Reducing Drug Usage and Drug Overdoses in Italy

APPLIED POLICY PROJECT

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Disclaimer: The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy at the University of Virginia. The paper was submitted pursuant to the requirements of the M.P.P degree course requirements. The conclusions are solely those of the author, and do not represent the conclusions nor the opinions of the Batten school, the University of Virginia, or any other agency.

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Merci.

Honor Statement:
On my honor as a student, I have neither given nor received unauthorized aid on this assignment.

Signature: 

United Nations
Interregional Crime and Justice
Research Institute

In honor of my parents Habib and Olfa Benamor.

Tous ce que je fais, est pour vous.

List of Acronyms, Abbreviations and translated terms

Harm Reduction International **(HRI)**
Sewage Analysis Core Group Europe **(SCORE)**
European School Survey Project on Alcohol and other Drug **(ESPAD)**
European Monitoring Centre for Drugs and Drug Addiction **(EMCDDA)**
United Nations Office Drugs and Crime (**UNODC)**
United Nations Interregional Crime and Justice Research Institute **(UNICRI)**
Caribinieri : **Italian Military Police**
MS5: **5 Star movement political party**
Naloxone **: Opiod antagonist**
Methadone: **Heroin Substitute**
Haxixe: **Hashish (cannabis)**
Drug Related Deaths (**DRD)**
Institute on Drugs and Drug Addiction (**IDT)**
Situacao do Pais em Materia de Drogas: Situation of the Country for Drugs (**SICAD)**

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Executive Summary

Italy faces heightening drug usage and deaths from drug overdoses as per analysis from the *Sewage Analysis Core Group Europe (SCORE)* and *Harm Reduction International (HRI).* Based on the study's analysis, the level of drug-associated stimulants found in municipal wastewater has increased since 2015. In the *HRI* report, as much as 11.9% of 15 to 19-year-olds have used hallucinogens and cannabinoids as of 2019 (Ronconi, Stagnitta, Fornero, 2019). In Europe, the prevalence rate of problem drug users normally varies from 2-9 per 1000 people aged 15-64. Italy has one of the highest rates, with around 8.5-9.2 people per thousand being a 'problematic drug users', meaning they have used drugs such as MDMA, Cocaine, heroin, or Amphetamines in the past 30 days. The increasing rates of drug usage and drug overdose is becoming increasingly problematic because it is not only hurting the Italian population, but negatively affecting the Italian economy, Italian society, and the overall health of the country.

The UNODC found in a 2008 study conducted in Europe that an estimated 29.5 million people, or around 5% of the general population aged 15-64, used cannabis in the previous year. In Italy however, 14.6% of Italians reported having used it in the previous year which is around 5.5 million users (UNODC, 2008). This rate is also increasing rapidly, with around 18% of the users using it continuously in their lifetime in 1995, to as high as 27% in 2003. (See figure 185 in Appendix) Regarding the trends of the annual prevalence of cocaine use among the population aged 15-64, Italy also ranks very highly compared to other European nations (see figure 6 in Appendix). Italy currently has a policy which mandates locking up drug dealers and users alike (Andragno, 2019).

Alternative 1: Let Present Trends Continue- Status Quo
Alternative 2: Harm Reduction, Treatment and Prevention Policy
Alternative 3: Decriminalization of Narcotics

I evaluated each policy alternative across 3 evaluative criteria. These include: cost effectiveness, longitudinal rate of drug use and drug overdose, and political feasibility. Based on this analysis, I recommend that the government of Italy enact the policy of Harm Reduction, Treatment and Prevention. This alternative is projected to decrease the longitudinal rate of drug use in Italy by around ~30-40% in the next 10 years, costing around 200-220 million euros. (UNODC). This alternative ranks highest in terms of Cost effectiveness and Longitudinal decrease in the rate of drug use and overdose. It is also projected to be politically feasible enough to pass in the Italian Parliament with proper budget planning and support garnering.

In the long- term, I also recommend that UNICRI advise the government of Italy to secure preliminary funding from the health ministry's stimulus package which was appropriated to promote anti-drug policies and create weaning supplies for treatment facilities. Furthermore, UNICRI should petition members of the Center-left coalition within parliament to draft a House budget decrying where future funding could be appropriated for in the least-costly manner, which would simultaneously promote the policy's effectiveness. Many stakeholders are concerned with costs remaining low, and any costs (social or direct) that need to be incurred need to be offset by benefits to society and reductions in drug usage and overdoses. Finally, I recommend a partnership with UNODC to follow the trends of drug usage and overdose to ensure that the Harm Reduction policy is providing the reductions in rates that are projected, and to institute or recommend amendments as deemed necessary

Problem Statement

My client is the Italian-based United Nations Interregional Crime and Justice Institute, which provides intergovernmental support to combat crime-related problems and develop broader policies for socio-economic change, particularly on drug control, terrorism and crime. Italy faces rising levels of drug usage as well as deaths from a drug overdose. Recent expense reports from the Dipartimento della Pubblica Sicurezza (Department of Public Security) state that state-funding for the Polizia di Stato (Police force) has increased by around 13% in the last 4 years to around 330,000, the highest number of agents per capita in the EU. This came after an announcement by President Mattarella in 2015 to 'address the drug issue', referencing the spike in drug usage in the last 15 years.

Like the USA, Italy has an anti-drug program stating the sale, usage, transport, and possession of narcotics is a state crime. Police forces were provided extra funding to hire more police officers to patrol the streets more effectively to help put an end to these practices. The Italian government has yet to develop a comprehensive drug policy to tackle rising drug usage which especially affects minorities and young people. The increasing rates of drug usage and drug overdose is becoming increasingly problematic because it is not only hurting the Italian population, but negatively affecting the Italian economy, Italian society, and the overall health of the country. The objective of my client is to create a policy that would effectively lower the rates of drug usage and drug overdose among Italian citizens in a politically feasible and cost effective manner. For policy to be effective in its implementation, it has to save the Italian government. Additional information about Italy's drug policy can be found in the literature review.

Introduction

Background

Culture

Drug use is rampant in the European nation of Italy. The rapid rise of Opioid and heroin use in Italy has left the country with the largest percentage of drug-related deaths in all of Western Europe (EMCDDA 2017). Health officials further purport that due to the practice of sharing needles while shooting heroin, resulting in over 150,000 Italians having been infected with AIDS and/or experiencing a drug overdose (Ronconi, 2019). The community oriented culture within Italy could attribute to the issue, it is a country where the young live with parents until marriage and seek other thrills in life that their conservative parents never allowed. This builds a culture bent around the willingness to seek thrills through illicit manners, frequently resulting in teenagers using and being hospitalized from drug use. (Wabwoba) The problem is particularly more rapacious in the industrial northern part of Italy in cities like Turin and Milan. Traffickers have pushed drug usage here because that's where many Italians moved to work in factories, resulting in "this being where the money is, and the traffickers know that". (Elena Rosci, UNODC Drug Health official from Milan, Wabwoba)

Over time, drug use has become more prominent and popular over the years in correlation with more of the population engaging in party-type lifestyles, music festivals and the rise of EDM music. This is not a cause of drug usage, but this natural cultural trend has contributed to a societal volition to accentuate these types of experiences by using drugs These types of festivities frequently advocate for partying while under the influence of illicit substances. With more clubs opening up in Italy, and tourism growing within Italian borders, drug use is very likely to also increase in a positive manner. The impact of this continuation into the future is more hospitalizations due to increased drug use, and more of a market for the drug. The problem is exacerbated with the influx of immigrants and lack of increasing job availability, forcing many immigrants to resort to the black-market sale of illicit drugs to make ends meet. This is consistent among all age groups, but we focus primarily on the 15-50y/o age group because they contribute the most to the economy, and they are most negatively affected by drug usage.

UN, UNICRI and Italian government concern

The United Nations Interregional Crime and Justice Institute has paid increasing attention to the issue given that its tenets correlate with hindering illicit substance abuse and UN mandates against drug use (UNODC). Its headquarters are also located in Turin, in northern Italy, so it is a much more personal issue for the institution. UNICRI also works closely with the United Nations Office on Drugs and Crime, based in Austria. They have tried to work together on providing the framework for ministries and police forces to conduct better policing and closer monitoring of borders to ensure the drug influx into the country is tackled as well as limit the drug use within the city. The Italian ministry of the interior also closely works with UNICRI to ensure inter-institutional measures on better policing and monitoring practices to limit drug use in Italy. Finally, the Italian Department for Anti-Drug Policies has been working as the middle man in terms of developing and implementing proactive action against drug use between UN offices in Italy and the Caribinieri (UNODC).

Furthermore, UNODC published a Statistical chart depicting the drug usage problems each EU country currently faces for individuals aged 15-64 (See graph below, UNODC). In Europe, the prevalence rate of problem drug users normally varies from 2-9 per 1000 people aged 15-64. Italy has one of the highest rates, with around 8.5-9.2 people per thousand being a 'problematic drug users', meaning they have used drugs such as MDMA, Cocaine, heroin, or Amphetamines in the past 30 days. Regarding the trends of the annual prevalence of cocaine use among the population aged 15-64, Italy also ranks very highly compared to other European nations (see figure 6 in Appendix).

The Political Debate

Politically speaking, there has been much debate around the issue. Italian courts have attempted to tackle major importers but little progress has been made. (Sede Del Ministro) Police and politicians have long been frustrated by the long debate in Parliament, legislators have failed to effectively update Italy's 1975 drug laws. The Socialist Party seeks to apply tougher punishments for drug sellers and suppliers and ban permission to hold small quantities of narcotics for personal use. Other parties, such as the Progressive party, argue that drugs must be liberalized altogether to take profits away from drug traffickers. Many conservative politicians argue that deterrents are currently ineffective since drug suppliers can earn massive profits, and only risk a couple years in jail. While conservative politicians argue for more stringent anti-drug policies, Progressives and Liberals, who work closely with Health officials, argue that addicts should be given the choice of going to jail or accepting obligatory rehabilitation.(Sede Del Ministro) There are just a few of the issues preventing parliament from producing new legislation to tackle the impending drug problem.

Market Structure

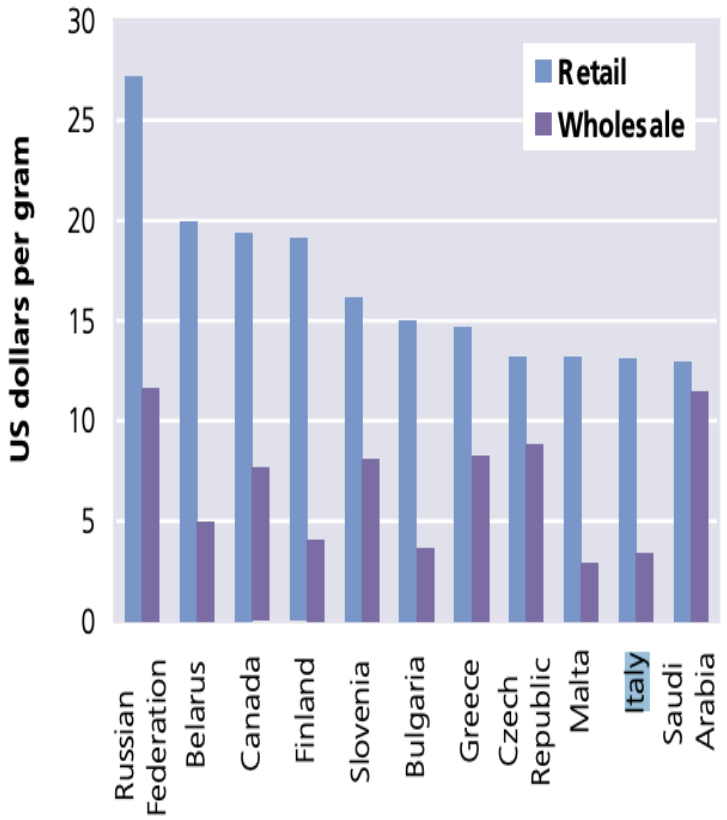
Regarding who is producing and purchasing narcotics in Italy, there are two factions. Immigrants to the country tend to be the ones who import narcotics into the country, given that most narcotics are created in South America and brought to Europe via black market channels located in West and North Africa. The immigrants who arrive in Italy are faced with the lack of job availability and turn to the black-market sale of drugs to generate revenue, frequently targeting university students and younger populations as their market. The producers (importers, rather) are the immigrant West African and North-African populations in Italy, and they target younger people between the ages of 16-23 most frequently as their market because of their susceptibility and cultural affinity for illicit substances.

