation schemes and the involvement of private social organisations and voluntary groups in the decision making process.

5) To prepare effective systems for the gathering and elaboration of data so as to be able to have ever more exact and up to date information available for epidemiological study, for the monitoring of the flow of new substances onto the market, and to be able to comprehend the precise scale of the phenomenon through specific analysis of trends and incidence.

6) To support those bodies (governmental and non-governmental) which operate in primary preventive health or in the reduction of the incidence of diseases related to the use of psychoactive substances, as well as supporting self-help groups.

7) To formulate the programmes taking into account this ethical Declaration.

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The Veneto Region's Ethical Declaration against the non-therapeutic use of narcotics and psychoactive substances also has the purpose of creating the basis for a common approach and providing guidelines for the formulation of a area plans oriented towards a modern view of the problem and which is also useful for dealing with another issue.

As a general rule, where co-ordinated action is required by a number of bodies and institutions, it is best policy to define in general terms at least, the respective areas of competence and responsibility of each body, especially as regards those of municipal authorities and local health authorities.

Areas of competence

For the sake of clarity, it should be recalled that in the field of action in relation to drug addiction, the local health authorities have competent for health and social matters including treatment, the prevention of related diseases and all that which specifically comes under the heading of 'treatment' of the person using psycoactive substances whether addicted or not.

The municipal authorities are competent for matters coming under the social assistance heading including primary prevention, education, rehabilitation and the reinsertion of the individuals into academic, working and social environments.

Specifically matters of prevention, marginalisation and social adaptation are the competence of the municipal authorities while the health authorities can participate in any such initiatives if so delegated to do so.

Naturally in practice there is not always a clear distinction between one category of care or need and another but it remains true that it is also necessary to clearly define these in order to understand who is responsible for which areas and thus to whom should be attributed the budgeting costs.

Guarantee of quality

Any body, organisation or individual must give the same preventive, treatment or rehabilitative care as would been given in the case of any other pathology. Such body etc. must also be properly authorised in law to carry out these functions, both in national and regional law.

Therapy, on whatever basis it is given, must be provided only by structures or professionally qualified persons who are so authorised in law and

accredited by the Region, and must be properly integrated with the social and social assistance frameworks.

In accordance with their specific areas of competence, the public bodies in question also have a duty to ensure that the services they provide through their operating departments and various authorised private organisations possess certain required levels of quality and professionalism and are able to offer equal, uniform and particularly ongoing, treatment to all members of the community.

Planning

Planning must be based on a detailed and realistic calculation of the prevention and assistance needs of the individuals in the community and not simply in relation to the resources of each operating department.

The calculation of the necessary resources will therefore be result of an analysis of needs and must only then be compared, both as regards public services and private resources, with the existing resources available.

The organisations which are able to provide the services are therefore identified strictly in relation to needs which have been established in advance and, as far as possible, quantified.

The competent public bodies have a duty, in relation to their specific functions, to formulate a general programme which specifies the bodies and organisations which shall run the programme, state which services have to be provided for the public (on the basis of the requirements of the institutions and the resources available) and which, on the other hand, may be entrusted to authorised and regionally accredited private social organisations backed by public funds.

It is important to emphasise that, at the planning stage, the principle of 'active participation' should be applied in the drafting of the programme, bearing in mind that while the organisations present in the area concerned are autonomous it is also vital to co-ordinate the same in the name of quality and the rationalisation services provided in relation to public costs, while at the same time improving the efficacy and efficiency of 'output'.

Consequently all action which is financed by the state coffers must satisfy real needs and offer guarantees of effectiveness and quality while forming part of an integrated system of services.

Permanent consultation

It must be remembered that the local health authorities and the local government authorities, as parties to the local programme and the Area Plan, must set up suitable and permanent forms of consultation with the effective participation of private social bodies and voluntary groups. This so that the action programme really is the fruit of co-operation between all of the forces in the field, right from the start and during the organisation stages, so as to ensure that it will be applicable practically and effectively in the future. It is felt that more than the regulatory framework in force it is the real and widespread agreement on objectives and strategies which determines that the action programmes are actually effectively applied on the part of the organisations involved. In other words, while the regulatory

stages and statement of the general course of action are important, it is considered equally important to pursue the creation of the requisites for professional behaviour with a well argued, shared and 'self-determined' basis for the organisations which are called upon to provide the services.

The public institutions must thus ensure, in the preparation of the general plan, their general respect for the above principles and for plurality. At the same time the private social organisations and voluntary groups must do everything they can to co-ordinated their actions (particularly where they have public funding) within the general action plan, as well as being internally well organised and co-ordinated within their own structures.

As far as the insertion of the work of voluntary groups within the general programmes, it should be remembered that it has an important role to play in supporting the work of public institutions. Such work may therefore be fully integrated into that of the organisation charged with provision of the overall service while the groups may retain their autonomy of action within the limits laid down by the law in relation to the exercise of assistance functions.

Voluntary and self-help groups

Voluntary organisations, also in the form of self-help groups (of patients or family members), have an especially important role to play in the processes of care and rehabilitation of persons with problems related to substance abuse. Voluntary and self-help groups must have, for the purposes of their recognition and funding, a real therapeutic goal with some guaranteed structure and organisation and effective and proper methods in accordance with criteria which are recognised at the level of the regional government.

The state authorities have a duty to support (with concrete help and not mere declarations of intent) and promote such initiatives, while at the same time taking care to properly integrate their activity into the general plans. It is also necessary to select those organisations which are really providing a socially useful service to meet real community needs.

Registration on the Regional Rolls and census of the organisations

It is essential for the public bodies to verify that the groups and associations are registered properly with the Regional authorities and collaborate with the census of voluntary organisations, therapeutic communities and social co-operatives. Care should be taken to define their organisation and functions and more especially to assess the real impact of the work they carry out, both in qualitative and quantitative terms, on behalf of the community. To do this specific and openly declared criteria need to be applied in a standard fashion to all of the organisations so as build up a 'registry of voluntary organisations, therapeutic communities and social co-operatives.' In this way it becomes possible to have an accurate overall view of the actual scale and assistance potential of each organisation going beyond what they declare to be the case and what is projected in their image.

The public bodies have a fundamental role in giving incentives to such organisations to make their particular contributions to the community; this

means not only the provision of specific financial backing but also making premises available so that they can carry on their activity in some comfort and dignity as well as offering special training and supervision with the objective of creating as far as possible a professional service.

Translation by: *Cristina Bonani*

Substance related damage: Cannabis and ecstasy

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AKADEMEIA
THE EUROPEAN STUDY AND RESEARCH ACADEMY
IN PREVENTIVE AND COMMUNITY MEDICINE

Editorial revision by Giovanni Serpelloni and Giancarlo Fibbia

Introduction

Never more than now has it been necessary to provide health and social workers in the drug addiction field with a clear position on the damage caused by drugs.

This paper has been written with the aim of giving a medical perspective, in a preventive and social context, on certain important aspects which usually remain in the background of the political debate on the legalisation of substances. We firmly believe that any position which fails to take account of scientific analyses into individual and group use of drugs (from the neurobiological, psychological and social standpoints) is wholly inappropriate to the process of 'political' decision-making in an area where the consequences are to be felt primarily in the health and social fields.

In our opinion the question of the consequences of substance use should principally be seen as a health services' issue, in which should be included not only strictly medical matters but also psychological and social factors which cannot be separated from the use of substances. The reader should thus start out from the general and very simple consideration that drugs are sought and used for the 'desirable' neuro-psychological effects they produce, insofar as pleasant and functional for the users, while at the same time may be accompanied by long-term risks and negative effects which are in most cases predictable and underestimated, both by the individual user and society as a whole.

Some basic concepts

It would be as well to make clear that the term 'soft', as applied to some psychoactive substances to mean of presumed low potential toxicity or not very dangerous, is not to be found in any scientific definition but is only a term in common usage whose lack of precision can only confuse anyone without a specific scientific background.

To put the matter simply, (perhaps oversimplifying but with the virtue of being comprehensible), in order to assess the danger and potential harmfulness of different psychoactive drugs to the individual, seven fundamental aspects should be considered:

1) the availability and ease of access to the substance (supply);
2) the quality, intensity and duration of the psychoactive effects (correlated

to the pharmacokinetics and pharmacodynamics of the substance);
3) the capacity to create tolerance (the need to increase the dosage to achieve the same effect) and lead to dependence, seen not only as the continuous taking of the drug with physical withdrawal on cessation, but also the need and compulsive craving for the substance;
4) its acute toxicity (short term) and its chronic toxicity (long term) and direct and permanent damage (biological and psychological) and mental and physical disorders related to the manner of taking the substances (frequency and gravity);
5) the capacity of the substance to interfere with the individual's relationships and to reduce the user's social and individual skills;
6) the capacity (intrusive integration), due to the psychoactive effects produced and aside from questions of withdrawal or craving, and in relation to the subject's relationships and social skills as he perceives them, to become a kind of 'psycho-metabolic paraphysiological' component whose presence is no longer felt as intrusive but as necessary and stable (as if a real part of the person's self), and which enables the individual to function in relationships and face the trials of daily life (also known as egosyntony);
7) the capacity of the substance to stimulate the susceptible individual, or individual with particular problems, to seek substances with stronger psychoactive effects and greater potential for causing harm (whether biological, psychological or social);

It should be recalled that the substances being abused are used insofar as their effects are perceived as subjectively pleasurable and/or functional in relation to the person's own psychological and neurobiological needs/expectations. When an abused substance is introduced into the organism it causes a stimulus which is 'magnified' by a series of effects perceived by the subject in a variety of ways and over varying periods. Only substances which are able to produce effects which are considered positive by the subject are normally abused, i.e. those substances which produce primarily pleasurable euphoric effects and also those which have anxiolytic/inhibiting effects and/or cause emotional or excited states or altered perceptions such as may be considered desirable and thus sought out by the subject (secondary gratifying effects).