One of the possible causes for an increase in drug usage, especially in younger Italians, is the prevalence and relative cheapness of drugs. Italy has one of the lowest retail and wholesale prices for drugs such as Cannabis than any other European Nation (see figure on the right, UNODC, 2008). The graph shows that cannabis resin prices are at around 3-4$ per gram wholesale, compared to around 11-13 in other European countries. This means that the drugs are easier to supply and cheaper to buy, giving the black market a stronger presence in Italy. (see Figure 23 in Appendix for how the Italian budget affected drug policy)

This is why many Italian policymakers sought to pursue decriminalization of certain narcotics, despite bipartisan opposition, as a means of pushing out the black market and centralizing the sale (wholesale & retail) of narcotics legally rather than let individuals freely purchase it for extremely low prices (UNODC ARQ, 2008). [1]

Fig. 171: High cannabis resin prices, 2008

Source: UNODC ARQ/DELTA



[1] While Cannabis is not seen as of harmful of a drug as Cocaine or as MDMA, its usage is still on the rise and it is still considered an illicit narcotic. The UNODC found in a 2008 study conducted in Europe that an estimated 29.5 million people, or around 5% of the general population aged 15-64, used cannabis in the previous year. In Italy however, 14.6% of Italians reported having used it in the previous year which is around 5.5 million users (UNODC, 2008). Similarly, for 15-16 year old's in Italy, the lifetime prevalence of cannabis use is higher than the European average. This rate is also increasing rapidly, with around 18% of the users using it continuously in their lifetime in 1995, to as high as 27% in 2003. (See figure 185 in Appendix)

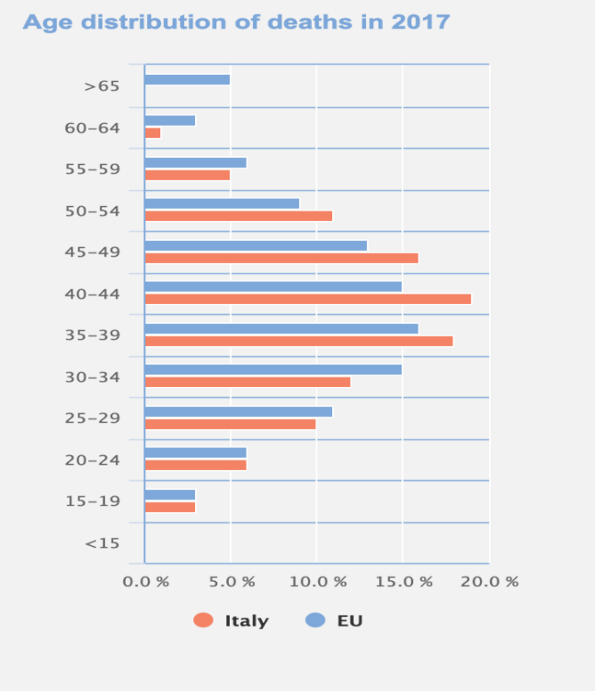
Cannabis symbolizes a gateway drug and users of Cannabis frequently end up trying and becoming subsequently addicted to other narcotics as well. The suppliers of Cannabis also end up pushing buyers to trying other narcotics, and this leads to the subsequent raise of drug usage for 'harder' drugs such as Cocaine and MDMA. For this reason, Cannabis is still placed in the same category as Cocaine, Heroin, and MDMA, this report addresses all illicit narcotics as a whole

Literature Review

Italy faces heightening drug usage and deaths from drug overdoses as per analysis from the *Sewage Analysis Core Group Europe (SCORE)* and *Harm Reduction International (HRI)*. Based on the study's analysis, the level of drug-associated stimulants found in municipal wastewater has increased since 2015. In the *HRI* report, as much as 11.9% of 15 to 19-year-olds have used hallucinogens and cannabinoids as of 2019 (Ronconi, Stagnitta, Fornero, 2019)

EMCDDA found that Italy had relatively high death rates, due to drug usage across all ages from 15-64 years old compared to other European countries, especially for the working age group from 30-54y/o (see figure 1on the right).
What is most concerning, is the fact that for the working class age between 25-54, Italy had some of the highest drug overdose rates in Europe.(EMCDDA, 2017) Italy currently has a drug policy where all drug usage, sale, transport, and possession constitutes as a federal crime.

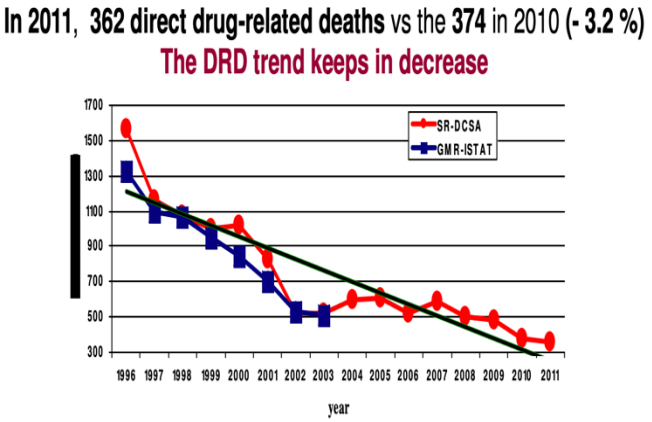
Figure 1: Age distribution of deaths



At the same time many European countries have seen their drug abuse and overdose rates fall by enacting 'harm reduction policies' (Werb, Fischer, Rafful, Wood, 2016). These drops in usage and overdose rates are associated with the implementation of a variety of policies enacted by government entities, UNODC, and Anti-Drug Justice Ministries. For example, Portugal enacted Harm Reduction policies in 2001 and UNODC followed drug usage trends in the ensuing years and determined that there a statistical correlation between the enaction of the policy and lower drug usage rates. Certain countries, such as Switzerland, treat the manufacture and sale of drugs as a federal crime, but treat usage and possession, often of amounts too small to distribute, as a health issue. Drug users are therefore regarded as victims or patients, rather than criminals (Bartlett, 2013).

Another *HRI* report published strong evidence that supports the notion that a 'harm-reduction' policy works and that it provides a cost-saving and cost-effective method to prevent drug usage and save lives (HRI, 2017). *HRI* published a report showing the effect of *Naloxone* implementation for opioid users in Italy. The cities of Milan and Vincenza were authorized to offer Naloxone as an over-the-counter medicine in all pharmacies within the city limits. The HRI report (see Figure 2 on the right, Simini, HRI, 2013 then published the results of this experiment and found that in the cities where *Naloxone* was available,

Figure 2: Naloxone effect on DRD



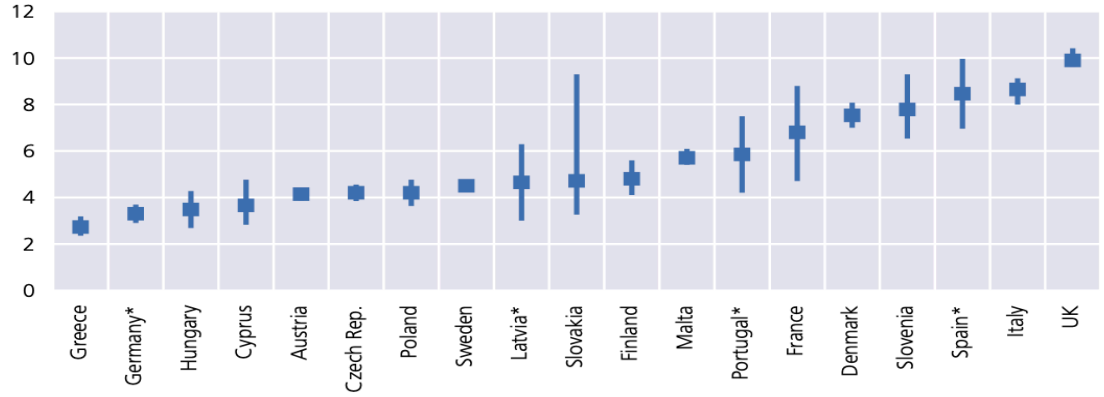
From EMCDDA based on a HRI report (2017). ISTAT and DCSA are Italian drug monitoring agencies

compared to cities where it wasn't available, the rate of drug-related deaths for opioid users dropped by around 3.2%.) This was good evidence of a causal effect because they controlled a random-sample population of people who didn't use Naloxone, and compared their DRD rates to the DRD rates of populations that used Naloxone. Despite positive results, the Italian government suspended the experiment due to lack of funding. (Campana) The results have not yet been published, but they are likely to show the same decrease in Opioid related deaths.(Campana) [2]

The figure below shows that higher drug use is reported in Western European countries, most notably in the UK, Spain and Italy.(EMCDDA)

Fig. 99: Europe: Estimates of problem drug use (rate per 1,000 population aged 15-64)*

* The methods for estimation of problem drug users differ between countries, but include capture/recapture, treatment multiplier, police multiplier, et cetera.
Source: EMCDDA, *Statistical bulletin 2009: Problem drug use population,* 2009



The EU average is listed at around 0.12% in terms of annual prevalence (per 1000 people), but in Italy it has risen from 1.1% to 2.2% in around 7 years, from 2001 to 2008 (UNODC). Italy also has the 2nd highest cocaine market in EU with around 1.02 million users in 2009 (UNODC).

A 2007 UNODC study found that in Italy, 5.5-6% per thousand 15-16 year old's had been drug users, the second highest rate in Europe. (see figure 155 in Appendix). Regarding the distribution of age, the lifetime prevalence of cocaine among 15-16 year old students in Europe was on average 3% per thousand people. (See Figure 3 'Past 30 days vs Lifetime Use from EMCDDA)[3].

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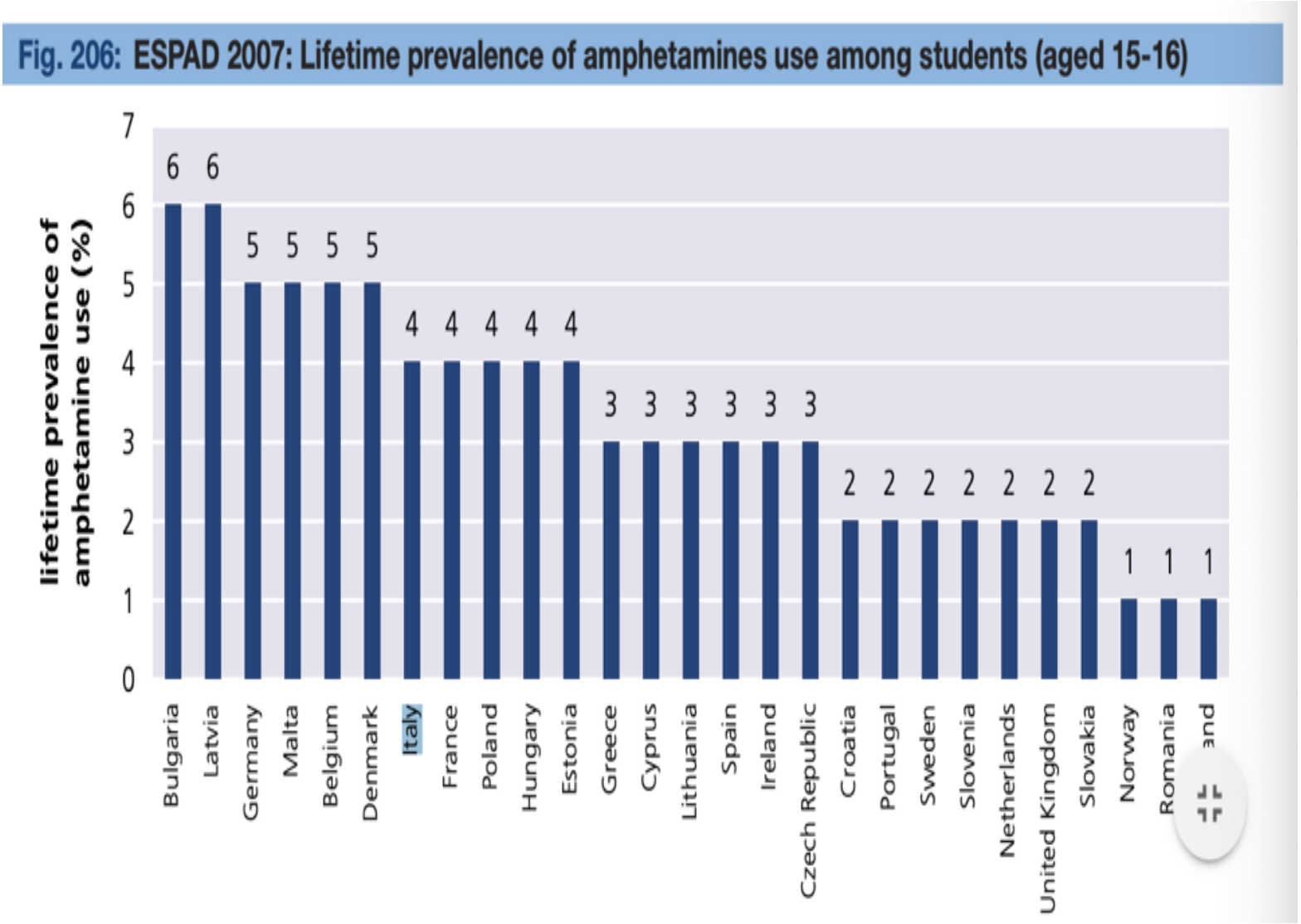
[2] The UN and EMCDDA sources are especially credible because they are derived primarily from EU institutions such as UNODC, whose sole purpose is to track and counter the increasing levels of illicit narcotics use through effective methods of surveying, data-reporting and research design. UNODC is involved in nearly all of the studies and policies implemented in these European Countries. The analysis from the UN, European public officials and European government institutions is one of the most reliable sources in terms of analysis and policy interpretation. While some studies' conclusions are drawn in a matter of years post-implementation, the graphs on *EMCDDA's EU Drug report for 2018* support a possible continuation of these results.

[3] Figure 'Past 30 days vs Lifetime Use' from EMCDDA shows several substance usage levels comparing Italian high school children versus high-schoolers from other EU countries (such as Switzerland, Norway, Germany). Italian youth use have higher rates of substance abuse than the average of nearly 35 other EU countries. Most notable is the Cannabis section, which shows 27% of Italian youth use cannabis versus the continental EU average, 15%.

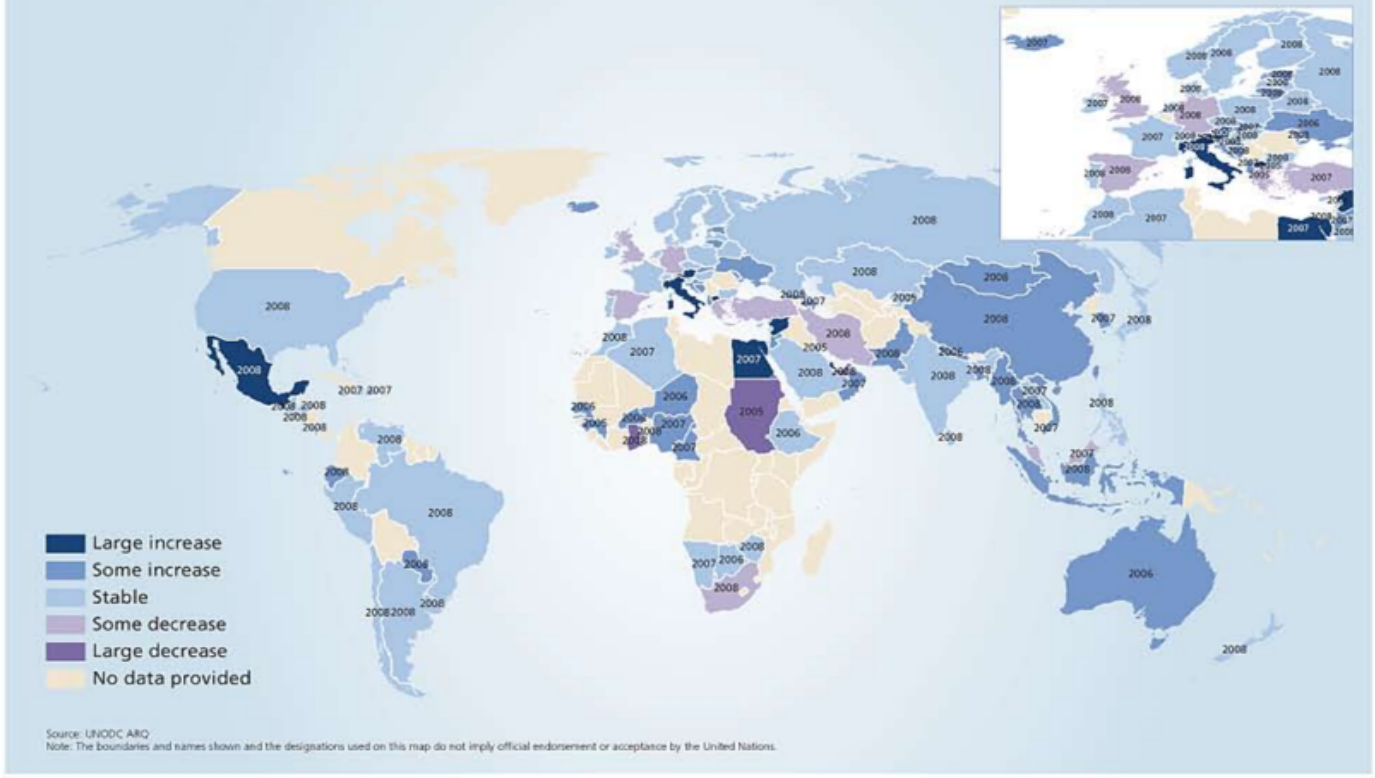
Regarding Amphetamines, 2.5-3.2 million Europeans aged 15-64 had used Amphetamines substances at least once in the past year with annual prevalence (European average) being around 0.5% of the population aged 15-64 (see figure 22 in Appendix for lifetime prevalence of drug use in Italy). The figure below from ESPAD shows that in Italy, around 4% of the population 15-16 experienced a lifetime prevalence of Amphetamine use.



This rate is high compared to other EU countries, but what is most concerning is the perception of trend changes in the use of amphetamines in 2008.

Experts from UNODC and ESPAD project that there will be a large increase in amphetamine use in the coming years compared to other EU countries, making this a long-term issue with the potential for exacerbation. (See Map 34 below, ESPAD & UNODC ARQ, 2008)

Map 34: Expert perception of trend changes in the use of amphetamines in 2008 (or latest year available)



This is especially problematic because it shows that Italy not only has a current problem with amphetamine use, but is one of the countries with the highest projections for future amphetamine use. (UNODC ARQ) This projection is the same for drugs such as Ecstasy. In an EMCDDA study from the *Annual Report 2008: the state of the drug problem in Europe, 2008,* trends were found regarding recent annual prevalence of ecstasy use among young adults. While the EU average for 15-34 year old's shows that around 0.02% of 1000 people are ecstasy users, Italy reported around 0.3% per 1000 people as ecstasy users in 2001. (see figure 219 in Appendix, EMCDDA) That number then tripled to 0.9% per 1000 people in 2009, which led to projections of a large increase of the drug's use in the coming years. (EMCDDA)[4]

[4] The quality of this data is strong because UNODC consistently collects data from EU Drug monitoring agencies as well as the data from numerous EU Health Ministries. UNODC and EMCDDA provide high-quality, research-backed evidence that has assisted with policymaking in Europe by proving valuable knowledge in drug domains. Data reports are conducted through national surveys implemented by UNODC in cooperation with national governments or are compiled from peer-reviewed, scientific literature. Data is also up to date and accurate as it is updated weekly, and studies as well as surveys are conducted and monitored on an annual basis

UNODC and Italian Ministries

The UNODC worked in coalition with Italy's department of Anti-Drug policy on a joint initiative dubbed "Prevention strategy and policymakers". The initiative, enacted in late early October 2012, granted access to UNODC international standards on the prevention of drug use as well as implemented evidence-based national drug prevention systems. This initiative is being used to draft policies that can prevent drug use and promote healthy lifestyles, particularly among minority groups and young people (Wabwoba, 2011). Furthermore, UNODC aimed to create regional 'prevention hubs' that made policymakers provide tools to improve national prevention systems such as drug prevention sample programs. It was created as a "balanced approach to illicit drugs, an approach that focuses on demand reduction and seeks to deliver treatment, rehabilitation, and reintegration for those suffering from drug addiction" (Fedotov, see Wabwoba 2011).

UNODC further affirmed that drug use, specifically Cannabis, Ecstasy, Cocaine and Amphetamine-type stimulants continue to be a problem in many parts of Italy and Europe (EMCDDA, 2019). Before this initiative, resources for drug prevention were 'extremely scarce' but science based evidence from well-designed research trials such as the Naloxone one conducted by SCORE and HRI (World Drug Report, 2019) as well as studies from UNODC sources showed that drug prevention worked (World Drug Report) and that it was "incredibly cost-effective, every euro spent saved 10 in future health costs". (Fedotov, 2011)

Large scale initiative to disseminate an evidence-based drug abuse prevention program

The UNODC delineated Switzerland and Portugal's strategy to combat drug use as 'three-pronged: police, educate, and medically treat' (Greenwald, 2009). UNODC policy analysis affirmed the following: Under this strategy, police officers in those countries are made to zero in on dealers, not users, to tackle the supply of drugs (Greenwald, 2009). From 2001 to 2008, UNODC found that in the first cities where this three-pronged strategy was implemented, drug usage rates dropped by as much as 4% per year (UNODC, Greenwald 2009). [5] The strong research design consisted of implementing the policy in select cities (experiment groups) versus cities where it was not implemented (control groups) and then comparing the rates. Users who are caught with drugs receive a warning and a government-mandated warrant to attend treatment and education facilities.

[5] *The World Health Organization* regarded anti-drug education programs as an essential component to tackle contaminated syringe usage and to lower the risk of unwanted consequences (*Harm Reduction International, 2018)*. *Anti*-drug education programs warn people about the dangers of drugs, however, despite its widespread implementation there is relatively little research on its effectiveness. (Coyle et al 1999) The medical community then steps in to battle health problems associated with drug use and help addicts re-associate with society (Greenwald, 2009).

Italy currently has a policy which mandates locking up drug dealers and users alike (Andragno, 2019). Countries with differing drug policies, such as the Netherlands, saw their rates of drug usage and overdose per capita drop to around half of Italy's respective rates since 2003, which was when many countries began decriminalizing drugs and implementing harm reduction policies. (Werb, Meacham, Fischer, Wood, 2016). The Netherlands similarly implemented the policy in preliminary test cities, and compared those rates to control cities where it was not implemented over the period of 2003-2005 and found that the strong research-designed experiment suggested a causal effect between the policy's enaction and lower drug rates. (Fischer, 2016) Dutch anti-drug abuse professionals discerned that no significant increase in pot-smoking and cocaine usage among young people existed since their legalization in 1970, whereas the number of lifetime pot-smokers in Italy has been rising, since 1995, from 18% to 27% in 2017 (see Figure 5 in Appendix*)*.

Decriminalization of Drug use

Multiple EU sources analyzed a policy initially enacted in Portugal consisting of decriminalization of certain drugs such as Cocaine and Marijuana. This policy ended up decreasing the number of addicts. Furthermoe, a SICAD cross-sectional experiment conducted in 2001 showed that in cities where drugs were decriminalized versus cities where they were still illegal provided evidence that decriminalized cities had lower drug usage rates in the ensuing years from 2001-2004 compared to cities where it was still illegal. (Greenwald, Hughes, Tavares 2009). Initially, jurisdiction over drug use was moved from the Justice Ministry into the Health ministry (Tavares, 2008).

Health officials focused primarily on assisting those who were already drug users by keeping them away from practices that could inflict increased harm. For example, officials went into the Vartuoso district in Lisbon, an area well known for drug use, and distributed clean syringes and cleanup supplies while carting out heaps of used syringes.

Drug use was present in nearly 1% of Vartuoso district's population, with almost one person in everyone's close or immediate family being a user (Easton, see Tavares 2008[6]*).* This generated a political will to deal with drug use in a different manner (Tavares, 2008).

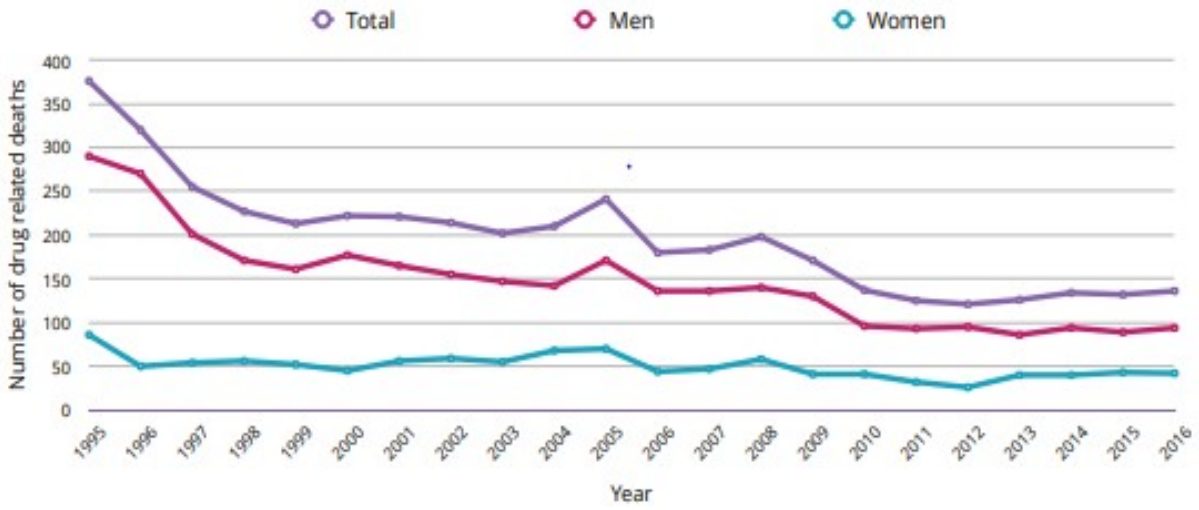
Under the law of 2001, illegal drugs remained illegal and dealers were prosecuted, but possession for personal use became an administrative offense rather than a criminal one (Vastag, 2009). Anyone caught with drugs was ordered to visit the local Commission for Dissuasion of Drug Addiction (CDDA) to attend rehabilitation programs. At CDDA, opiate substitutes such as methadone, were available to users who wanted to quit (Tavares, 2009).

[6] Conducted during a study in Portugal in 2005 which analyzed the effects of the decriminalization of drug use during the Portuguese "National Strategy for the fight against drugs".

An analysis conducted by the *Beckley Foundation Drug Policy* Programme made statistical conclusions that after decriminalization in 2001 and the implementation of harm reduction programs: Heroin usage decreased, there was a reduction in drug related deaths, and there was an increase in the uptake of treatment (Hughes, Stevens, 2007). For information about Public expenditure of Italy's Drug policy versus other countries, see Figure 23 in Appendix.

In Switzerland, where the same 'harm- reduction policy' was enacted in 1995, Drug-related deaths dropped most notably by ~50% from 1995-1999 (see EMCDDA Figure below).

Figure 2.1: Drug-related deaths in Switzerland, 1995-2016



The Longitudinal study of the effect of Portugal's decriminalization policy conducted by the Berkeley Institute by researchers Caitlin Hughes and Alex Stevens produced the following conclusions based on statistical indicators: Increased use of cannabis, Decreased use of heroin, increased uptake of treatment, and reduction in drug related deaths. This strong evidence was garnered based on longitudinal analysis of the years prior/post implementation. (Hughes, Stevens) [7]

Portugal's Similar Drug Policy

We use Portugal as one of the comparable examples. Portugal has a similar population age structure as Italy, with nearly the same demographics in terms of drug usage, as well as age groups that use these drugs. It is important to recognize numerous commonalities in terms of work life, culture, societal structure between Portugal and Italy.

[7] Decriminalization and treatment helped cut Portugal's overdose rate to one of the lowest rates in Europe (World Drug Report, 2019). The policies enacted in Portugal were based on 'harm reduction' approaches that were pioneered in countries like Switzerland which emphasized prevention over punishment, claimed Brendan Hughes of the European Monitoring Center for Drugs and Drug Addiction (Greenwald, 2009).

It is also important to recognize that despite these commonalities, Portugal and Italy are not the same country, What may work in one country, may not be as effective in the other. We are relying on data-proven administrative alternatives and efforts to tackle drug usage. The European School Survey Project on Alcohol and Other Drugs (ESPAD) engaged in general population surveys in Portugal beginning in 2001 to follow the effect of the establishment of treatment clinics and the availability of substitution substances to wean drug users off of drug usage. Studies from UNODC, EMCCDA, and ESPAD uncovered data that suggests a causal effect between strategies and developments in Portugal after strategy implementation. [8]

After the establishment of treatment facilities in Portugal, there is strong statistical evidence to support these developments which were effectively discerned after a series of random-sample and cross-sectional research experiments conducted by institutions like EMCDDA and UNODC:

The 2009 National Report to the EMCDDA by the Reitox National Focal Point, a Drug analysis institution in Europe, produced a thorough research paper named "Portugal, Developments, Trends, and in-depth information on selected issues" The report delineated that there was increased uptake of treatment such as substitutional substances (methadone), as well as:

- *Drug related pathologies, as published by the Cato institute in a white paper about the 'Marijuana Policy Project', reportedly decreased dramatically for 13-16 year old's. (Cardoso)*

IDT reported new developments and trends regarding Portugal's drug policy in conjunction with EMCDDA reports. They made the following claims in a report named "2009_NationalReportOnPortugal_EMCDDA", published by the UNODC which examined long-term causal effects by overseeing implementation and long-term supervision of Portugal's Harm Reduction policy:

- *Drug-related deaths has decreased. The number of drug related deaths in Portugal is slightly below the number prior to policy implementation (Cardoso)*
- *Reported lifetime use of 'all illicit drugs" decreased from 12% to 7.8% since 2001, this is comparable to Italy in the same time period where drug usage conversely increased (EMCDDA does not provide data as to the levels of the increase during this time period).*

Finally, the Berkeley Foundation, which is a non-governmental initiative dedicated to providing independent review of the effectiveness of national and international drug policies, published a peer-reviewed research paper for the International Drug Policy Consortium (IDPC) in 2007. In the report named 'The Effects of Decriminalization of

[8] While this causal effect is not firmly established, it is coupled with data that suggested common trends that occurred after policy implementation. There are also statistical indicators that suggest the following correlations between the drug strategy and following developments.