To these effects can also legitimately be added those deriving from the rituals connected with usage, the sense of belonging to a group and of rebelling against social rules and an increase in self-efficacy in interpersonal relations.

There is also a series of substances which are at times inert or unpleasant which, although not possessing the above described properties, are nevertheless abused by certain subjects as their use or way of being used are functionally satisfying in relation to particular compulsive/obsessive disorders which are frequently a matter for psychiatric treatment.

All this said it can be seen how it is extremely difficult to define when a 'drug' can be classified as 'soft' or 'hard' in the absence of objective and unambiguous scientifically based criteria, as opposed to personal opinion. This is particularly the case if we consider another fundamental concept which is generally overlooked and that is that the acute reaction to various sub-

stances (even on being taken only once) can vary considerably from individual to individual, with often very unpredictable reactions which may range from a complete absence of symptoms to the development of permanent psychiatric disorder on intake of equal dosages of the same substances.

Another concept given little consideration when estimating the dangers of substance abuse is the presence in some individuals of a predisposition to have recourse to permanent use of such substances and the tendency to seek greater stimuli through substances which are more and more psychoactive. These persons, owing to their psychological and neurobiological make ups are thought to be more vulnerable to develop habits of continuous and repeated usage with pathological dependence which may lead to serious and permanent alteration to their psychological state with resulting prejudice to their ability to develop and maintain dignified personal and social relationships and status.

In other words not all adolescents approach their first joint with the same neurobiological baggage, with the same social and family background and therefore with the same protection mechanisms.

It is undoubtedly true that most people who come into contact with drugs, after experimenting and satisfying their curiosity, do not go on to develop dependence. It is equally true, however, that from 10% to 20% of these persons develop dependency with its attendant serious risks and damage to health.

Some considerations on the use of Ecstasy

As reported by L. Marau in 'Medicina delle Tossicodipendenze', the molecule MDMA (methylendioxymetamphetamine), discovered in Germany in 1912 by Merck researchers and patented in 1914 as an appetite suppresser, has a structure which is similar to amphetamine and to mescaline. MDMA acquired popularity as a 'recreational drug' in 1985 and came onto the streets with a variety of names including: *Adam*, *Ecstasy*, *XTC*, *E* and *MDM*. MDMA has never been sold by the pharmaceutical industry but, as its synthesis requires only a minimal knowledge of chemistry, it is easily manufactured in clandestine laboratories where there is little attention to cleanliness and reactions are performed in common kitchen equipment using coffee filters to separate the products.

The taking of this substance causes an increase in physical activity in the human organism, enhanced mood and alterations in sensory perceptions for 5 to 6 hours. It seemed that *ecstasy* had no long term effects but in some individuals it has produced serious acute reactions such as malign hyperthermia, alterations in cardiovascular functioning, respiratory difficulties, rhabdomyolysis and intravascular coagulation, sometimes with fatal results.

The first study on its pharmacological activity in man was in 1978 and showed that MDMA caused a state of altered consciousness with emotional and sensorial hypertonia which could be useful in psychotherapy. Later studies showed its supposed usefulness in this field not to be the case, despite its having been used from the early seventies.

Scientific and social interest in *ecstasy* become significant when the DEA (Drug Enforcement Agency) in the United States added MDMA to the most restrictive table of legally controlled substances. The DEA gave as its

reasons the absence of any documented therapeutic or medical utility, its spreading use as a psycho-stimulant and the risks of neurotoxicity.

The following table summarises the main effects of MDMA.

The most frequently reported effects of the use of MDMA (ecstasy)

Subjective Sensations (as defined by observers and subjects themselves)	% of 20 subjects
Alterations in the perception of time	90
Increased ability to interact with others	85
Diminution of defence mechanisms	80
Decreased fear	65
Decrease in sense of 'distance' from others	60
Alterations to visual perception	55
Increase in consciousness of emotions	50
Decreased aggressiveness	50
Changes to verbal expression	45
Awareness of previously unconscious memories	40
Diminution of obsessions	40
Alterations to cognition	40
Diminution of unease/nervousness	30
Diminution of impulsiveness	25
Diminution of compulsive behaviour	20
Diminution of anxiety	15
Alterations to the perception of spatial relations	15
Diminution of the desire to sleep	10
Increased libido	1
Short term Psychological / Behavioural effects	**% of 500 subjects**
Euphoria	97
Increased energy	91
Sexual arousal	83
Paranoia	16
Depression	12
Long term Psychological / Behavioural effects	**% of 500 subjects**
Depersonalisation	54
Insomnia	38
Depression	38
Flashbacks	27
Physical Effects	**% of 500 subjects**
Pupil dilation	8
Bruxism	54
Lumbago	32
Nausea	22

The use of stimulants by young people is a current and extremely serious problem. In addition to heroin (a 'downer' – i.e. with inhibitory effects,) which remains the most dangerous drug in both toxicological and social terms, there has also been in recent years a large-scale entry onto the market of 'uppers' (i.e. stimulants) especially amphetamine and hallucinogens (Ecstasy and LSD).

This has led to the creation of a pool of new drug takers with social and psychological characteristics which are quite different from heroin and cocaine users of today and the past.

These new users come only sporadically into contact with the dependency support services as they are not considered to have the requisites of 'addicts', i.e. they are not aware of having a problem and widely underestimate the risks and damage which can result from even occasional use of such substances.

These factors make it difficult to obtain detailed knowledge of the problem and even now the real extent of the use of ecstasy and other non-opiate substances remains elusive to the attempts of scientific epidemiological approaches at quantification.

These are usually very young, uninhibited and socially integrated people who primarily take substances to increase their ability to interact socially and to amplify the sensorial stimuli from such activities as listening to music and dancing.

The drug is not usually taken on a continuous basis but periodically and generally at the weekend.

The quest 'to get out of it' is pursued by many young people who seek to produce stimulation of the cerebral pleasure centres and increase their ability to interact socially and thus, with the help of these substances, overcome shyness and any lack of self-confidence while at the same time inhibiting the existential anxieties and self-doubts so often found in adolescents.

The sensations which this type of substances can produce are undoubtedly pleasurable and functional in that they enhance ability to engage in social intercourse and improve self-esteem for most of the young people. These aspects should not be underestimated or misunderstood and, together with the fact that they do not cause serious physical dependence problems, (and the associated drawback of withdrawal symptoms), render these substances particularly attractive.

The damage which can result from the use of these substances is nevertheless just as great, causing both physical and psychological problems especially in relation to the central nervous system. This takes the form of damage which is irreparable in animals while the long terms dangers for humans are still not well understood. We should also not forget that deaths have also been reported from acute toxic reactions of a neuro-metabolic nature.

Many other serious effects have also been observed on personality and behaviour leading, at times, to acute psychosis and permanent psychiatric disorders.

A recent study by McCann et al. has shown the chronic use of MDMA to be associated with a drop in the number of cerebral serotoninergic neurones. The functional consequences of such neural damage are not yet completely clear but may include depression, anxiety, memory problems and other psychiatric disorders linked to the serotoninergic system.

Diminution in the ability to concentrate and in the principal neuro-cognitive functions associated with a false perception of heightened performance and skills, (often aggravated by the use of alcohol), are also among the main cause of road accidents.

Another extremely serious and well documented danger consists in the possibility that the use of ecstasy may lead to the use of heroin.

Many ecstasy takers have in fact stated that in order to prolong the state of excitation produced by the substance, they use heroin as a 'sedative counterdrug' for its inhibitory effect. Ecstasy may in fact prevent them from sleeping and getting back to normal studies or work on Monday morning.

The most striking thing about ecstasy takers is the disinformation they absorb and their ignorance in relation to the dangerousness and toxicity of the substance. These lead to the immediate consequence that the taking of the drug may be very casual accompanied by an underestimation of the dangers.

Ecstasy is not considered to be a real drug by many users in the sense that they think of 'drugs' as substances causing physical addiction and this is practically absent in the case in question.

Many young people have said that the first time they took ecstasy it was something quite 'normal', as part of already widespread ritual behaviour of the peer group. Some have said that they did not feel any concern about damage to their health as they considered the substance harmless with no after effects and not to be addictive.

They felt that worries expressed by doctors were exaggerated and they were more likely to see health service information as advice tainted by a supposed moral stance rather than as being aimed at preserving their physical and mental health.

The need for correct and full information was the factor which emerged most strongly from the surveys.

Information thus represents the first step on a long educational journey which has to be made in an attempt, which can neither be avoided nor delegated, to inform these young people in such a way that their behaviour is determined in the light of knowledge and awareness and a sense of responsibility in relation to choices which may affect their physical and mental well-being.

Changes in the demand for and spread of new drugs

The history of demand for psychoactive substances, as well as the present situation, shows that the initial appetite and subsequent craving for drugs, both individually and collectively, are indiscriminate and indifferent to supply. Indeed, a number o of indicators show demand spreads across age bands which are not limited to the young, and across social classes and occupations of all kind. The phenomenon finds fertile ground in individual and group lifestyles and conditions which favour use of non-injected stimulants. Demand spreads indiscriminately though currently the spread is towards synthetic substances, primarily amphetamine analogues.

Among the few data which have been published in the literature on the subject, the epidemiological study by the American Medical Association (AMA) and the Medical Education Research and Information Division of

Chicago is significant. It was conducted through a questionnaire which was given to 2,046 students in their last year of medical school in twenty-three American colleges; two samples of high school students and other university students. The percentage of reported use of amphetamines at least once in the person's life was higher (39.1%) in the high school group, showing an increased incidence in the consumption of amphetamine type drugs in the younger age bands.

Other data which show the growth of the phenomenon in Europe can be seen from the monitoring of cases of MDMA poisoning by the National Poisons Information Service of the University of London, where clinical and fatal intoxication at St. George's Hospital showed an increase of about 300% from 1990 to 1991.

Other useful indicators for an understanding of the trend come from anti-doping analyses carried out by 22 authorised laboratories from the International Olympic Committee's network of test centres. Of the 'prohibited' molecules found in athletes' urine samples, the stimulants ephedrine, pseudo-ephedrine and amphetamine, were in second place (22.1%) after the anabolic steroids (57.3%).

Unfortunately it is not possible to find objective data when assessing the extent of the problem in Italy due to the lack of any epidemiological studies.

The University of Padua's case studies, from the Forensic Toxicology Anti-doping Department (STF) of the Forensic Medicine Institute, does however furnish us with some useful information gathered in its forensic toxicological, clinical and chemico-toxicological tests and checks.

The data collected by the STF on the clinical and chemico-toxicological status of Saturday night drivers give us further positive indications of how widespread is the use of amphetamines. Checks were carried out from June to September 1994 on a total sample of 255 drivers and showed that 9% were acutely intoxicated with amphetamines. The type of amphetamines found included the substances MDA, MDMA and MDE which were present both singly and in combination. The amphetamines were in third place in terms of their incidence behind cannabis and cocaine. Further confirmation of the prevalence of the supply and use of amphetamine analogues in public gathering places, (related to their 'social' properties), lies in the fact that the persons intoxicated with these substances came from discotheques or other gathering places. While it is true that the low numbers in the sample do not permit extrapolation with regard to the real extent of amphetamine influenced driving, the frequency found (9%) is well in line with search and confiscation data from the local and national forces of law and order.

Other significant data is available from the chemical and toxicological analyses carried out by the STF laboratory on biological samples sent in by health service departments (hospital departments and SERT,) and from forensic and toxicological tests carried out by the STF in driving licence review cases referred by the police medical board where drivers were suspected of having consumed psychoactive substances.

An overall assessment of the chemical and toxicological analyses and toxicological forensic tests carried out in the years 1993 and 1994 show a very low number of positive tests for amphetamines; this in apparent contradiction to other epidemiological studies, leading to the conclusion that:

- amphetamine users are probably outside the ordinary social and health service sphere (of hospital departments and SerTs) which deal primarily with heroin addiction.

- The driving licence review procedure (from roadside checks and referrals from the judicial authorities under article 125 of the D.P.R. decree 309/90) almost exclusively affected users of heroin and cannabis.

Amphetamines and death

Psychoactive substance abuse death is a complex matter in which many heterogeneous causal factors concur. According to Janssen these factors can in practice be categorised as accidental or intentional overdose, long term drug abuse, drug related suicide and fatal accidents linked to drug use.

In accordance with the above categorisation an examination of deaths related to the use of amphetamines reveals a heterogeneous range of causal factors and contributory causes. An assessment of the cases reported in the literature allows us to make the following general deductions:

1. Acute amphetamine poisoning, or overdose, is characterised clinically by irreversible cardiovascular failure leading rapidly to death.
2. Chemical and toxicological tests of biological samples in post mortems in overdose cases show variable concentrations of amphetamines which leads to the supposition of some idiosyncratic mechanisms at work in low dosage cases.
3. Death may occur from indirect concurrent causes, such as malignant hyperthermia and related complications (rhabdomyolysis and renal failure) or as a result of reckless behaviour leading to death from violent causes (such as road accidents, electrocution and falling from heights).
4. The circumstances in which the person took the drug may be important in determining the pathology (such as in the case of malignant hyperthermia). In particular an increase in physical activity (e.g. dancing) and staying long periods in hot places (such as discotheques), in combination with the toxicodynamics of the drug, (dehydration from profuse sweating and diminished liquid intake with diminished perception of thirst), can determine a failure of the central thermoregulatory system (perhaps also though direct poisoning).
5. Pre-existing pathologies, whether manifest or hidden, such as micro-cardiopathology, functional arrhythmia and asthma, characterised by a basic lack of oxygenation to the heart muscle, can be aggravated by the amphetamines through toxically induced arrhythmia.
6. The international scientific literature has recently indicated the fatal interaction between ritonavir (an anti-retrovirus drug used for HIV infection) and MDMA; this would indicate the danger of using MDMA and other illicit substance with pharmaceutical products which may increase plasma concentrations to life-threatening levels.

Amphetamines and disability

The role played by amphetamines and its analogues on psychomotor performance correlated with the ability to drive and work can be inferred, as with any other xenobiotic substance, from epidemiological studies and experiments on the interaction between man and machine.

Epidemiological studies in relation to amphetamines and road accidents give us only aggregated data which do enable us to separate out the individual amphetamine substances.

In general the frequency with which these substances are reported in the single studies presents a great range, partly dependent upon the different types of usage in different geographical areas.

As with any other psychoactive substance, the positive identification of amphetamines in biological fluids of drivers involved in traffic accidents, is not held in itself to be causally connected to the occurrence of the road accident.

Epidemiological studies in relation to accidents at work are still quite rare because of labour union resistance which still persists today to the drafting of laws aimed at regulating toxicological investigations. Those which have been carried out, however, have shown the presence of a variety of psychoactive substances (including amphetamines) in biological fluids taken from the bodies of persons who died at work. The lack of careful statistical evaluation in such studies means, however, that it is not possible to extrapolate data on any role amphetamines may have had in determining the accidents.

Experimental studies on the interaction between men and machines aimed at investigating effects on psychomotor performance have been carried out only on the amphetamines and correlated molecules used in treatment. There have still been no experimental studies on psychomotor changes produced by MDA or MDMA.

The effects of low doses of amphetamines on psychomotor performance have been experimentally shown to be as follows:

1. increased cerebral arousal, assessed by tests such as the CFF (Critical Flicker Fusion);
2. diminished reaction time to simple and complex stimuli.

These observations indicate that the effects of amphetamines on psychomotor performance are similar to those produced by other stimulant substances. Improvements in psychomotor performance tests resulting from experimental studies is in apparent contrast with the incidence of amphetamines found in persons who have died or been injured in road accidents. It is therefore probable that improvements in psychophysical performance is associated with prejudice to the subject's ability to assess the risks of certain behaviour, leading to increased risk-taking. This implies that amphetamine users are unable to evaluate the danger inherent in certain situations and, in particular, tend to overestimate their own ability to react to danger. These are psychodynamic states which do not lend themselves to adequate exploration under experimental conditions, as the behaviour of the subject is likely to be influenced by the test itself (e.g. in a real or simulated driving test).

The so-called 'soft' drug cannabis

We report here below a summary of some of the principal studies on the effects of cannabis about which we consider there is very little general awareness despite its widespread use.

In September 1996 Brouwer W of the CAD (Drugteam Amsterdam Holland) gave a paper on 'The use of Cannabis in Holland' at the National SITD Congress in Padua. In this he reported some data with respect to the legalisation of cannabis in Holland showing that about 4.5% of the Dutch regularly use cannabis (about 700,000 people). Among youngsters under 24 years of age the usage was 50% and 4% used the drug on a daily basis. It is estimated that about 25,000 people develop problems linked to the use of cannabis, particularly in the form of poor social adaptation, dropping out of school, psychological and memory disorders, and social and affective isolation. A significant percentage turn to disintoxication and support centres.

The principal characteristics of the substance

Cannabis products come from the *Cannabis sativa* plant. The psychoactive constituent is -tetrahydrocannabinol or THC.