Drug Use in Portugal", Drug Researcher Caitlin Hughes, made the following discoveries:

- *Drug use among adolescents (13-15yrs) and 'problematic users" declined. (Hughes)*
- *Drug-related criminal justice workloads decreased. (Hughes)*
- *Decreased street value of most illicit drugs. (Hughes)*
- *The number of drug related deaths reduces from 131pm (per million people) in 2001 to 20pm in 2008. As of 2012, Portugal's death toll from drug usage sat at 3pm, in comparison to the EU average of 17.3 per million. (Carapinha)*[9]

Another important note is that sometimes a shift in drug-related deaths is not directly associated with drug abuse, sometimes drops in drug-related deaths is associated with public health improvements such as cleaner facilities and more efficient practices. (Hughes)[10]

Potential Alternatives

We will first describe and analyze each of the alternatives. We will then evaluate each criteria alongside the evaluative criteria and determine what the best course of action is regarding choosing one over others. The Outcome Matrix in this report will compile the evaluative findings and assist with deciding which alternative would provide the best and most effective outcomes.

Alternative 1: Let Present Trends continue, Status Quo.

This Alternative suggests that Italy retains its current policies concerning drug usage. If present trends were allowed to continue, drug usage, possession, consumption, transportation and sale would continue to be illegal. (See Figure 17 in Appendix for current trends)

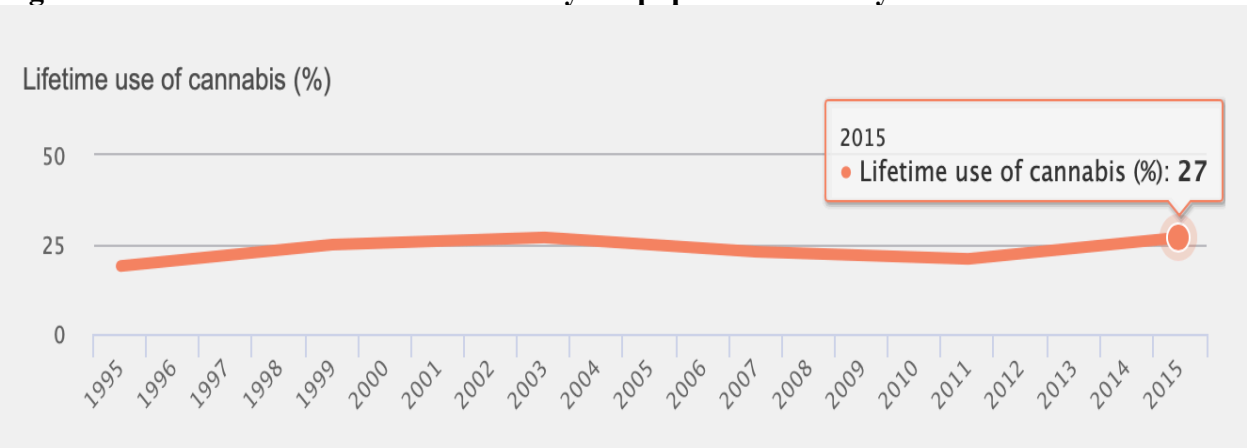
This insinuates that the key to tackling the drug problem is to jail everyone who has utilized or supplied an illicit narcotic. No further action is needed to carry out this alternative. It is relevant to UNICRI because it is the current policy for tackling the drug problem in Italy. There would be no time frame as it is already in order. Progress would be determined via UNODC's report on drug usage in Italy since starting the 'anti-drug' program in 2015 which is published yearly.

[9] Most notably, HIV infections and drug-related deaths have decreased. Portugal's shift towards a more health-centered approach to drugs, as well as wider health and social policy changes are responsible for the positive changes observes. (Balsa)

[10] The Berkeley Foundation conducted a report alongside UNODC and EMCDDA to delineate the effects of Portugal's harm reduction policy. The findings are the sole words of Caitlin Hughes and Alex Stevens.

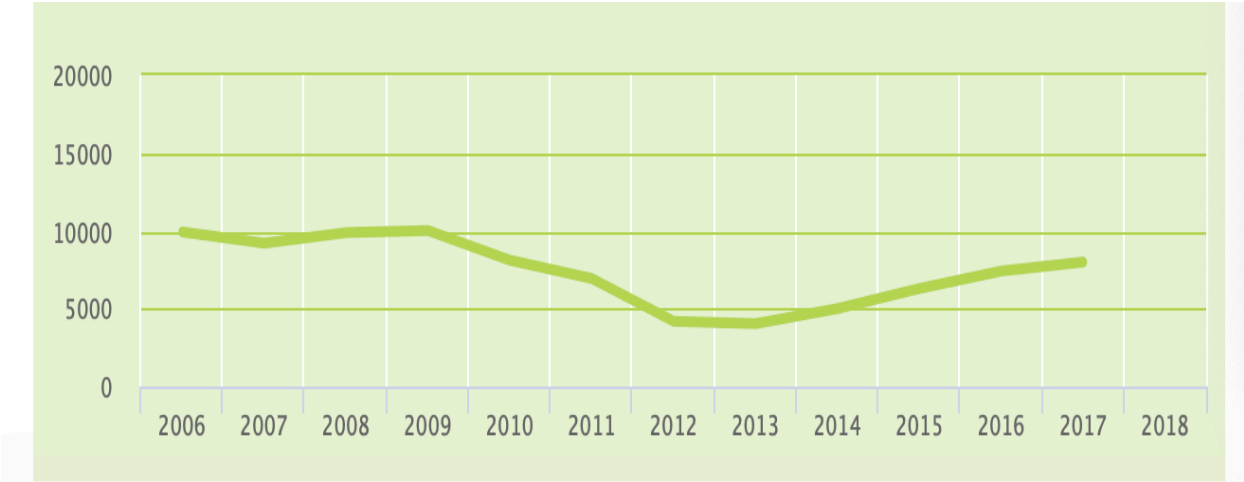
Figure 7 below begins reporting in 1995 where the level of lifetime use of cannabis was around 18% (ESPAD). It has since risen to 27% in 2015, which was when ESPAD concluded its study. Should present trends continue, we would likely see a continual increase in a similar fashion regarding cannabis usage for this demographic. Cannabis usage will likely continue to rise if present trends remain at status quo.

Figure 7: Lifetime use of Cannabis in Italy for population 15-24 years old



Similarly, the longitudinal trend of cocaine users entering treatment in the city of Milan is shown below (Figure 9). Should present trends continue, we could expect to see relatively stable maintenance of the number of entrants to treatment clinics for cocaine (see Figure 8 in Appendix for the longitudinal trends for cannabis users entering treatment). There were no significant increases from 2006 to 2017, and the number of entrants eventually stabilized. This suggests that if left at status quo, the number of entrants to treatment clinics would not increase significantly.

Figure 9: Cocaine users entering treatment in Milan from 2006-2017



(Source: EMCDDA data 2017. Data are for first-time entrants)

Milan is one of the most populated cities in Italy, with people from all around Italy living within the industrial town. Current trends of entrance to treatment clinics is important because treatment clinics already exist, but are seen as unhelpful regarding the cessation of drug usage. The fact that there are more Italians using drugs coupled with the fact that there is not much of an increase of Italian drug users entering treatment facilities contributes to rising drug overdose rates, as those new drug users do not seek treatment and many succumb to eventual drug overdosage.[12]

In regards to High-risk Drug use, EMCCDA collected data from studies administered by ESPAD, SCORE and UNODC to identify estimates for possible future trends given current trends of drug usage. The latest estimates show that there were approximately 235,000 high-risk heroin users in Italy in 2018 and that there were 101,000 cocaine users out of roughly 1.02 million users (EMCDDA, 2015).[13]

Alternative 2: Harm Reduction, Treatment, prevention Policy

Tenets

-Create 'prevention hubs' where users can receive medical attention for their addiction as well as weaning supplies.
- This alternative insinuates that drug users are not viewed as criminals, rather as patients who have an illness
- The focus, therefore, is not to incriminate drug users, rather upon discovery of drug usage the individuals are issued a government-mandated warrant to come to a treatment clinic.

-This is the Police, Educate, medically treat, and Reintegration method.

- Police Officers are to zero in on the dealers- not users- to tackle the supply of drugs

This alternative recommends the establishment of treatment facilities as well as easier access to substitution treatment for drug addicts. This also includes needle and syringe exchange programmes, substitution programmes, rehabilitation, and outreach teams within the facilities. These are all included with the aim of preventing drug-related risks such as infectious diseases, drug overdose, drug usage, social exclusion and delinquency.

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[12] The EMCCDA is one of the EU's decentralized agencies and was inaugurated in Portugal in 1995. It provides 'factual, objective, reliable and comparable information concerning drugs, drug addiction and their consequences'. It gathers data that is publicly listed by each European Countries Ministry of Health and/or Ministry of Drug Control. It also works closely with the United Nations Office on Drugs and Crime to provide the most accurate and up-to-date data regarding drug usage. Finally, it relies on data-collection methods approved and administered by European Governmental agencies to ensure accurate data reporting.

[13] It is important, however, to acknowledge that this data only comes from EMCDDA survey of users who visited a treatment clinic. There could be hundreds of thousands of drug users throughout Italy who do not visit treatment clinics that are not yet accounted for.
Note: The literature review section delineates precisely how to enact the Harm Reduction Policy, see "*Large scale initiative to disseminate…*" in Appendix'

This is to be undertaken by the Ministry of Health. Under the Institute on Drugs and Drug addiction and under close oversight by UNICRI, healthcare is organized mainly through public network services of treatment for illicit substance dependence. These public services are to be provided free of charge and to be made accessible to all drug users to seek treatment. Substitution treatment is to be coupled with this, where methadone is used as a substituting substance for heroin and Cocaine. (See figure 19 in Appendix)

In the years leading up to the harm reduction, prevention, and treatment policy Portugal enacted in 2001, the number of drug-related deaths soared. (EMCDDA) Portugal allocated greater resources to drug prevention, improving treatment, harm reduction and social reintegration programmes. Between 2000 and 2005 rates of problematic drug use and injecting drug use decreased (EMCDDA).

The Portuguese Ministry of Health produced a graph which collects data through surveys and hospital records regarding drug consumption rates (see Quadro 29 [Graph 29] in Appendix). SICAD (Situacao do Pais em Materia de Drogas-)[14] is a Portuguese drug examination group which collects data on the drug usage levels of certain demographics since the 2001 reforms. These reforms are the same reforms that are being proposed within this alternative. The graph shows that between 2011 to 2015, Cocaine usage dropped for nearly every age within the 13-18 year old age group. (SICAD) Most notably, SICAD found that after policy implementation, specifically between the years of 2011 and 2015, Cocaine usage dropped by 40% for 13 year old's (2% to 1.2%), by 37% for 15 year old's (3.8% to 2.4%) and by 36% for 17 year old's (3.4% to 2.4%) (see Quadro 29 [Graph 29] in appendix).

While these numbers may not constitute as a causal effect in terms of whether the harm reduction policy's implementation directly lowered the usage of drugs among populations, it provides solid statistical evidence to show that there may be a relationship between the policy's implementation in 2001 and the statistical decrease of drug usage over the ensuing years. We remain skeptical about these numbers, resulting in us being unable to confirm this as a causal relationship. However, this points to a suggestion that if a similar policy was implemented in Italy, it could provide similar effects or trends.[15]

For example, schools may have become more stringent on pat-downs and monitoring of students during 'leisure hours' during the day, which is when students frequently congregate to use illicit substances. There may have also been a shortage of drug supply, or a stronger policing presence during the years when this study was conducted. As a result, the causal effect of this experiment is shrouded in uncertainty, however, this policy was implemented during a specific time and the rates were monitored on the same population, in the same time period, holding all other outlying factors constant.

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[14] SICAD is a Portugese Drug Policy institution which analyzes the trends and projections, as well as current effects, of Portugal's National Strategy to combat drug usage

[15] In a similar vein, Portugal's GDP remains static and had not risen or dropped during the years listed under SICAD's longitudinal analysis. While we hypothesize that the policy's implementation may have had an effect on lowering the cocaine usage rates among this population in Italy, there could be underlying factors that contributed to this decrease in usage.

Despite all of that, rates did drop substantially, insinuating that the policy may well have had an effect. Therefore, while this experiment may not point directly to a causal relationship it suggests that the policy implementation played a role, despite not being a complete or direct role, in lowering the cocaine usage levels among this population in Portugal. For this reason, we suggest that if a similar policy was instituted in a similar manner in Italy, holding all else constant and perhaps nullifying other outside factors such as drug supply or stronger policing, similar effects or trends could very well ensue.

Based off of the rates of drug usage and deaths from drug overdose since the establishment of treatment facilities and a harm reduction policy in Portugal, we can associate the downward trends with policy implementation, even if it not a causal effect.[16] Furthermore, I suggest that it is likely that we see a similar downward trends in drug usage rates for the age group between 15-64 (y/o), after the implementation of the harm reduction and treatment clinic policy in Italy.

This provides a very politically feasible option because the government of Italy is likely to want to expand on a non-pervasive policy such as the building of treatment facilities and the supply of weaning supplies. In regards to cost-effectiveness, this would also provide an option that is relatively fundable because there is already funding available in the Health Ministry for projects like these. That is to say, treatment facilities are already being funded, and extra funding is available in the Health Ministry, simply expanding on the treatment facilities and supplying weaning supplies would to constitute the need to create a new budget plan. Rather, the government could simply allocate money already allocated to the Health Ministry to expand on these facets of the harm reduction policy.[17]

For Italy, this means that a harm reduction is in fact a politically feasible option that is strongly supported by data to suggest that it would lower the longitudinal rate of drug abuse and drug overdose. This also provides Italy with a cost-effective method of tackling this issue because it would use funding already allocated for such projects, and is statistically supported by data to suggest that it would also be effective in lowering the drug abuse and drug overdose rates in Italy.

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[16] Conclusions induced in conjunction with the results of the numerous Drug Policy analytical studies in Portugal and other comparable countries like Switzerland.

[17] As previously discussed, the two countries are societally similar, despite Italy having a larger population and higher GDP. Italy however, has a cultural affinity for compliance. Essentially, Italians comply by the societal norm. If the societal norm were to be that drug users were frowned upon in society, and that going to treatment facilities was not frowned upon, more people do it. Italy's cultural revolves around 'trends' meaning that if the trend was that people were using drugs then more people would be willing to begin using drugs, as well as continue using them from the ensuing addictions. If more treatment facilities were available in Italy, and it became something that wasn't seen as abhorrent or shameful, more people would frequent them in a form of cultural groupthink.

Given that the harm reduction policy already proved itself to be statistically supported by data from neighboring countries as a method of reducing drug abuse rates, it would likely have a similar effect in Italy. Once more, we do not state that this is a causal effect, rather, a likely trend based on statistically supported research data. [18]

Alternative 3: Decriminalization of Narcotics

Tenets

- This alternative effectively states that drug usage is no longer considered a crime, rather, the sale and trafficking of drugs is the crime.
- Police officers are instructed to actively pursue the suppliers and traffickers of drugs, rather than simply the users.

We can also turn to Portugal for a plausible outcome should this alternative be implemented. Portugal implemented a policy of decriminalization of narcotics in 2001. In July 2001, Portugal enacted Law 30/2000[19], which decriminalized the use, possession and acquisition of all types of illicit substances for personal use, which was defined as being up to ten days supply of that substance (Hughes). Substance abuse was defined as any use of illicit narcotics in the previous year, regardless of times used.

The problem they were addressing were not just substance abuse, rather, the effects of drug use such as (but not limited to): drug overdose, HIV/AIDS from dirty needles, lifetime usage of substances. It's important to note that these changes did not legalize drug use in Portugal, possession still remained prohibited by Portuguese law and criminal penalties still applied to drug growers, dealers and traffickers (Stevens).

We do not know for certain whether Decriminalization or the Harm Reduction policy was responsible for the reductions, because they were implemented around the relative same time. Decriminalization became a facet of the harm reduction policy in Italy, which is why analysts attributed the reductions to Harm Reduction.

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[18] Additionally, I believe many of the statistically consistent developments previously listed could also take place in Italy after this alternative's implementation. Finally, I believe that downward trends in terms of drug use and drug overdose rates will also be likely to occur in Italy should this alternative be enacted.

[19] Information on 30/2000 found at EMCDDA and Berkeley study conducted by Hannah Laquer. See references.

The main tenets of these changes were as follows (Hughes, Stevens):

Portugal's Drug Laws Governing Psychoactive Drugs

	Before 2001	After 2001
Personal possession/use	Criminal Offense Law 15/93 of January 22, 1993, Chapter IV, Article 40–41	Administrative Offense—"Decriminalized" Law 30/2000 of 29 November 2000, Art 2. (Entered into force July 2001)
Production, sale, and distribution	Criminal Offense Law 15/93 of January 22, 1994, Chapter III, Article 21–28, & Chapter IV, Article 40 regarding cultivation for consumption	Criminal Offense Law 15/93 of January 22, 1992, Chapter IV, Article 40–41

As well as:

- Introducing a system of referral to Commissions for the Dissuasion of Drug Addiction
- Ending the use of penal sanctions for drug possession (before this, offenders were liable to fines or up to a year in prison)[20]

[20] One of the things that is important to acknowledge was that decriminalization of narcotics was enacted before the rest of the harm reduction procedures were enacted. After the decriminalization of narcotics in 2001, Portugal enacted a multitude of policies as facets of the harm reduction policy in the ensuing years to add strength to their holistic endeavor to tackle drug abuse. It was only in 2006/2007, 5 years after narcotics had been legalized, that other harm reduction policies such as treatment clinics and weaning supplies began going into effect in Portugal. For that reason, we have to look at the years between 2001-2006 to evaluate the effect of the decriminalization policy specifically. (See Figure 20 in Appendix for foreseeable outcomes of Decriminalization in Italy based off evidence from Portugal studies).

Similarly, the evaluation of the effectiveness of the harm reduction policy is only evaluated after the 2006 harm reduction policy implementation. That is to say, if the years 2001-2006 showed a 2% decrease in drug abuse, it would be attributed to the decriminalization policy. If the years after 2006 showed a 3% decrease in drug abuse, we would attribute it to the harm reduction policy, but the causal effect would be affected by the effects of the decriminalization policy.

This is another reason that it is important to recognize the various policies taking effect in Italy, and which policy really caused the numbers to shift as they have been since the time that the policies were instituted. In regards to decriminalization, it is important to remember that this is not a drug free-for-all. Users cant utilize narcotics in public, nor can they buy and sell chemicals with no fear of prosecution. It seeks to change the way society deals with the problem of addiction from a legal perspective.[21]

The Portuguese experience, however, doesn't provide a definitive guide to the effects of decriminalization of drugs. Rather, it provides indications of the results of decriminalization in the relatively specific Portuguese context. (Trace)

It is also not truly possible to tell the extent to which changes were caused by decriminalization or the wider drug strategy which includes the harm reduction policy. Decriminalization will depend partly on the evidence identified in support of it, but also for national views as to whether it is the best policy response for the country where it is implemented.

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[21] The Berkeley study found that there had been a large drop in deaths related to the use of heroin and cocaine. Deaths recorded as being related to the use of other drugs rose, most notably with cannabis, but there was an overall fall in drug related deaths of 59% between 1999 (two years prior to Law 30/2000) and 2003 (two years after Law 30/2000). This is most likely because cannabis had already been a drug in high use, and its legalization led to more people willing to use it since there were no more penal costs associated with it.

However, Portuguese officials claimed that they were not so concerned with Cannabis usage rising as it was not seen as a 'harmful drug' of a similar caliber to Cocaine and Heroin. The magnitude of the effect of the decriminalization is two-pronged. It brought about a large decrease in drugs such as Heroin and Cocaine, but it sprung a large increase in cannabis usage.

Attached are several UNODC publications[23] describing the effects of the decriminalization model for several countries (Rosmarin)[24]

The Portuguese Decriminalization Model

In 2001, Portuguese legislators enacted a comprehensive form of decriminalization of low-level possession and consumption *of all illicit drugs* and reclassified these activities as administrative violations. Alongside decriminalization, Portugal significantly expanded its treatment and harm reduction services, including access to sterile syringes, methadone maintenance therapy and other medication-assisted treatments.

After nearly a decade and a half, Portugal has experienced no major increases in drug use. Yet it has seen reduced rates of problematic and adolescent drug use, fewer people arrested and incarcerated for drugs, reduced incidence of HIV/AIDS, reduced drug-induced deaths, and a significant increase in the number of people receiving treatment.[9] According to the United Nations, "Portugal's policy has reportedly not led to an increase in drug tourism. It also appears that a number of drug-related problems have decreased."[10] Independent research concludes that "there is ample evidence of a successful reform."[11]

Netherlands: The Netherlands has a long-standing policy to instruct prosecutors not to prosecute possession of roughly a single dose of any drug for personal use. Neither civil nor criminal penalties apply to possession of amounts equal to or lesser than this threshold. The Netherlands has lower rates of addiction than the U.S. and much of Western Europe. The Dutch also have much lower heroin overdose rates and prevalence of injection drug use compared to the U.S. The number of young people who use drugs problematically has also decreased.[16]

Sources include: Drug Alliance Agency, Federal Bureau of Investigation, and Bureau of Justice Statistics in compliance with UNODC.

[23] While we cannot confirm this causal relationship, this suggests that if a similar policy was implanted in Italy, it would provide similar effects.

[24] Czech Republic: The Czech government conducted an in depth evaluation and found that criminal penalties had no effect on drug use or related harms and were therefore unjustifiable (Rosmarin). In 2009, the country formally adopted a decriminalization law that defines personal use quantities, establishing some of the most pragmatic threshold limits of any country to have yet decriminalized. What data are available indicates that the Czech model seems to be producing net societal benefits. (UNODC)

It is important to equally recognize that decriminalization of drugs also occurred in Portugal after the harm reduction policy had already been in place. This means that decriminalization's effects are mitigated since the statistical drops in the number of drug users reported over time is not explicitly attributed to drug decriminalization, but may be a combination of the harm reduction policy's implementation in conjunction with decriminalization. (See figure 21 in Appendix for more likely trends based off Portugal's decriminalization enaction)

The main conclusions derived from Portugal's decriminalization were not necessarily a drop in drug rates, rather, a drop on convictions and incarcerations of Portuguese sellers and users of narcotics. (Laqeuer) On the other hand, there are no other comparable European countries that have explicitly and solely implemented a policy of decriminalizing drugs.

Many of these countries such as the Netherlands and Czech Republic also have harm reduction policies in place in conjunction with decriminalization, but decriminalization is never implemented alone. For this reason, the causal relationship between rates of drug usage and decriminalization cannot be strongly determined.

Discussion

Each alternative consists of effective programs conducted in EU countries with similar drug problems. Italy's circumstance is different because of the large fiscal budget allocated to policing since 2015. This provides a key opportunity to reallocate resources, at no extra fiscal cost, to programs that have solved the drug abuse problem in many EU countries.

These alternatives are specialized to fit Italy's context and are projected to be economically possible and politically feasible.[25]

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[25] Prior evidence has shown that treatment clinics, rehabilitation centers, drug education, specialized policing on suppliers, and decriminalization of many forms of illicit narcotics have drastically lowered the drug usage and drug overdose rates in countries like Portugal, Germany, and Switzerland.

Portugal, for example, had a population drug usage rate of 8% in 2001(UNODC). It has since decriminalized drugs, created rehabilitation center where users are educated and weaned off drugs, and provided modules for police forces to target drug suppliers. It now has a drug usage rate of under .08% (UNODC).

Evaluative Criteria

Alternative 1: Let Present Trends Continue- Status Quo

Alternative 2: Harm Reduction, Treatment and Prevention Policy

Alternative 3: Decriminalization of Narcotics

I present 3 alternatives that address the heightening drug usage and overdose rates in Italy. These alternatives will be evaluated using the following criteria:

1- **Political Feasibility**

2- **Cost Effectiveness**

3- **Longitudinal decrease in the rate of drug usage and overdose**

Types of Evaluative Criteria

We have carefully selected 3 evaluative criterion that holistically analyze the likely cost, effectiveness, success rate, and projected trends of each of the alternatives. These criteria are important because they also acknowledge the political feasibility of each option and whether they are likely to be instituted. They also analyze whether the current budget of the Italian government would suffice to implement the process.

Furthermore, they evaluate the costs associated with each alternative in conjunction to the benefits to society and the likely shift in the rate of drug usage and overdose over the long term.

Finally, they analyze the projected trends of each alternative, what that could mean for Italy, and how much confidence we have in our assertions about each alternative (frequently pointing to peer-reviewed data and EU Drug Policy institutional research). [26]

[26] These criteria are also explicitly relevant to the client because they take into consideration the costs, effectiveness, political feasibility, and long term success of any drug policy that is petitioned to the Parliament of Italy. Furthermore, the issue itself has to do with rising drug abuse and drug overdose rates.

These criteria, especially the cost-effectiveness and longitudinal analysis criteria, explicitly answer the question "How do we decrease the drug usage and overdose rates in Italy over the long term." Finally, we will conduct a qualitative and quantitative analysis of the criteria in pertinence to the issue of rising drug usage and overdose in Italy.

Criteria 1: Political Feasibility

This evaluative criterion will predict a probable outcome of the alternatives by concurrently examining the actors and political environment where the alternative will be proposed. Political feasibility is important because of the current political administration in Italy as well as the administration within the Ministry of Interior (MOI) and UNICRI. UNICRI, MOI and the Italian Presidency are all bureaucratic institutions where policies have to be approved across the board by multiple individuals within each respective institution.

For an alternative to be proposed to or enacted by UNICRI, it has to be supported by officers within the institution as it needs to be pitched to the Director a.i of UNICRI who will propose it to the ensuing ministries in Italy, and finally to Parliament where it will be voted on. Full chain of command is shown in Figure 16 on page 48.

Political Feasibility is of paramount importance because, without enough support from officers and statesmen throughout this process, the proposed policy alternatives could fail to progress through the Italian government.

This evaluative criterion is not concerned with cost-effectiveness or benefits, rather, it addresses how well a proposed alternative would be accepted by the decision-makers and subsequently the general population throughout its proposal. If an alternative is not politically feasible, it speaks to the lack of support or the controversy surrounding the support of a proposed alternative.

A proposed alternative with a lot of political feasibility, a.k.a support from statesmen and decision-makers, is more likely to be funded and would be faced with a much easier path to realization and implementation.

This criterion also addresses the risks and costs associated with each alternative, as alternatives that are deemed to be too costly or too risky are unlikely to receive much support and would subsequently have low political feasibility. [27]

Political feasibility is important because UNICRI's goal is to provide a solid and effective policy proposal that would tackle the rising drug usage and drug overdose levels in Italy.

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[27] Political feasibility is needed to make the implementation of an alternative possibility, but by itself does not assure that a proposed alternative will succeed. Rather, it assures that the policy would have support, funding, and would be enacted in its proposed entirety.

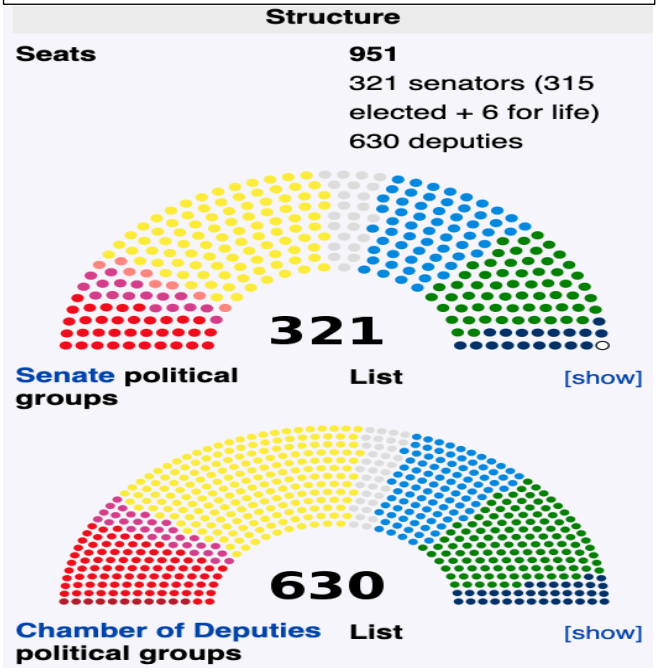
We measure political feasibility as the projected likelihood (based on support and decision-maker votes) that policy would go into effect.
How will we measure this?

Political feasibility is therefore measured by 2 factors:

1- The likelihood that it would pass in the Italian Parliament- the legislative body that deliberates and passes any new legislation.
2- The highest levels of a simple majority vote in support of the legislation at each level of the legislative process that these policy alternatives would have to follow. The chain of command is as follows.
    a- UNICRI officers. Weight (0.1)
    b- Director of UNICRI. Weight (0.1)
    c- Ministry of Interior. Weight (0.2)
    d- Parliament. Weight (0.4)
    e- President. Weight (0.2)

Weight is determined by how important each level is at determining the political feasibility of a certain alternative. Parliament, for example, is likely to have a long and arduous deliberation on each of the alternatives, and will be the most difficult level to pass, so it has more weight than UNICRI officers (because they are likely to approve any measure targeted at altering drug policy) and the President (because he must constitutionally vote in favor of Parliament's decree, unless he vetoes).