GP Guelfi, in his 'Clinical aspects of cannabis abuse' states that the traditional forms in which the substance is consumed are: *Marijuana* (flowers and dried leaves), in which the THC percentage can vary from 0.5 to 5% in the varieties without seeds and from 7 to 14% in those containing seeds, called 'sinsemilla', while even higher concentrations are found in Netherwood marijuana; *Hashish* (cannabis resin and pressed flowers)with THC concentrations from 2 to 20%; and *Hashish oil* (a THC extract using organic solvents) with concentrations of 15 to 20%.

The typical 'joint' contains from 0.5 to 1.0 grams of cannabis of which only a part is inhaled while the rest is dispersed in the air; the THC content varies from 20% to 70% and the bio-availability of the THC amounts to from 5 to 24%. The amount of THC which enters into the circulation from a joint is not easy to quantify as it depends on numerous variables, first of these being the concentration of THC in the product being used.

For those who use cannabis occasionally 2 to 3 mg of THC effectively absorbed are sufficient to produce the desire effect while habitual or 'heavy' smokers of the drug take in larger dosages as they become tolerant (of the order of five or more joints per day).

Cannabis related products act on a specific receptor which is widely distributed in various regions of the brain concerned with the ability to understand, with memory, the perception of pain and with motor co-ordination.

Part of the THC is distributed in unaltered form to adipose tissue. Following habitual intake of the drug the level of THC accumulated in lipid tissues increases; as a result of this the substance can be detected in the organic liquids for days or even for several weeks (28–45 days). The long persistence and slow release of THC has implications still not clear but may be the basis for the occurrence of alterations to perception some time after the last time the drug was taken. They may also be one of the reasons why physical withdrawal symptoms from hashish/marijuana are so attenuated as compared with those associated with other substances.

Patterns of cannabis usage

Cannabis has been used by many young European adults and by the greater part of American and Australian young adults.

In these two countries about 10% of the users take the drug on a daily

basis and another 20%-30% use the substance at least once a week.

The 'heavy' use of cannabis is defined as daily or almost daily usage of the substance. Such use exposes the smoker to a large risk of collateral adverse health and psychological and social effects. Daily consumers of cannabis are the most frequent takers of amphetamines, hallucinogens, stimulants, sedatives and opiates, they are more often male and have lower levels of education and habitually use alcohol and tobacco.

Collateral effects

According to Hall and Solowij, the authors of the most recent work on the effects of cannabis use, the acute and chronic consequences of cannabis use can be summarised as follows:

Acute effects

The main acute effects are anxiety, dysphoria, panic and paranoia, especially in non-habitual joint smokers and subjects receiving THC for therapeutic purposes. Even habitual joint smokers may have reactions of this kind after ingesting the cannabis products *orally*.

Distortion and intensification of sensorial experience such as eating, watching films and listening to music.

Disturbances in cognition, especially in relation to memory and the ability to concentrate. Short term memory is prejudiced and mental associations are slowed down. This detachment from contingent reality is the basis of the pleasantly experienced reverie while it makes it difficult to sustain purposeful mental activity.

The toxicity of cannabis is very low and there are no recorded cases of fatal poisoning from the substance.

Acute mental disturbances

RB Millman and A Borwine Beeder in 'Cannabis; Textbook of substance abuse treatment. The American Psychiatric Press 1994' reported information on the effects of cannabis on mental reactions affirming that these are variable and depend on dosages, the way the drug is taken, the personality of the individual, the individual's previous experiences with the drug, personal expectations and the social context in which the drug is taken.

The main symptoms can be summarised as follows: general alterations in the perception of colours, taste and sound; a flow of disconnected ideas; loquaciousness or alternatively mutism; altered perceptions of the passage of time and the sensation of having oppressive problems.

Other symptoms include, sudden and powerful mood swings; mild euphoria at times accompanied by anxiety and depressions of intensities which may vary from mild discomfort to real hysteria; psychotic disturbances, more usually persecution mania and associated anxiety, emotional instability, depersonalisation, amnesia and hallucinations; a state of delirium which presents as states of confusion, slowness of thought, visual and auditory hallucinations, paranoia, violent and bizarre behaviour, disconnected speech, and motor imbalance; and flashbacks, i.e. recurrence of the sensations and

transitory perceptions experienced under the effect of cannabis, taking the form of visual distortions and depersonalisation etc.

Acute cognitive disturbances

T. Lumdqvist of The Department of Psychiatry and Neurochemisty Lund Sweden, speaking on cognitive disfunction in cannabis users at the National SITD Congress Padua September 1996, reported observations on subjects who had been using cannabis for periods varying from six months to twenty-five years, in an investigation of the effect of such usage on numerous cognitive functions.

It is a common notion that the use of cannabis causes problems in relation to the ability to concentrate, to memory and learning but these problems had never been studied systematically.

The author shows that all of the subjects tested presented cognitive deficit, and in particular:

– they had problems in finding the exact word to express their thought;
– they were unable to get interested in common recreational and cultural activities;
– they experienced sensations of boredom and solitude;
– they were nevertheless convinced that they were perfectly well;
– they had difficulty in critically examining their own behaviour;
– they had disturbances in concentration and attention;
– they were inflexible in their ideas and opinions;
– they were unable to plan the day ahead.

The 'sense of coherence' was also attenuated, i.e. the subjective perception of having control over their own lives and planning their future.

These deficits diminish and disappear after about 60 days of abstinence from cannabis products.

The author concludes that these cognitive deficits, which frequently do not come out in common therapeutic practice, form the basis of some of the problems cannabis users have, both in the course of treatment (e.g. in the inability to create their own motivation, or ask for help), and even more so in daily life.

These results are in contrast with the popular opinion that the use of cannabis favours socialisation.

Psychomotor effects and driving vehicles

Cannabis prejudices proper psychomotor functioning, with a consequent increase in the risk of motor accidents if an intoxicated person is at the wheel of a car. Cannabis produces effects on muscle control, reaction times and the ability to complete simple and complex tasks. The consequences of these facts can be seen in real and simulated driving situations. There have been convincing demonstrations, resulting from investigations into blood THC levels, that driving while under the influence of cannabis is the cause of an increased risk of road accidents. Intuitively the loss of some inhibitions may also play a role, leading to an excessively casual atti-

tude to the task and underestimation of risks when driving. Frequently both cannabis and alcohol are used at the same time with a clearly cumulative effect of one upon the other and a greater alteration in the ability to drive.

Chronic effects

Effects at the cellular level and on the immune system

Cannabis smoke may be carcinogenic; it is mutagenic both in vivo and in vitro. In laboratory animals cannabinoids affect the cellular-mediate and humoral immune response so reducing resistance to infection. These results have not however been confirmed on human subjects and so it cannot be affirmed that the use of cannabis has a negative effect on the human immune response system. The use of cannabis in HIV infected homosexuals has not been associated with an increase in the risk of progression of AIDS.

Respiratory effects

Habitual cannabis use is associated with symptoms of chronic bronchitis such as coughing and the producing of expectorate. There is also the combined effect of cigarette smoke and cannabis causing histopathological changes in pulmonary tissue which may take pre-cancerous forms.

An increased risk in malign tumours of the respiratory and digestive paths has also been observed (in the oral cavity, pharynx and oesophagus).

Effects on the reproduction system

The administration of cannabis to animals causes a reduction in their secretion of testosterone, jeopardises the secretion of spermatozoa and anomalies in the ovulation cycle.

There is also an increased chance of giving birth to low weight babies when the pregnant woman has smoked cannabinoids as well as in increase in the risks of leukaemia, rhabdomyosarcoma and astrocytoma in babies exposed to cannabis when in the womb.

It is not known for certain whether the use of cannabis in pregnancy can induce congenital defects in the new-born child.

There is some evidence which suggests that exposure to cannabis during their life in the womb can have adverse behavioural and developmental effects in babies in their first few months after birth. Between four and nine years of age children who have been so exposed in the womb are deficient in their ability to concentrate, in memory and upper cognitive function. The clinical significance of such deficiencies is unclear as no comparative studies have been carried out with the maternal use of tobacco.

Behavioural effects in adolescence

The particular risk of cannabis use on certain groups of individuals has been emphasised on many occasions. The first among these is the adolescent group which is affected in a number of ways, notably; changes in and slow-

ing down of mental development, fall off in motivation, facilitation of the process where the use of one substance can lead to another, a fall off in the ability to work (and particularly carry out complicated tasks) and decline in educational performance.

According to Baumrind and Moselle 'the prolonged use of marijuana in young adolescents intensifies and consolidates motivational disturbance where it already exists. Habitual smoking of hashish/marijuana leads to lower adaptation levels in those individuals who had more problems and less resources to start off with.

As far as going on from cannabinoids to harder substances, such as heroin, is concerned, the debate is even more heated, but the data in favour of an association between the use of cannabis and future use of heroin are extremely convincing.