Figure 12: Structure of Italian Parliament (gov.it)



There would need to be at least a simple majority in favor of passing the legislation at each level of this chain of command. That means that at the UNICRI level, at least 5 of the 9 UNICRI officers would need to be in favor of the policy for it to be brought to the desk of Mrs. Bettina Tucci Bartsiotas, who is the head of UNICRI.

At the Director level, the Director would simply have to be in favor of the policy for it to be proposed to the Ministry of Interior.

At the Ministry of Interior Level, there would need to be support from at least 10 of the 18 MOI cabinet members for the legislation to come to Mrs. Luciana Lamorgese's desk.

After it passes that level, Mrs. Lamorgese would simply have to be in favor of the policy for it to be brought to Parliament. [28]

[28] Parliament is the unique level in this regard: There are 321 Senators and 630 Chamber of Deputy members in Parliament, comprising the 951 total seats in this legislative body. For legislation to pass at these levels, it requires a simple majority in both the House and the Senate. That means if there are at least 486 seats in favor of the legislation (322 in the House and 164 in the Senate) then legislation would become a bill and would move to Prime Minister Giuseppe Conte's desk for approval, which is required for any such legislation.

It is at this final level that the policy would be voted on and signed into law, the President would have to vote in favor of Parliament's decree as decried by the Italian Constitution. If the President does not support the legislation for whatever reason, he could veto it, and it would return to Parliament and require a 2/3rds vote to pass it without the President's signature.

Since Parliament is the level with the most legislative power in this regard, we have to look to the political parties of which the members align with to measure the likelihood of a certain legislation passing. Drug policy has always been a divisive issue in Italian Parliament, with various political parties remaining stoic on their policy towards drugs. Due to this, we can effectively determine which political parties will support which alternative.

**Disclaimer: while there are many other political parties in parliament, many of them have too few of members to sway any vote in any favor. The top 3 coalitions (Right, Left, MS5) normally sway each vote in a way that negates the votes of the few small political parties. Italy has long had a problem with corruption and bipartisanship in this regard, but this is how Italian politics are and we will conduct the APP with this in mind.*

*** We don't know for sure what each faction within each coalition will vote, but following trends over the past 40 years it seems that parties within each coalition vote in unison with the universal opinion of the entire faction. Because of this, we treat each party as a member of each faction, and view each faction vote in its entirety, rather than the presumed vote of each specific political party.*

******Political Defectors:** Every coalition is comprised of multiple political parties that vote in favor or against legislation. Sometimes, parties within each coalition vote against the vote of the coalition. Although this does not happen frequently, it is still worth acknowledging. We do not predict any defections in this regard, but should defection occur (example: Forza Italia chooses not to vote with the Centre Left Coalition's vote in support of status quo), we do not deem it powerful enough to alter the likelihood of the legislation reaching a simple majority vote. If enough parties voted against the coalitions vote, then it would alter the coalition vote in its entirety, for that reason, we negate this factor*

Figure 13: Political makeup of the House within the Italian Parliament (gov.it)

Coalition	Party	Seats	%
Centre-right coalition	League (Lega)	124	19.6
	Forza Italia (FI)	106	16.8
	Brothers of Italy (FdI)	31	4.9
	Us with Italy (NcI)	4	0.6
	Total seats	**265**	**42.1**
Five Star Movement (M5S)		**227**	**36.1**
Centre-left coalition	Democratic Party (PD)	112	17.8
	More Europe (+Eu)	3	0.5
	Together (IEI)	1	0.1
	Popular Civic List (CP)	2	0.3
	SVP–PATT	4	0.6
	Total seats	**122**	**19.4**
Free and Equal (LeU)		**14**	**2.2**
Associative Movement Italians Abroad (MAIE)		**1**	**0.1**
South American Union Italian Emigrants (USEI)		**1**	**0.1**
Total		**630**	**100**

POLITICAL FEASIBILITY EVALUATIONS

Alternative 1: Status quo

Center left parties are not in favor of the current drug policies because they see them as too conservative and harmful to society, as well as too expensive in terms of maintaining current policing and prison budgets. They would not vote in favor of maintaining status quo. (265 votes in House, 137 votes in Senate) (122 votes in House, 60 votes in Senate)

Center right parties are in favor of maintaining the status quo as they have a hardline towards any types of drug policy and choose to enforce the most stringent policies to quell drug abuse. They are also the political factions that voted in favor of higher policing and stricter drug laws, which is the current status quo. They would vote in favor of the Status Quo

(MS5) Five Star movement: This party advocated for zero-cost politics, populism and a relatively right wing conservative political party. They aligned with the Centre-right on issues such as drug policies or immigration, however, they have begun advocating for left-wing politics since Vito Crimi, a progressive from the North, began serving as leader. As such, this party, with many members in both the House and Senate, holds quite a bit of power in breaking the stalemates formed by deliberations between the center left and center right parties.

M5S would likely vote in favor of withholding the status quo should there not be any options that are deemed cost-effective or de-centralized enough to garner further support in Parliament. They would vote in favor of the status quo (227 votes in House, 112 votes in Senate)

Figure 14: Political makeup of Senate within the Italian Parliament

Coalition	Party	Seats	%
Centre-right coalition	League (Lega)	58	18.4
	Forza Italia (FI)	58	18.4
	Brothers of Italy (FdI)	16	5.1
	Us with Italy (NcI)	5	1.6
	Total seats	**137**	**43.5**
Five Star Movement (M5S)		**112**	**35.5**
Centre-left coalition	Democratic Party (PD)	53	16.8
	More Europe (+Eu)	1	0.3
	Together (IEI)	1	0.3
	Popular Civic List (CP)	1	0.3
	SVP–PATT	3	1.0
	Aosta Valley (VdA)	1	0.3
	Total seats	**60**	**19.1**
Free and Equal (LeU)		**4**	**1.3**
Associative Movement Italians Abroad (MAIE)		**1**	**0.3**
South American Union Italian Emigrants (USEI)		**1**	**0.3**
Total		**315**	**100**

Rank in factor 1 of political feasibility: with 492 votes in the house and 249 votes in the Senate , the vote would be well above the simple majority required.

Rank in factor 2 of political feasibility: the likelihood that it would pass ____ level is ___

a- UNICRI officers. Weight (0.1). **HIGH**
b- Director of UNICRI. Weight (0.1). **HIGH**
c- Ministry of Interior. Weight (0.2). **HIGH**
d- Parliament. Weight (0.4). **HIGH**
e- President. Weight (0.2). **HIGH**

After the above political feasibility analysis, we conclude that this alternative ranks **HIGHLY** in terms of Political Feasibility.

Alternative 2: Harm Reduction, Treatment and Prevention Policy

Center Left: The center right is the political coalition that first proposed a change in the current drug policies because they opposed the hardline policy of the left. Political parties within this faction such as the Democratic Party (DP) and More Europe (EU) party are the leaders of the movement to liberalize narcotics and provide a more de-centralized, progressive option for drug users to seek help because they do not believe higher policing and fuller prisons is effective enough to quell the issue. The More Europe party specifically looks to other European countries to mimic effective policies that could be implemented in Italy, and they would vote for this alternative wholeheartedly because it proved effective in Portugal. They would vote in favor of this alternative (122 votes in House, 60 votes in Senate).

Center Right: The center left would likely not be in favor of this policy because they would see it as too progressive and too lenient on many drug policies. Their consistent hardline approach towards drugs would cause them to provide continued support for the status quo hardline policy. Therefore, they would not vote in favor of this alternative (265 votes in House, 137 votes in Senate).

MS5: MS5 voted in favor of the Status quo alongside the Centre right coalition and would normally be unlikely to vote in favor of this alternative primarily due to their zero-cost politics policy. However, if the budgeting committee in the House, led by the Democratic Party, could comprise a budgeting agenda that would allocate resources from budgeting plans that have already been administered, presenting no new serious costs to the Italian government, then MS5 would be in support of this alternative. Their primary concern is that of cost to the government, and we will discuss further in the cost-effectiveness section why this alternative is a cost-effective alternative that would not pose any concerning new costs, politically or economically, to the Italian government that wouldn't be offset by benefits to society. For this reason, they would vote against this alternative unless a concise budgeting plan for implementation is drafted. (227 votes in House, 112 votes in Senate)

Rank in factor 1 of political feasibility: with 492 votes in the House and 249 votes in the Senate, the vote would not meet the simple majority required unless a budgeting plan is drafted.

Rank in factor 2 of political feasibility: the likelihood that it would pass ____ level is ___

a- UNICRI officers. Weight (0.1). **HIGH**
b- Director of UNICRI. Weight (0.1). **HIGH**
c- Ministry of Interior. Weight (0.2). **HIGH**
d- Parliament. Weight (0.4). **MEDIUM/LOW (based on budgeting plan)**
e- President. Weight (0.2). **MEDIUM**

After the above political feasibility analysis, we conclude that this alternative ranks **MEDIUM/HIGH** in terms of Political Feasibility. The most important factor here to ensure its political support, is the budget plan that needs to be proposed by the House budgeting committee.

Alternative 3: Decriminalization of Narcotics

Center Left party would be somewhat likely to vote for this alternative because it is relatively progressive, but many political parties within this faction would oppose it because legalization of narcotics is likely to cause dissent within the Mafia and Catholic Church, two groups which have a lot of pull within the Democratic Party and serve as powerful lobbyists. They could vote in favor of this alternative, but it more likely that they wouldn't because of lobby groups. (122 votes in House, 60 votes in Senate)[29]

Center Right party would be strongest opposers of this alternative because of their hardline policy towards drugs. They would vote against it wholeheartedly. (265 votes in House, 137 votes in Senate).

MS5: This party has historically opposed legalization legislation and would likely continue doing so. (227 votes in House, 112 votes in Senate) [30]

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[29]In regards to political feasibility, it is relatively unlikely that decriminalization would be met without opposition in Italy. The church still vehemently opposes illicit drug use and many of the politicians in parliament, the legislative body that moves forth new legislation, are members of political parties with close ties to the Vatican and Catholic Church. In a similar vein, the mafia also plays a significant role in Italian politics. The mafia still controls much of Italy, especially the south, and many politicians still have familial ties to the mafia. The mafia also profits off black market sale of narcotics in Italy.

[30] The mafia's lobby plays a strong role in Italian politics, with many politicians having secret ties to the mafia and voting for legislation that would be more in favor of the mafia's agenda. The mafia would also be a stalwart opposer of any decriminalization legislation because it would centralize the drug trade within the government of Italy and take illicit profits away from the black market, and subsequently the mafia. They remain capable of influencing politics and while they are not considered an important stakeholder, they still influence politics enough to work against the political feasibility of this alternative.

Rank in factor 1 of political feasibility: with 614 votes in the House and 309 votes in the Senate, the vote would not meet the simple majority.
Rank in factor 2 of political feasibility: the likelihood that it would pass ____ level is ___

a- UNICRI officers. Weight (0.1). **HIGH**
b- Director of UNICRI. Weight (0.1). **MEDIUM**
c- Ministry of Interior. Weight (0.2). **MEDIUM**
d- Parliament. Weight (0.4). **LOW**
e- President. Weight (0.2). **LOW**

After the above political feasibility analysis, we conclude that this alternative ranks **LOW** in terms of Political Feasibility.

Criteria 2: Cost- Effectiveness

Cost-Effectiveness is one of the more important criteria for the alternatives because decision-makers and government actors in Italy need to be able to afford what each alternative proposes. Many of the alternatives consist of ambitious policy changes that will require considerable amounts of money from the state's budget to be able to be implemented. Most of the alternatives consist of building treatment facilities or providing substitutions and weaning supplies to users. The rest of the alternatives consist of changing policing strategies and altering legislation to provide classes and better training for police forces. All of these alternatives will take considerable amounts of money to implement. [31]

The effectiveness aspect consists of actual change in the rate of drug usage and drug overdose. We will measure effectiveness by how much a drop or shift in drug usage and drug overdose levels can be attributed to the policy alternative. While there are many outlying factors, the general trend based on evidence from other countries such as Portugal show that when a policy is enacted, trends in rates that they are targeting alter. The drop or shift in the rates targeted by the policy can be measured by a certain percentage over a certain time period.

In this regard, we will measure effectiveness as around a 2% drop in drug usage and drug overdose rates per year (based off average drops in Portugal per year post-implementation), which is a substantial enough number to entail a shift in the right direction. In Portugal, between 2001 and 2005, they spent around 12.3 million euros per year on the harm reduction policy. They saw on average a 2.3% decrease across the board for each type of drug in terms of usage. (HRI,

[31] Cost-Effectiveness is an important criterion also because heightening drug usage and overdose rates inherently cost the government of Italy more money. When there are more drug users in Italy, police will have to spend more time and resources cracking down on suppliers and users. When drug overdose rates heighten, hospitals will spend more money on rehabilitation and costs for treatment for drug users. More drug users are essentially more costly for a country because when otherwise healthy citizens are out of commission due to their addictions, frequently leading to their hospitalization or incarceration, they will end up hurting the economy because there are fewer workers active in the workforce. It is all around more costly to incarcerate an individual, especially with the opportunity cost of removing an adult from the workforce to jail them for drug use. Therefore, the cost is one of the most important facets to address these alternatives.

Hughes) In the HRI study, they measured cost effectiveness as a 2% decrease in drug usage per million population, which was a considerable amount given their population, per 10 million euros spent on treatment facilities and weaning supplies. (HRI) For this APP, we will measure effectiveness as at least a 2% decrease in rate of drug usage and drug overdose per 10 million euros spent as well. Remember, countries had similar GDPs, allocation to health ministries, and drug user populations.

We need to ensure that the proposed alternatives not only are affordable for the government of Italy but that it would be less costly compared to the status quo. Cost-effectiveness entails that the state of Italy and its citizens are better off with the new policy alternatives and that it is less costly for the economy, government, and society compared to if they had not been implemented.

Cost-effectiveness can be measured in terms of direct costs and opportunity costs. For example, in one scenario we have the status quo. In the other scenario, we have a policy alternative that proposes the construction and maintenance of drug treatment facilities. If an alternative reduced drug usage by more, but also costed more, we would determine if the ratio of reduction versus cost is close to 2% per 10 million euros, and if it is, it would give that alternative more weight.

The government of Italy spends roughly 1% of its total GDP on drug-related expenditures (EMCDDA, 2019). This includes social costs and opportunity costs (i.e the cost to society if one drug user is unable to work and has to be incarcerated or hospitalized). For the alternative to be cost-effective, we need to ensure that the cost of building treatment facilities effectively saves Italy the cost of having to incarcerate or otherwise hospitalize drug users. Since the users are able to rehabilitate and wean off of drugs in the treatment facilities, they would be quicker to return to the workforce, keeping social costs lower than if the status quo remained. [32]

The connection that exists between this criterion and the problem has to do with enforceability. The alternatives will not be accepted by decision-makers if it is seen to be too costly to justify its effectiveness. If the alternative uses too much of the state budget to be enforced and does not effectively lower the drug user rates and overdose rates of drug users, then it will likely not be considered ‘cost-effective’.

This criterion is well-suited to assess the alternatives because budgeting is a large reason that Italy has not already sought to address the drug problem more effectively. This criterion would evaluate whether increasing the drug policy budget for the policy in relation to the projected reductions is justified.

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[32] The goal of the client is to create a better drug policy to curb drug usage and the overdose levels of drug users. For policies that would effectively achieve this goal to work, it has to be affordable at an economic and social level. Some policies are more likely to achieve greater reductions than others, but we classify each policy exclusively as separate alternatives and will regard them as exclusive to be able to attribute certain reductions to certain policies. That’s why cost-effectiveness is an evaluative criteria, to see which alternative would provide the greatest reductions at the lowest cost.. By measuring cost-effectiveness, which would be measured by whether or not the enforced alternatives lowered the rate of overdose and of drug users, we would be able to evaluate whether the inherent costs associated are worth it.

This criterion would also look at whether the status quo (when the policy alternative had not been implemented) was more cost-effective. This could be the case if the money spent on a policy alternative had not noticeably lowered the drug usage and drug overdose rates. UNICRI and the Government of Italy are both concerned with the economic and socio-political implications of continued incarceration and hospitalization rates of drug users and the goal of the policy alternatives is primarily to find a cheaper and more effective way to lower drug usage and drug overdose rates.

We define costs as direct costs (to the government of Italy) in terms of hospitalization, incarceration, and treatment costs. We also define costs as ancillary costs such as social costs (the cost to society of a worker not being able to contribute to the economy because of their drug usage) and opportunity costs (the cost to society and the individual drug user of not being able to work due to hospitalization, incarceration, or otherwise lack of normal functionality because of drugs). We will measure costs in euros, as in euros that were spent (before and after) on hospitalizations and incarcerations by the government on drug users and overdoses.

We will measure effectiveness as the ability for a policy to return otherwise dysfunctional and noncontributing members (due to drug usage) to society and the ability to have them work and contribute to society while saving the government money because they no longer need to be held in state-funded hospitals or prisons because of their drug practices.

Regarding effectiveness, we will explicitly look at users who had been drug users and who had not ever visited a treatment facility to see if their rate dropped because they began using the harm reduction program, or if they never visited one at all. We will measure how many individuals reduced their dependency on drugs by keeping a list of individuals who checked into treatment facilities as users. After they check out of the facility, we will follow up with them 1,2, and 5 years later to see if they recidivated into drug use. Those who had not recidivated will be seen as positive patients and account for an effective result of the program.[33]

Alternative 1: The status quo would come at little to no additional cost, rather, the current costs to maintain the status quo of a hardline policy against drugs would be held at constant. Regarding effectiveness, we have determined the current drug-related public expenditure to be estimated at around 0.18% of GDP (see figure 15 in Appendix) The Social costs of drug use is estimated to be around 1% of Italy's GDP. (EMCDDA) There is not a 2% reduction per 10 million euros spent, rather, there is an increase in drug abuse and overdose rates despite the money being spent on drug policy. Since the costs are already higher than the benefits to society (rather, the costs to society exceed the benefits to society that the status quo provides), we deem this alternative to be **Low/Medium** in regards to cost effectiveness.

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[33] The population explicitly consists of 16+-year-old citizens (working age in Italy) who are drug users. The data itself will come from medical records from hospitals, prison records, and state budget records from the drug-related budget set aside to address drug policy concerns. Data will also come from institutions like UNODC and ESPAD who will check in with users who have utilized facilities enabled by this policy to keep tab of the effectiveness of the program and whether or not patients recidivated. There are also other research studies that have documented the effects of these alternatives, such as those in Portugal, which will be analyzed to provide context for Italy's endeavor with these policies.

Alternative 2: The Harm Reduction Policy in Portugal costed an estimated 217 million euros since 2006 (EMCDDA), and it lowered the use of drugs such as Heroin and Cocaine by around 30-40% depending on the age group. Portugal had 2 treatment facilities prior to the policy, and around 35 now. They also purchased an estimated 150 million clear syringes and ~4 million units of methadone and Naloxone. (EMCDDA, Stevens) Italy would likely spend a similar amount on the harm reduction policy, likely saving money on the treatment facilities because there are currently 9 already in Italy (although Italy's population is higher).

For Italy to spend ~217 million euros, they would have to see around a 35-40% reduction in drug usage and overdose rates similar to the Portuguese experience. Since the data statistically supports the likelihood that such a drop will occur in Italy since a similar program produced such an effect in Portugal (Stevens, HRI), we believe that the policy would be deemed effective enough to merit the costs. Furthermore, the social costs to society with the creation of a rehabilitation and treatment program within the Harm reduction policy would also be reduced, further supporting this policy's cost effectiveness. Since the costs are accounted for, and statistically support that a trend would occur in Italy as it did in Portugal given similar resource expenditure, we deem this alternative to be **Medium** in regards to cost effectiveness. We still cannot confirm a causal effect between the policy and reduction of rates in Portugal, so that prevents us from ranking this highly in Cost-effectiveness.

Alternative 3: There would be minimal costs incurred by the Italian government to implement this policy. On the other hand, there is statistical evidence to support the notion that decriminalization of narcotics would lower the rate of drug usage in Italy. The costs would not be associated with direct costs, rather with social costs.

The legalization of narcotics could allow many working class Italians begin engaging in drug usage and inhibit their ability to work, which is a social cost to society. However, the decriminalization data from Portugal statistically supports the notion that decriminalization is associated with a drop in harmful drug usage such as Heroin and Cocaine, which keeps many individuals out of hospitals and allows them to work, providing social benefits and saves the health system a lot of funding.

Therefore, we deem this alternative to be **Medium-High** regarding cost effectiveness because there are no direct costs associated with it. Rather there are benefits to the government once drugs becomes centralized, as the government would sell narcotics and make a profit off of it while regulated the economy to crowd out the black market. The social costs would then have to be scrutinized to ensure that the policy does not raise the rate of drug users because drugs have now ceased to be illegal. [34]

[34] Ultimately, because no costs would be incurred and because this policy is likely to cause *some* reduction in the drug usage and overdose levels, it is likely that there would be a 2% reduction of drug rate per 10 million euros spent. This is a unique case, because any level of reduction would come at relatively no cost, which still satisfies the requirement of 2% reduction for 10 million euros.

Criteria 3: Longitudinal Rate of Drug usage and overdose

This is another important evaluative criteria because of its relation to the problem statement and client. The main topic of concern for this problem statement and for the client is the rate of drug users as well as their drug overdose rate. The client's problem statement is centered around the fact that drug usage rates and overdose rates are problems. This criteria is different from cost effectiveness because we are not determining whether the effectiveness of the policy is influenced by cost.

We are not performing a form of benefit-cost analysis to see if the costs incurred are offset by the benefits to society. Rather, we are simply looking solely at the rate of drug usage and overdose in the long-term. We are looking for future trends and projections, as well as the likelihood that the trends would continue. This criteria does not take into account the costs associated with an alternative, simply if the rates decrease after the policy is instituted.[35]

We will analyze each alternative longitudinally, meaning that we would look at the rates before policy implementation, and again after a certain amount of time after policy implementation. I believe that 2-3 years after policy implementation would be a solid amount of time to reevaluate whether a policy works in terms of its effectiveness at lowering the rates of drug usage and drug overdose.

The alternatives are all aimed at lowering the rates of drug usage and drug overdose for drug users in Italy, so a longitudinal analysis of the rate of drug usage and drug overdose would be a clear and effective gauge of whether an alternative is effective at what is it trying to achieve.

In the clearest of terms, we would evaluate the current rates of drug usage and drug overdose within a certain population in a city. We would then enact the policy (such as building treatment facilities or implementing harm reduction tactics). After the policy has been in place and we can confirm that drug users are frequenting the newly instated treatment facilities by gauging the number of users that visit the facilities, we would then re-evaluate the rate of drug users and drug overdose levels.

We would plan on reevaluating the rates every 6 months to a year at a time, and then build a chart keeping track on how the rates are changing (if the rates are decreasing, increasing, or if they have not changed).

After comparing the before and after rates, we would explicitly compare the cities where the policy had effectively been instituted with either the status quo rates or cities where the policy would not have been instated (such as a city where a treatment facility had not been built).

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[35] What my client wants to do is create a policy that would lower both of these rates. In terms of figuring out whether a proposed alternative is effective, we would look to see how both rates changed after policy implementation in regards to a causal relationship. For example, this criterion would evaluate whether building treatment facilities for drug users would lower the long term usage of drugs for current drug users and if it would lower the drug overdose rates for drug users that visited the facilities.

After comparing the levels between 'control cities' (cities where there aren't treatment facilities and where the drug user community had been left at status quo) with treatment cities (cities where there were treatment facilities and where we can confirm drug users were actively frequenting the facilities), we would be able to determine a causal relationship between the rates and policy implementation. [36]

Rankings[37]

Alternative 1: The currents rates of drug usage and drug overdose are currently increasing at alarming rates. If the status quo were to remain, they would continue to increase. For that reason, we rank this alternative **LOW** in terms of whether it would longitudinally decrease the rate of drug users and drug overdose.

Alternative 2: This alternative is supported by statistical evidence in the literature review in terms of whether it would decrease the levels of drug usage and overdose. In Portugal, The Netherlands and Switzerland, the Harm reduction policy was associated (even if it wasn't the exclusive reason) with a reduction in the longitudinal rate of drug usage and drug overdose. This evidence is supported statistically with data from numerous EU and Drug Monitoring agencies, with projections that the trends are likely to continue to decrease should the policy remain in place. For this reason, we rank this alternative **HIGH** in terms of whether it would longitudinally decrease the rate of drug users and drug overdose.

Alternative 3: The Causal relationship between drug usage rates and decriminalization are not explicitly measured as decriminalization frequently is implemented in conjunction with harm reduction policies. In the countries where decriminalization was instituted, there were also harm reduction policies set in place. While it can be attributed to decriminalization that a reduction of drug usage and drug overdoses occurred, it cannot be uniquely attributed to the decriminalization of narcotics. The relationship, however, does provide for a statistically significant effect that decriminalization had on countries where they experienced a drop in their drug rates. In regards to evaluative criteria, it also ranks low on the longitudinal decrease of the drug usage rate criteria since it could be attributed to an increase in the rate of cannabis usage. For that reason, we rank this alternative as **MEDIUM-UNKNOWN** in terms of whether it would longitudinally decrease the rate of drug users and drug overdose

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[36] This criteria ultimately helps the client, as well as the government of Italy, determine whether the policy was effective at lowering the rates of drug usage and drug overdose levels within a community. We would effectively measure the longitudinal rate by using drug reports from EMCDDA, the Ministry of Interior, Medical Records and Prison records to determine whether it has changed over time, before and after policy implementation.

[37] Note- We will compare pre and post policy rates of drug usage to determine long term reductions, however, we cannot begin doing so until a policy has been implemented. For that reason, we focus on projections based off similar policy enaction and trends.[37]

Outcomes Matrix

Outcomes Matrix	Political Feasibility	Cost Effectiveness (2% reduction of drug rate per 10 million euros spent)	Longitudinal decrease in rate of drug users and overdose
Option 1: Let Present Trends Continue	**High-** Rank in factor 1 of political feasibility: with 492 votes in the house and 249 votes in the Senate , the vote would be well above the simple majority required. Rank in factor 2 of political feasibility: the likelihood that it would pass level is a- UNICRI officers. Weight (0.1). **HIGH** b- Director of UNICRI. Weight (0.1). **HIGH** c- Ministry of Interior. Weight (0.2). **HIGH** d- Parliament. Weight (0.4). **HIGH** e- President. Weight (0.2). **HIGH**	**Medium-** In terms of costs it would be relatively cheap to continue with the status quo. When effectiveness is put into the equation we have to acknowledge that it is not explicitly effective to remain at the status quo since it has become such a pervasive issue for Italy already. The costs would remain low, but the social costs to society remain high. **With Status quo, there is not a 2% reduction per 10 million euros spent, rather, there is an increase.**	**Low-** The rates of drug usage and overdose rates are currently increasing at alarming rates. If the status quo remains they will continue to increase.
Option 2: Create 'prevention hubs' where users can receive medical attention for their addiction as well as weaning supplies. Harm reduction, Treatment, and Prevention Policy	**Medium/High-** This alternative would be relatively proactive, progressive and not too difficult to implement. It would be readily supported by Italian policymakers, as long as the costs is not too substantial to state budget. Rank in factor 1 of political feasibility: with 492 votes in the House and 249 votes in the Senate, the vote would not meet the simple majority required unless a budgeting plan is drafted. Rank in factor 2 of political feasibility: the likelihood that it would pass ____ level is ___ a- UNICRI officers. Weight (0.1). **HIGH** b- Director of UNICRI. Weight (0.1). **HIGH** c- Ministry of Interior. Weight (0.2). **HIGH** d- Parliament. Weight (0.4). **MEDIUM/LOW (based on budgeting plan)** e- President. Weight (0.2). **MEDIUM**	**Medium-** It would be one of the more effective alternatives and is statistically likely to decrease the rater of drug usage. In terms of costs, it would cost substantial funds to build treatment clinics and provide harm reduction supplies. The social cost to society would be mitigated since the harm reduction policy works to lessen the harm to society. In this case, the direct costs to implement the alternative is offset by the benefit to society. **Based on comparable statistics from comparable countries harm reduction cost analyses after Harm Reduction implementation, Italy is projected to spend ~217 million euros in 5 years to see a ~35-40% reduction in drug usage rates. *Disclaimer, no causal effect can be determined**	**High-** This alternative is supported by statistical evidence in terms of whether it would decrease the levels of drug usage and overdose.
Option 3: Decriminalization of Narcotics	**Low: The Italian government is unlikely to support the explicit decriminalization of narcotics.** Rank in factor 1 of political feasibility: with 614 votes in the House and 309 votes in the Senate, the vote would not meet the simple majority. Rank in factor 2 of political feasibility: the likelihood that it would pass level is a- UNICRI officers. Weight (0.1). **HIGH** b- Director of UNICRI. Weight (0.1). **MEDIUM** c- Ministry of Interior. Weight (0.2). **MEDIUM** d- Parliament. Weight (0.4). **LOW** e- President. Weight (0.2). **LOW**	**High-** There would be minimal costs incurred by the Italian government to implement this policy. On the other hand, there is statistical evidence to support the notion that decriminalization of narcotics would lower the rate of drug usage in Italy Ultimately, because no costs would be incurred and because this policy is likely to cause *some* reduction in the drug usage and overdose levels, it is likely that there would be a 2% reduction of drug rate per 10 million euros spent.	**Medium-Unknown:** Causal relationship between drug usage rates and decriminalization are not explicitly measured as decriminalization frequently is implemented in conjunction with harm reduction policies.