A great part of those using heroin had previously smoked cannabis. Furthermore, studies of cannabis users tend to show that, looking at the percentages of those who go on to use heroin, the probability of using opiates increases as the frequency of cannabis use increases. A study by O'Donnel and Clayton showed more precisely that only one person per thousand who had never used cannabis used heroin; of those who had used cannabis from 1 to 9 times in their lives the incidence of heroin use was 10 times greater, i.e. 1%; when the use of cannabis rose to from 10 to 99 times in their lifetimes the use of heroin rose to 3.7%; for those who had used marijuana from 100 to 999 times the use of heroin was at a percentage figure of 12.4% and in the case of heavy cannabis smokers, i.e. those who had used marijuana 1,000 or more times, heroin had been used by 33.2% of individuals. These data show that the number *of heroin users in a population of marijuana smokers grows as the frequency of use the latter drug grows*: the more an individual 'smokes' the greater the risk of becoming a heroin user, and one in three heavy cannabis smokers try heroin.

Other studies of large samples in Italy and America put the estimated figure of habitual cannabis smokers who come into contact with heroin at 30%. This does not mean that all of these become addicted to opiates but it does mean that they expose themselves to such a risk by taking a step in that direction.

While it cannot be affirmed that the use of cannabis is the *cause* of heroin use it can be said that cannabis use *is a serious risk factor* with respect to this.

Dependency syndrome

Animals develop tolerance to the effects of repeated doses of THC and some studies show that the cannabinoids affect the same cerebral pleasure centres as alcohol, cocaine and the opiates.

The development of a *dependency syndrome* in relation to cannabis, characterised by an inability to give up or to keep the habit under control despite an awareness of its negative effects and the desire to stop. The dependency syndrome is analogous to that for alcohol. In the USA this form of dependence is the most common form of dependence to illicit substances to be found in the general population. It is estimated that the risk of develop-

ing dependence on cannabis regards 1 in 10 of those who are sporadic smokers and 1 out of 3 who smoke on a daily basis. This risk can be approximately superimposed over that of alcohol(15%) rather than with the opiates (23%) or nicotine (32%) which have higher risk levels.

Cognitive effects

Habitual or chronic use of cannabis does not produce the severe and debilitating results which can be observed in chronic heavy alcohol drinkers, such as loss of memory and concentration and impairment of cognitive function.

There are subtle forms of cognitive impairment (of memory and concentration) which persist for as long as the chronic intoxication continues. Long term use of cannabinoids may result in an impairment of the ability to organise and assimilate complex information, and consequently influence the ability function in daily life. It is not clear if such impairment persists after the user stops smoking cannabis.

Psychosis

Large doses of THC produce confusion, amnesia, delusions, hallucinations, anxiety and agitated states. Such responses are rare and occur mainly where there is a heavy use of cannabis; in most cases the symptoms quickly disappear when the drug ceases to be taken.

People with pre-existing diseases are at risk of exacerbating these of precipitating episodes of their underlying pathology. There is an association between the use of cannabis and the development of schizophrenia and other serious psychotic disturbances.

People who have psychiatric disorders such as forms of schizophrenia or psychoses correlated to that disturbance are to be considered at risk because the use of a psychogenic substance like cannabis has the effect of exacerbating psychotic disorders in schizophrenic individuals (causing delirium, hallucinations, and symptoms of derealisation and depersonalisation). In the case of vulnerable individuals where the latent pathology has not openly manifested itself, the use of cannabis may unleash a disorder which was up to then dormant or controlled. When an individual with schizophrenic disorders takes cannabis higher dosages of ant-psychosis medication are used to control the symptoms.

Premature death

Two epidemiological studies looking at the incidence of death in relation to cannabis usage have been carried out in Sweden and the USA. The Swedish study showed a higher premature mortality rate amongst conscript soldiers who had smoked cannabis more than 50 times from the age of 18. The main causes of death were violent and accidental. The American study showed a small increase in the risk of premature death in regular cannabis smokers.

Table 2: Summary of the effects of cannabis

Acute effects:
- Anxiety and panic, especially in new smokers.
- Difficulties in concentrating, impairment of memory and motor function during use.
- An increase in the risk of accidents if the person is at the wheel of a motor vehicle while high on cannabis and especially if the cannabis has been taken in combination with alcohol.
- A raised risk of psychotic symptoms in vulnerable individuals where there is a family or personal history of psychosis.

Chronic effects:
- Chronic bronchitis and histopathological changes which may become pre-cancerous.
- A dependency syndrome characterised by an inability to stop or to control the use of cannabis.
- Impairment of memory and concentration which persists during chronic intoxication and may or may not be reversible after a prolonged period of abstinence.

Possible adverse effects:
- An increased risk of cancer of the mouth, pharynx and oesophagus; and of leukaemia in babies exposed to cannabis in the womb.
- Loss of ability to concentrate in adolescents with consequent learning problems and reduction in the cognitive capacity in adults required in the carrying out tasks requiring special skill.

Groups which are most at risk:
- Adolescents with a history of poor academic performance are at greatest risk of using other illicit drugs and becoming dependent on cannabis.
- Women who use cannabis in pregnancy may give birth to low weight babies.
- Individuals with asthma, bronchitis, emphysema, schizophrenia or with a history of alcohol or other drug abuse may worsen their state of health by smoking cannabis.

The principle problems in the issue of legalisation

The supposed repercussions and consequences of legalisation on the illegal market and suppression of the underworld profiteer organisations should be considered very carefully. Quite apart from any ethical considerations a whole series of health and social problems would have to be solved if such a choice were to be made.

The principal problems may be summarised as follows:

1) Incompatibility with article 32 of the Constitution which sees the state as responsible for the health of its citizens as well as promoting good health and healthy lifestyles.
   There can be no doubt that taking the above position would mean increasing access to substances which are may be abused.
   In health terms, making the use of harmful substances more available and legalising their use, would also mean, for example, legalising the current illicit use in factories and exposing workers to products which are harmful to mental and physical health. All this in the name of combating the black market by liberalising their use and leaving the choices to the individual worker or employer.

2) Which substances, and on the basis of which criteria, may be considered the 'open to legalisation'. In other words is it possible to make a classification of the substances' pathogenic potentials, (biological, psychological and social), on the basis of their pharmacokinetic and pharmacodynamic characteristics and possible patterns of abuse and consequent social and health consequences for every single individual? What would be the cut-off point where the dangerousness of the substance means it should be banned?
   In assessing such questions account must be made of the extremely varied individual responses there may be to the substances and the psychological and social consequences which may result.

3) What would be the repercussions on laws regarding personal licences etc. such as the driving licence, licence to carry firearms, certificates of fitness to work in particular jobs, and so on?
   Would a person who lawfully, under such legislation, uses a substance (even occasionally) be able to hold the above licences etc., and if not what criteria and safeguards would there be?

4) What health and social safeguards would be put in place to protect the mental and physical health of those young people who, due to social conditions, psychological problems or neurobiological predisposition, are at greater risk of abusing the substances and developing dependence, particularly when the drugs become more readily and freely available?
   The correlation between Behavioural disorder in youth and Anti-social Personality Disturbance (according to DSM IV) as important predisposing factors are well documented. T.J. Crowley's interesting survey showed how these predisposing factors to the use of drugs are present in 3-5% of the young population and that there are also many other risk factors present which could bring the group at risk, in the adolescent age bands, up to as much as 10%. Studies have shown that these groups are at very high risk of developing dependency on substance abuse in adolescence.

5) When the use of psychoactive substances capable of interfering with the judgement, ability to 'intend and will', the neurocognitive functions and the performance of an individual is legalised, the problem arises of how to define the legal capacity and responsibility of the person if he has to

respond for this actions, exercise his rights or carry out his duties while under the effect of these 'legitimate substances' or while suffering from withdrawal symptoms or in an overdose state. These questions apply and are complicated by whether the individual is temporarily or chronically under the influence of the drug or is seriously or slightly affected, depending on its pharmacodynamics and the variability of individual reaction to the substance.
Can we legitimise the use of the substances and their behavioural consequences and thus implicitly accept that the consequences of this behaviour are to be 'justified' or 'tolerated' in some way?

6) How could the doctor, charged with safeguarding the health of his patients, get round the confusing and contradictory message being received by patients from a government legitimising the use of substances which are harmful to health?

These are the main doubts which we feel require answers before embarking on a programme of legalisation or even liberalisation which, we repeat, would have to take account of health consequences in the broad sense.

The role of the health care worker: a question of awareness and conscience

In the light of all of the above, and on the questions of preventive health, the general attitude towards drugs and information programmes to the public (whether we are talking about 'soft' or 'hard' drugs, tobacco and alcohol included), it is essential to clarify the preventive role which health care workers have to carry out in a variety of contexts in relation to the problem.

We feel at this point that it is absolutely necessary to distinguish and define the roles of the government, and health care workers and doctors. The former has the task of putting into effect policies and programmes to protect society and individual health, along with the necessary controls and legislation required for maintaining the cultural and social fabric.

The latter, on the other hand, may not use coercive or repressive methods but must educate its patients to be responsible and aware in relation to the need and opportunity of behaving in particular ways in order to promote their own health.

All this needs to take place in climate of mutual trust which we could call a 'therapeutic alliance'.

It is essential to remain free from preconceptions and superficial attitudes when considering the dangers of drugs. This includes always keeping in mind (and explaining to users) what scientific research has drawn to our attention on many occasions, i.e. that the harmfulness and dangers always present in the various substances open to abuse exist on three levels, namely biological, psychological and social.

We feel that it is necessary to progress beyond the simplistic positions of 'legalise – don't legalise', 'soft drugs – hard drugs' and 'more tolerance towards biologically less harmful drugs' etc.

Those who work in the health and social services must remind themselves that their prime function, and duty, is promoting and safeguarding the health of people. This goes deeper than any political, ideological or re-

ligious positions and is supported by the Italian constitution and the World Health Organisation.

In other words their duty is to work, on the basis of awareness of conscience, for the well-being of those in their charge.

It is clear, in this regard, that the role and function of those working in the field of drug addiction, must be at all times coherent with these fundamental and irrevocable principles which they are mandated by the state to put into practice, i.e. to promote and safeguard public health in the awareness that the war is against drug addition and not the drug addict.

In particular the doctor cannot absolve himself from responsibility in his role as 'public health carer,' since the state has charged him with the task of promoting, safeguarding and protecting the health of its citizens. Firstly, therefore, the doctor is called upon to promote responsibility among potential users of substances by supplying information which is based neither on some reductive 'unreasoned prohibition' or 'irresponsible liberalisation', but which is aimed at stimulating the conscious adoption of preventive behaviour with the primary aim being that of explaining clearly the need not to abuse substances.

The information supplied to the patient should be emptied of any moral content which may only serve to engender a response running counter to the social and health aims which are the purpose the information.

Conclusions

Over the centuries substances have certainly played a part in the culture and history of many peoples and especially as used in religious rituals. This cannot however be used today as justification for the liberalisation of substances. Never in the past has there been a real market in drugs as there is now, a market which has precious little to do with mystical quests, intellectual liberty or ethical or cultural models and everything to do with profit at all costs. Aside from any cultural or social value which might be attributed to a social rule which 'legalises' the chance to freely stimulate one's brain with toxic psychoactive substances, (capable of causing harm to mental health and ability to engage in interpersonal relations), it is unacceptable to us for the state to give its stamp of approval, through legislation, to a wilful underestimation of the damage to personal health and to society of the use of these substances.

We are therefore unable to embrace the principle of legalisation, still less that of liberalisation, and would hope for different approaches to sanctions against those who use substances or commit crimes related to substance use, (excluding dealing and trafficking). Any such sanctions should be aimed at educating the user or engaging him in socially useful work rather than locking him in prison. Emphasis finally must be given to the dissemination of information which systematically explains the harm which can be caused by drug abuse in an effort to finally counterbalance the ambiguity and confusion surrounding the disinformation which has created such fertile ground in recent years for the trade in drugs.

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BEYOND DAMAGE LIMITATION: A NEW VIEW POINT FOR THE THIRD MILLENNIUM

Beyond damage limitation: a new view point for the third millennium

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Over the past few years the Veneto Region has set up programmes and policies taking in a global view of the situation and tackling a whole range of problems related to drug addiction, from prevention to primary care and rehabilitation. This pursuit of affective preventive action, treatment and rehab must be vigorously kept up by all parts of the community with the aim of dealing both the use of drugs and the sickness and social problems related to dependency.

There can be no doubt that the prevention of the health and social problems arising from the use of drugs is a fundamental priority, but it should not be the only aspect to consider when organising our actions, treatment and rehabilitation.

In our opinion it is too limiting just to concentrate on a single aspect of the work required to help drug addicts and their families.

It is reductive and misplaced to place the emphasis of our programmes so markedly on this question without addressing the individuality of the person, his or her dignity and the need to give back life and hope to someone who, enslaved by his own behaviour, has lost his direction and freedom.

Nobody could deny the importance of the avoidance of deadly infections like HIV and viral hepatitis, and we all seek, as far as it is possible, to prevent people from overdosing, turning to a life of crime or to prostitution. These aims must be constantly pursued by the Ser.T workers and therapeutic communities as primary duties, correlated to their care work, but at the same time being seen as a continuous offer to guide addicts along a path of high level rehabilitation aimed at getting to the root of the problem, avoiding the passive acceptance of dependence which serves only to rob the individual of his nobility and pride.

The Veneto Region has thus gone beyond the obsolete and politically exploited notion of damage limitation, with its global approach and scientifically based programmes which respect the individual and are aimed at harnessing the resources and dignity of that individual as a whole person.

Drug dependency has to be viewed as a real 'illness' with serious psychological and social repercussions which have to be addressed by acting on a number of different levels and through customised programmes while never losing sight of the final objective of getting people to completely stop using drugs in as short a time as possible.

A damage limitation philosophy of passive acceptance of the continuous abuse of drugs as a kind of "norm" is simply not acceptable.

We are also aware that nothing can be done for an addict who is dead, it is too late for rehabilitation, and the idea that you first have to 'hit the bottom' to start climbing out is completely false and such an attitude can only cost lives. The 'damage limitation' philosophy is equally unacceptable in that it implicitly condemns the addict to accepting their situation as ongoing and permanent, thus killing (among other things) the hope and dignity which are most dear and important to the person in difficulty.

So we have to go beyond mere damage limitation while keeping well in mind that it is necessary to adopt a new attitude towards drugs and one which is different from the current stereotyped attitudes which impede the achievement of culturally and socially more positive positions.

The general attitude to take towards drugs when giving information or intervening in the community must thus be characterised by freedom from preconceptions and superficiality with regard to the dangerousness or harmlessness of drugs. We need at all time to act on the basis of what the scientific evidence tells us and that is that the harmfulness of the various abused substances operates on three levels, i.e. biologically, psychologically and socially.

We have to get past the old debates involving "prohibition versus anti-prohibition", "soft drugs and hard drugs", "more tolerance towards biologically less harmful drugs, etc.", in order to promote and protect public health over and above considerations of politics, ideology or religion as indeed is envisaged by the Italian constitution and the World Health Organisation.

We have therefore, without false concepts or hypocracy, recognise and spread the word about the harmfulness of drugs and generally substances which are subject to abuse, cause dependence or have mind altering effects to such a point as to prejudice the psychological functioning and social and relational abilities of the individual.

It should also be made quite clear that there are no "harmless" or "fairly safe" drugs whose use is "tolerable", because even if this is open to debate on a purely neurobiological point of view it is not open to discussion from a social and bio-ethical viewpoint insofar as the use the individual makes of the drug and his own unpredictable level of vulnerability add dangerous variables to the situation. The importance of not underestimating this is above all very much in the interests of more vulnerable adolescents who may also be underprivileged and more exposed to developing dependency. These people are primarily minors and often disoriented by personal problems of an existential nature and it is precisely such young people who most frequently seek out and get hooked on the stimulating or euphoric effects, or the tranquillising 'downer' effect of the various psychoactive substances. It is very difficult for these people to engage in the so-called "controlled use of drugs". These same individuals may be particularly vulnerable and must therefore find proper protection from their own state in a society which is offering and adopting cultural models which are centred on the promotion of good health.

Finally we maintain that, as well as the individuals at risk, all those people who take psychoactive substances in harmful ways, non-therapeutically

or involving risk, as well as their families, have the right to support, accessible and early treatment and care (while ensuring their free choice of the place and type of care), which is aimed at the rehabilitation of the person through the voluntary giving up of the use of the substance and his return to a dignified and independent lifestyle.

Venice, February 1999

Translation by: *William George*

Attachments

Framing of a European proposal on drugs

Presentation

We have thought it important to also include in this volume a preliminary proposal for a document which could be useful for the framing of a European proposal from an Italian group which is collaborating with a number of European experts.

We would like to thank Dr. Franco Marcomini for his collaboration in occupying himself with the English translation of this part.

The hope is that all those who dedicate themselves to these matters find here an opportunity to debate and discuss the problems together in an effort to come up with joint proposals to tackle as effectively as possible the very serious problem of drug dependency.

Giovanni Serpelloni

Introduction

This document is the proposal of a small group of people belonging to the working group, to which the results will be soon presented.

The small group includes: Valentino Patussi, Università di Firenze-Istituto Andrea Devoto; Franco Marcomini, Commissione Sanità ANCI Veneto; Vanna Cerrato, Comune di Porto Viro (RO); Tiziana Codenotti, Ass. EUROCARE Italia. This group has been supported by the City of Padova, in particular by Assessori Giovanni Santone e Anna Milvia Boselli, and by Fortunato Rao, Head of the Department of Social Services . Also ANCI Veneto, in particular the President of Health Commission Vincenzo Melone, has supported the group.

The idea to produce such document came out in Berlin during the MCAP on Drugs in April 97, where ANCI Veneto made the proposal of a document on drugs to be presented to the Italian regional and national institutions. The document should be the basis of discussion among the Member States of the European Region of World Health Organization.

This draft document was also discussed during the MCAP on Drugs meeting held in Padova in December 98. The European experts attending the meeting gave useful indications and suggestions which will be discussed with the Italian working group in the next meetings.

Finally, it is necessary to underline that this is not a document by WHO - Regional Office for Europe. This international organization provides technical support and encourages the Italian initiative.

Ethical principles

1. **All people, of any age, sex, ethnic race, culture and nationality have the right to live in an environment which protect them from the negative consequences of the use of illicit drugs and of the illicit use of licit psychoactive drugs.**

This statement is based on the following premises:

a) Each community must have a clear plan for the prevention and for health promotion in relation to the use of drugs.

b) Each citizen that uses drugs legally or illegally has the right to access to ordinary health care services including primary health care, specialised and hospital care.

c) There must be no specific procedures for ordinary services, because this might promote a form of unacceptable alienation.

d) Whenever a citizen requires specific interventions created for his or her need to suspend the use of drugs, such as:
   - pharmacological interventions
   - residence in therapeutic communities
   - day-care centres
   - social interventions
   - these must be guaranteed in terms of quality and must not coincide with the creation of specific services, but instead they should be inserted within the context of ordinary programs.

e) The satisfaction of the needs of drug users must not create privileges within the world of individuals who live with social, cultural and economic disadvantages. In this context, the substance abusers who live in particularly difficult social conditions must be included in general programs against social alienation and the struggle against poverty.

f) The programs for health promotion and protection must refer to the principles contained in:
   - the Alma Alta declaration
   - the Health for All by the Year 2000 principles
   - the Ottawa Charter
   - the Adelaide Conference
   - the Copenhagen Declaration
   - the Healthy Cities Project
   - the principles of health promotion in prisons, hospitals, schools and workplaces
   - the Jakarta declaration
   - the Athens declaration.

g) A balance must be found between the policies of harm reduction, demand reduction and the policies that affect the supply system.

h) It is necessary to be coherent with the principles stated in the Charter on Alcohol and the Charter on Tobacco.

i) The citizen's health care programs must respect the Universal Declaration of Human Rights.

j) All the programs must be structured for greater and more efficient co-operation at the international level through the creation of co-operation networks.

k) The characteristics of each individual must be interpreted in the light of his or her most important relationships, whether these regard the fam-

ily, society or the community.

h) All the programs must be founded on the principle of subsidiarity and of intersectorial co-operation.

2. ALL CHILDREN AND ADOLESCENTS MUST BE PROTECTED FROM A CONTEXT WHICH MIGHT BE SUGGESTIVE FOR THE USE OF DRUGS, AND ALSO FROM THE NEGATIVE CONSEQUENCES OF THE ADULTS' USE OF DRUGS.

a) The protection against the use of drugs must be extended throughout each phase of growth and begin from the moment of creation of the embryo. In this sense, all the health care services for the protection of pregnant women must include screening and educational programs for the protection of future children and mothers.

b) The pediatricians must be made aware of the need to refrain from prescribing the use of psychoactive drugs that alter the moods of children for any other reason than a precise diagnostic and therapeutic purpose.

c) In the areas where children are hosted, such as: child care centres, nursery schools, elementary and middle schools, children must be provided with an education that is capable of preventing their future use of drugs, and in particular those behaviours that accompany the use of drugs, such as:
   - the reliance on pharmaceutical products to solve physiological existential problems;
   - behaviours that encourage excessive competition and violence;
   - behaviours that lead to social isolation and reduce the levels of solidarity.

d) The mass media and television programs that are explicitly oriented to children must not transmit messages that directly or indirectly promote the use of drugs.

e) For the benefit of children who live in families in which substance abuse has been ascertained, an objective diagnostic process regarding the parental capability of the parents must be begun and every means that can be adopted must be applied to encourage the participation of both parents and children alike in alternative educational programs. In any case, the period of exposure of the children to the risk factors must not be excessively prolonged, and a network of families must be created for temporary custody or adoption in order to avoid every form of institutionalisation.

f) Surveillance must be increased in the areas where children play in order to eliminate or hinder the supply of drugs.

g) Children must be given the opportunity to compare the information on the effects of the use of drugs that they perceive indirectly from their real-life surroundings with scientific knowledge on the subject. This must be performed through a dialogue that takes the psychological characteristics of the child into consideration and not merely through the presentation of scientific information.

h) Each city must prepare urban safety programs that permit children freely meet informally without risk.

i) Children must also be protected from the involuntary ingestion of psy-

choactive drugs through the education of the adults and a precise definition of responsibility.

j) Children born under the effects of drugs must be provided with a detoxification and psychological observation program.

In addition to the interventions above described, every prevention effort must be taken in the adolescent age in order to avoid dispersing the resources in information-only programs, and particular attention must be given to the following aspects:

- types of behaviour that are directly or indirectly related to the use of drugs, and extra attention must be given to the use of legal drugs, alcohol and tobacco during adolescence;
- approaches and attitudes that may in some way encourage the use of drugs or oppose the use of drugs;
- ability: in this case, the child must learn to solve his or her own problems using his or her own ability and learn to accept the failure to achieve success as an inevitable part of the growth and maturity of a person and not as a tragedy.
- knowledge and awareness: these must always be measured on the basis of the knowledge or awareness existing in the child at the start of the process.

3. FAMILIES AND THE NETWORK OF FAMILIAR RELATIONSHIPS WITHIN THE LOCAL COMMUNITY ARE THE MOST SIGNIFICANT EDUCATIONAL CONTEXTES FOR BOTH THE PREVENTION AND THE MANAGEMENT OF DRUG-RELATED PROBLEMS.

a) The family is the first social medium in which the child grows, receives the emotional input for growth and maturity, encounters significant models of behaviour, and is provided with attitudes and skills for the first time.

b) The family is also the party that must deal with the consequences linked to the use of drugs and in particular must often take part in the long process of rehabilitation in which it plays an important role in effecting the subsequent change in lifestyle.

c) The family is also the unit in which children first witness and experiment with behaviour models for the reduction of states of anxiety and the regulation of circadian rhythms that adults manage with the use of psychoactive substances.

d) The family is also the place where the behaviour patterns most accepted by society, such as the use of alcohol and tobacco, are encountered that may serve in the formation of a cultural matrix or role modelling.

e) The family must be provided with support in its educational role, and specific training courses must be organised for families.

f) The family can also serve as a place of welcome for children who suffer solitude due to the use of drugs by their own parents. In such cases, programs must be created that encourage the processes of adoption and temporary custody.

g) Problems related to the use of drugs often lead to the creation of economic problems for the family. Tax reduction programs must be defined and implemented for families who choose to participate in rehabilitation programs and make economic contributions of their own for such purpose.
h) The family must also be offered a direct management program for the rehabilitation services through the presentation of a budget drafted for access to certified and accredited services in order to avoid all forms of merely economic support.
i) A specific program must also be prepared for single parent families, especially if the head of the family continues to use drugs but demonstrates the ability to continue functioning as a parent. The offer of services in this case must be accompanied by a precise evaluation process.
l) Co-operation between families with drug problems must be encouraged by placing these relationships in the dimension of co-operation associated with activities by other citizens rather than self-help associations extraneous to the community. Forms of co-operation with other families in the community in the context of a health promotion program in the field of primary assistance must also be provided.

4. LIVING AND WORKING CONTEXTS MUST BE PROTECTED FROM THE CONSEQUENCES OF THE USE OF LICIT AN ILLICIT DRUGS.

a) Screening systems with the following characteristics must be provided in living and working contexts in order to improve the quality of the health promotion processes:
   • complete respect for privacy and the confidentiality of all data;
   • finalisation for the protection of health.
b) General information must be offered on the consequences of drug use and specific information must be provided in regard to the given social context.
c) Counselling service must be offered for all those who desire assistance.
d) Safety regulations must be established that prohibit the use of drugs whenever dangerous types of work must be performed.
e) A relationship with the primary heath care system, the specialised and hospital services, and the social workers must be established in order to create continuity in the assistance offered that begins in the following living and working contexts:
   • work areas
   • hospitals
   • the services systems associated with both the primary and the specialised assistance systems
   • prisons
   • schools
   • transport systems
   • entertainment establishments
   • cultural associations
   • sports associations

- volunteer associations
- the army
- the police
- the political world
- the justice system
- the religious world
- where specific programs must be identified for personnel or members that perform management or leadership functions. They should have the purpose of:
- clarifying their own attitudes in regard to drug use;
- clarifying their own behaviour;
- admitting their own problems, where it is the case, and dealing with them.

f) An assessment system for the programs offered must be introduced.
g) Forms of intersectorial co-operation between various agencies and their reference contexts must be commenced.
h) Specific educational and sensibilization material for each agency and context must be produced.
i) A training process capable of preparing operators for the health promotion programs must be started in order to eliminate the need for the services of professionals.

5. LOCAL COMMUNITIERS, REGIONS AND STATES MUST PROTECT THEIR CITIZENS FROM THE CONSEQUENCES OF CULTURAL AND COMMERCIAL MESSAGES WHICH ENCOURAGE, PROMOTE OR INDUCE, DIRECTLY OR INDIRECTLY, THE USE OF DRUGS OR THOSE BEHAVIOURS USUALLY CONNECTED TO THE USE OF DRUGS.

a) One should recognize that the behaviours related to the use of drugs, beyond the negative consequences, are embedded in the existing general, health and social culture:
- to alter the people' mood with pharmaceutical products is very common;
- to take risks is very common among adolescents, and it is often related also to the adults' behaviour;
- to use pharmaceutical products to get better performances or to alter his or her appearance is very common among adolescents and adults;
- to prescribe medicines to solve existential problems is quite common among doctors.

b) One should also recognize that cultural models which emphasize competitions and challenges indirectly are cultural elements that favour behaviours related to the use of drugs.
c) The behaviours of some successful and popular people who use drugs can be copied.
d) Some advertising messages which alter reality actually produce phychological conditions which induce the use of drugs. This is particularly true for alcohol, where there are implicit messages to alter reality.
e) It is necessary to identify indicators of behavioural risk and social dan-

ger in the cities.

f) It is also necessary to provide educational programmes which should include not only information on drugs, but also interventions on the behaviours.
g) Protection programs for general population in regard to risky behaviour must be created.
h) Measures for the containment of risky behaviour must be adopted.
i) The leading causes of risky behaviour and the respective safety measures must be identified.
j) An evaluation system for the modification of the social matrix of risky behaviour must be prepared.

Strategies

The principles indicated above represent an ethical basis without counter-productive moralism for the establishment of an articulated strategy for plans of action that represents the political and scientific basis for the construction of a European drug abuse prevention plan. This plan must be based upon the clarification of the following aspects:

1. ***The active participation of the citizens in the preparation and management of the plans for action***: this initial aspect means that it is the citizens who must consciously make decisions in regard to their own behaviour and the self-promotion and protection of the health processes required without delegating such choices to the social and health services or relying exclusively on national legislation.

2. ***The application of the principle of subsidiarity***: this means that each plan for action must respect the levels of planning and management that start from the grass-roots level (bottom line approach) and position within the local communities both the forms of self-management and the compatibility and coherence of the same with the services offered. In addition to this subsidiarity that may be referred to as being "horizontal", the need for a "vertical" subsidisation that is capable articulating the planning process in accordance with the points below must also be acknowledged:
   - the local municipality, town or city: by drawing inspiration also from the principles expressed in the Healthy Cities Project, these authorities must prepare plans for action that are coherent with both the resources available and the local needs identified and that possess the characteristics of intersectorial co-operation, the establishment of the values of equality and social justice in the local community through the community programs, the development of the primary assistance system, and the involvement of the local population as the foundation of every program.
   - The regional, national and European government levels introduce guidelines that ensure homogenous levels of assistance throughout the European territory in complete respect of the characteristics of local autonomy.

3. ***Intersectorial and inter-institional co-operation***: the use of drugs is essentially a form of behaviour that may be accompanied by negative consequences at the levels of health, society, economy and education. The tendency in the past few years has been to restrict the use of drugs specifically to the field of health and this is an error that must be corrected. The problem of drug use must be defined at the level of policy and not at the moment of delivery of services, and it is not possible that one single problem, however significant, should require the regulation of such a complex pattern of behaviour.

4. ***The balance between the policies of the reduction of demand and the limitation of damage and interventions on the supply system***: in this case as well, the first step is to acknowledge the levels of complexity inherent in drug abuse. Any solution that is limited to just one single aspect of the problem is entirely insufficient, and all the more so if it is burdened by ideological slant.

5. ***The passage from the traditional distinction between primary, secondary, and tertiary prevention to a wider concept of health promotion***: this passage means establishing a continuity between the use of drugs, cultural matrix and the respective patterns of behaviour in order to prevent the phenomena of stigmatisation and alienation.

6. ***The production of specific programs for specific areas***:
   - schools for the promotion of health
   - work places for the promotion of health
   - transport systems and the promotion of health
   - hospitals for the promotion of health
   - prisons for the promotion of health
   - entertainment establishments and the promotion of health

   In these cases, programs characterised by the specific contexts must be defined in which the concepts of health promotion are applied by identifying the patterns of behaviour and attitude involved in drug abuse or the prevention of the same that can be applied in programs for the changing of user life styles.

7. ***The definition of a system of indicators***: which must be capable of measuring the complexity of the variables in play and must have both qualitative and quantitative values, and must be placed in relationship with the institutional data at both the local and European levels.

8. ***Co-operation at all levels through the creation of co-operation networks***: in addition to encouraging the exchange of experience, this co-operative approach can provide the scientific basis founded on sharing for the identification of the objectives to be submitted to the evaluation process, which must be applied to both the process and the result.

9. ***The re-orientation of the services system***: the planning of the system on the basis of needs instead of services as indicated in many national health programs must achieve an organisational flexibility re-oriented as

follows:
- the appropriate use of admittance structures, which must be divided into interventions for specific conditions and those for rehabilitation purposes. In any case, there must be a quality certification process;
- a primary assistance system that must be organised on the basis of population areas of 100,000 inhabitants (health action zones);
- a specialised services system based on the complications that arise in drug abuse, and not on specific services for drug abuse.

The passage must be made from the definition of services to the identification of programs.

10. ***Collaboration between the public and private sectors***: this dichotomy must be overcome, given that the important thing is the respect of homogenous quality standards, and the only aspect that must be entirely entrusted to the public sector is the supervision of the health care that each services system must provide.

Translation by: *Franco Marconcini*

DRUG USE

WHO GETS HURT?

1) YOUR NERVE CELLS AND YOUR BODY
- Because it has been proven that direct damage increases with long term use
- Because you could develop physical dependence

2) YOUR MIND
- Because physiological changes take place
- Because you may stop feeling 'normal' without the effects of the drugs and become psychologically dependent

3) YOUR POCKET
- Because it's expensive

4) YOUR SELF-ESTEEM
- Because you could have to do undignified things to get hold of drugs and lie to people who care about you

5) THOSE AROUND YOU
- Because it diminishes your control and ability to drive safely
- Because certain sensitive individuals with poor self-control may decide to copy you and develop serious dependence

6) THE COMMUNITY
- Because with this behaviour lifestyles are accepted which do nothing to encourage or protect health and your behaviour may induce others to use drugs too.
- Because you could become physically addicted

7) YOUR IMAGE
- Because as a drug user you are no longer reliable and you could also get into serious trouble with the law

8) YOUR FREEDOM
- Because it is much easier to develop dependency than you might imagine

9) YOUR MOBILITY
- Because the law takes away the driving licences of those who use drugs

10) YOUR CHANCES OF BEING A SUCCESS
- Because you could become an outcast and get discriminated against
- Because you could be regarded with suspicion and considered unreliable

From: G. Serpelloni, O. Hunter - Addiction Communication Report -1998 -WBF.UK

Tanslation by: William George

DRUG USE

WHO BENEFITS?

1) THE PUSHERS AND THE RACKETEERS
- Because they get rich off you

2) THOSE WHO WANT TO MANIPULATE YOU
- Because they get you to do what they want, trampling on your rights

3) ALL THOSE WHO THINK FOOLISHY THAT TO HAVE A GOOD TIME OR FEEL GOOD IN YOURSELF OR WITH OTHERS YOU HAVE TO POISON YOUR BRAIN WITH CHEMICALS
- Because they have lost touch with reality

4) CERTAIN POLITICIANS
- Because those who take drugs do not claim their rights so much and in any case are not considered worthy of being listened to.

5) LOAN SHARKS
- Because they make a fortune out of people who need cash

6) ALL THOSE WHO TAKE ADVANTAGE OF PEOPLE'S WEAKNESSES AND NEEDS

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Prevention and Drugs

(Information for health workers)

NOT ALL ADOLESCENTS WHO SMOKE THEIR FIRST JOINT HAVE:

THE SAME NEUROBIOLOGICAL MAKE UP

Some people are genetically and biologically more sensitive and so more vulnerable

THE SAME FAMILY SUPPORT

Some families have problems and may have little money and a poor educational background

THE SAME SOCIAL CONDITIONS

Some environments are particularly stressful and create fertile ground for drug abuse

THE SAME PSYCHOLOGICAL MAKE UP

Some people have psychological disturbances, which do not depend on them, and which make them more vulnerable to drugs

WE DO NOT ALL HAVE THE NECESSARY DEFENCES FOR 'CONTROLLED' DRUG USE

SOME ADOLESCENTS ARE AT HIGHER RISK THAN OTHERS OF DEVELOPING DEPENDENCE AND THEY MUST BE RESPECTED AND ABOVE ALL PROTECTED

ABSTINENCE FROM SUBSTANCES IS THE BEST FORM OF PREVENTION

From: G. Serpelloni, O. Hunter - Addiction Communication Report -1998 -WBF.UK

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Note

Note