Note: The projections are made based off of statistical evidence from past experiments, studies, and data from EU Drug Policy institutions which oversee and project future trends for countries who implement similar types of policies. These evaluative scores are important because they give us an idea of possible trends or outcomes should each policy be implemented. Many scores provide an insight into factors of Italian culture and society that would be otherwise shrined in the unknown, such as the political feasibility scores associated with the members of parliament regarding whether they would support a policy or not.

Recommendation

We recommend Alternative 2. Based on the evaluative criteria, we see that the strongest scores associated with the second alternative. The Harm Reduction, Treatment, and prevention policy provides a progressive option that would be supported by Italian policymakers and is politically feasible. It also would be a cost-effective method by which the social cost to society would be mitigated since the harm reduction policy works to lessen the harm to society. The direct costs to implement the alternative is offset by the benefit to society. Finally, based on the findings in this report….

Alternative 2 would decrease the levels of drug usage and overdose in Italy in a politically feasible and cost-effective manner. These claims are supported by the aforementioned graphs and statistical evidence from EMCDDA and numerous other European drug monitoring agencies. In regards to policy goals, we are seeking for the most politically feasible, cost effective alternative that would work to lower the rate of drug usage in Italy in the long term.

In terms of tradeoffs, Alternatives 1 would inherently be the best politically feasible option since it is already supported by the Italian government as it has been the drug policy for decades. However, alternative 1 would do little to decrease the longitudinal rate of drug usage in Italy since the current status quo is currently contributing to an increase in drug usage in Italy. The most cost effective method would be Alternative 3, the decriminalization of narcotics, as it does not incur any additional direct costs to the Italian government and it would likely be accepted within the Italian population. However, the Italian government is unlikely to support the implementation of this policy because many Italian policymakers and members of Parliament are vehemently opposed to the decriminalization of narcotics.

One of the more concerning factors of Alternative 3, is that after Decriminalization in Portugal, many citizens began using drugs such as Cannabis since they were now legal. Due to the possible occurrence of a spike of drug use with this alternative, we scale it lower on the Longitudinal decrease on the rate of drug usage evaluative criteria. Regarding the long term (LT) vs short term (ST) we see:

- Alternative 1: Raising Drug usage and overdose rates in both LT & ST
- Alternative 2: Reducing Drug usage and overdose rates in both LT & ST
- Alternative 3: Increasing Drug usage and overdose rates in the ST, but reducing them in the LT

Ultimately, these tradeoffs are mitigated because although alternative 2 may not be the strongest option in every evaluative criteria, it is consistently strong across the board and remains the best option in terms of the most cost effective, politically feasible alternative to decrease the rate of drug usage and overdose over the long term in Italy.

Based on preceding analyses, experiments, and real-life policy results from comparable countries such as Portugal, the conclusive best approach is **Alternative 2: The Harm Reduction Policy.** There is also a statistically-supported reason to believe that the success that the Harm Reduction policy faced in Portugal and numerous other countries would likely have a similar effect in Italy.

Discussion of Implementation

My recommendation will be directly proposed to my contact within the United Nations Interregional Crime and Justice Research Institute. Their role is to advice overseers from the multiple ministries of Italy and provide the framework for policies such as these, as well as methods for successful implementation. His name is Fabrizio De Rosa and he works in the Communications department as an Editor in Chief. He provides weekly memo updates and serves as an advisor for the Director a.i of UNICRI, Mrs. Bettina Tucci Bartsiotas. Once my APP gets handed to Mr. De Rosa, he will read it and analyze the recommendations and then propose them to his overseer, Mrs. Bartsiotas.

Upon approval from the Director, she will propose the framework for the alternative to the head of the Ministry of the Interior, Mrs. Luciana Lamorgese. She does not support Italy's current 'anti-drug' program and has stated that the 'anti-drug' program is not effective and is in search of 'other options'. This stakeholder is of priority importance because she has an affinity for new measures to battle drug usage in Italy. She is opposed to the current policy because her political party is center-left and relatively progressive; her party voted against the current drug policy law when it was in Parliament. The policy does not reflect her views, rather the views of the majority of the members of Parliament who were representing their own constituencies by voting in favor of the current drug laws. She is the direct adviser to the President of Italy and is one of the most important decision-makers in terms of interior politics and programs that affect Italy.

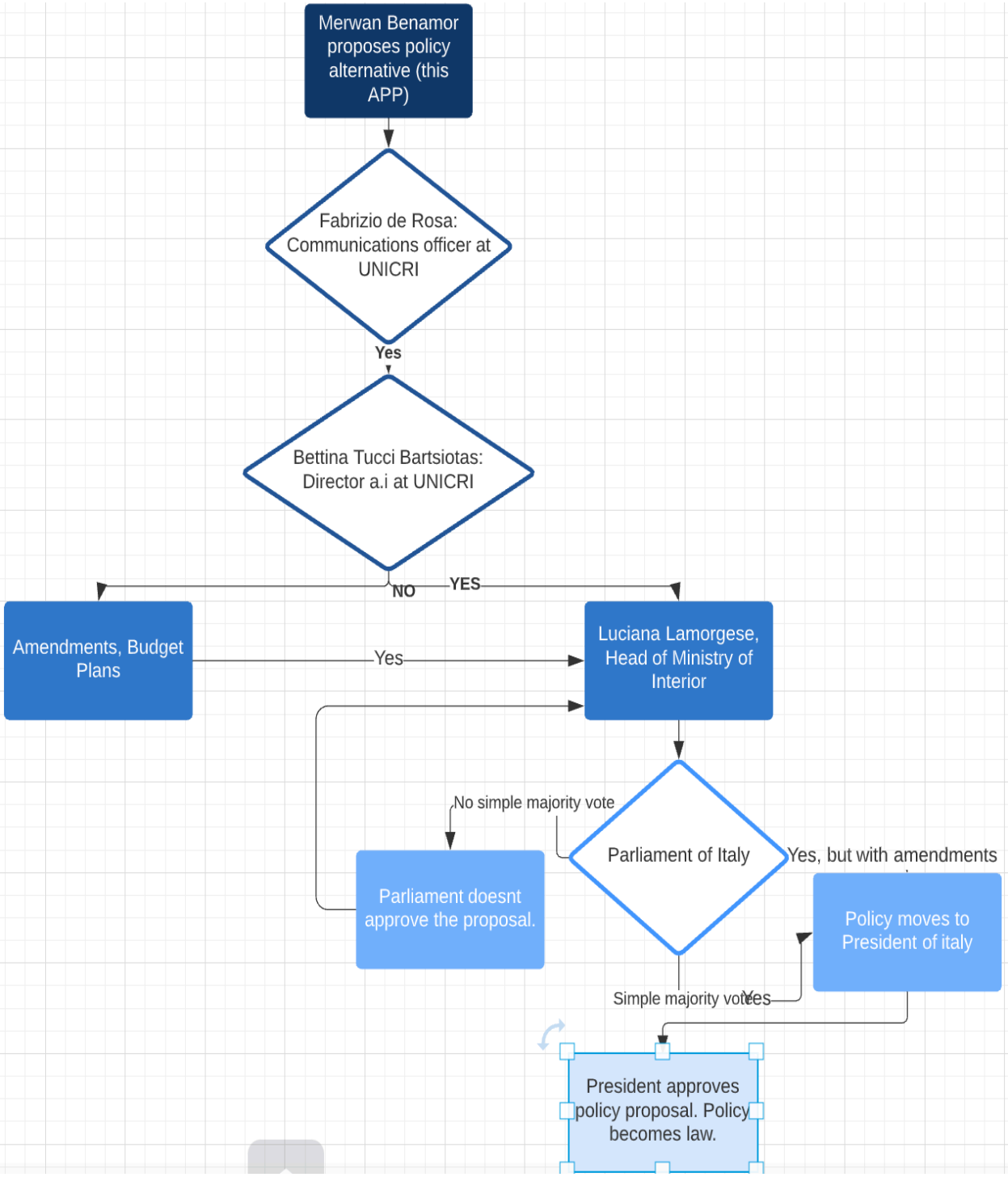
Many of the alternatives fall under the direct jurisdiction of the Ministry of the Interior, so approval upon proposition from the President's office is not required. It may be required should extra funding need to be appropriated to the Ministry of the Interior to effectuate some of the alternatives.

A key strategy here is garnering political support beforehand. To ensure it will pass the Parliamentary level, officers from UNICRI should reach out and petition to the numerous political parties to see if they would support the Harm Reduction Policy beforehand. If they had any amendments beforehand that would make it more likely to be supported by their members or constituents, then this strategy would help amend parts of the policy to ensure it has higher political feasibility. Furthermore, money could be re-allocated from other funding projects. For example, in the Health Ministry there was a 2015 stimulus package bent on providing supplies to the few treatment facilities that existed but the funds were never fully used. Areas like these could provide immediate funding required for enacting the Harm Reduction policy and would generate more support for the cost-effectiveness of the policy by working to eliminate some of the costs that would require further government funding.[38]

[38] Should extra funding be required, there will be an attached request for government funding which will require Ministry approval. Should the proposal be determined to be politically feasible, and effective in relation to what it will cost, it will move forward to the Ministry of the Interior. The framework for the alternative will be analyzed and, if need be, amended as she sees fit to ensure that it is politically feasible enough to propose to her superiors. Mrs. Lamorgese will engage with her ministry's cabinet to deliberate upon the alternative's implementation. Mrs. Lamorgese serves as the direct adviser to the President of Italy and has the ability to bring proposed legislation and policy frameworks to the desk of the President for direct consideration after it is approved by Parliament.

The chain of command (shown in figure 16 below)in terms of moving the recommendation forward is as follows, these are some of the most important decision-makers to ensure the policy's success:

Figure 16: Chain of Command for Policy Proposal



Stakeholders

There are multiple stakeholder groups who will be affected by the recommendation. They include the following:

Stakeholder: *Ministry of Interior:* The ministry of Interior functions as the stakeholder who is most concerned with costs. It is the institution that directly implements policies and drafts budgeting reports to ensure there are enough funds that can be allocated for any alternative. The Ministry of the Interior is headed by a Minister who has an affinity for measures that can curb the increase of drug usage in Italy, given that it does not cost too much for the government. This stakeholder will be very supportive of any measure that seems effective enough to curb drug use. The only resistance that this stakeholder would present would be in ***regards to cost***.

If it costs too much, or it doesn't seem effective enough to warrant the cost, this stakeholder will likely not support the alternative, or would seek to amend it so that it becomes less costly. Most of these measures are likely to cost *some* sort of funding. The key here is justifying the costs, which is why the cost-effective evaluative criteria is so important. Resistance can be mitigated if unnecessary costs are curbed, and the money that is requested effectively implements the proposal, preferably saving funds to ensure continued support from the Ministry. Leadership will need to exercise a strong ability of ensuring that funding requested is in fact worth it for the government, and that the funds can efficiently enact the policy without squandering funds, while eliminating financial loose ends. A consistent and detailed budgeting plan for the alternative would be required to gain this stakeholder's support.

Stakeholder: The *United Nations Office of Drug Control* works to evaluate anti-drug policies to ensure that they are effective enough to address drug-related issues. UNODC would be most concerned with whether the alternative does in fact curb drug use. In this regard, they are most concerned with *the* ***longitudinal rate of drug use.*** UNODC will be supportive of an alternative if it is evaluated to effectively work in similar countries, since the UNODC has been involved in implementations of similar policies in various EU countries. UNODC resistance would address whether the policy itself has been proven to lower the rate of drug usage. UNODC does not support the status quo because they conducted drug policy analysis that proves that the problem will only exacerbate at status quo.

They also produced reports showing how harm reduction policies worked in countries such as Portugal, for this reason, they would support the Harm Reduction policy. Resistance can be mitigated if facets of the alternative have been proven to be effective, using UNODC data, in comparable countries. It would be mitigated if UNODC itself published data proving that a certain policy works, which exists for these alternatives since the findings are derived from UNODC/EMCDDA sources. Leadership will need to meet consistently with UNODC officials to ensure that the policy has been effectively decreasing the rate of drug use in Italy, and work closely with UNODC to monitor trends and the longevity of the policy's success.

Stakeholder: President Mattarella's political party: President Mattarella is currently an independent, but has strong political ties and support from the Democratic Party (DP) of Italy. The DP is primarily concerned with maintaining liberal values in Italy and has been advocating for less stringent drug laws for decades. The DP would be unlikely to support measures that call

for more stringent legislation, but would be open to measures that are proven to lower rates of drug usage.

This combination of resistance and support can be addressed will an alternative that is progressive, such as decriminalization or the promotion of free-entry treatment clinics to limit government involvement while giving drug users who need and seek treatment the ability to do so. An effective strategy for this group would balance progressive, liberal facets within the alternative while jointly making sure that drug usage is effectively lowered. A policy that is too pervasive or stringent on the government's part won't be supported (such as mandatory warrants or stricter policing), it needs to be progressive while still effectively lowering drug usage.[39]

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[39] Note: See figure 18 in Appendix for Worst Case Scenario examples


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References

1. Hughes, Caitlin; Stevens, Alex(December 2007), The Effects of Decriminalization of Drug Use in Portugal (PDF), Briefing Paper 14, Oxford: Beckley Foundation, archived from the original(PDF) on 26 April 2015
2. United Nations Office on Drugs and Crime (2009). *Confronting unintended consequences: Drug control and the criminal black market* (PDF). *World Drug Report*. United Nations. p. 174. ISBN 978-92-1-148240-9.
3. Vale de Andrare & Carapinha, Paula & Ludmila (2010). "Drug Decriminalization in Portugal". NMJ. 341: c4554. Doi:10.1136/bmj.c4554. PMID 20833743
4. Hughes, Caitlin; Stevens, Alex (21 July 2010). "What can we learn from the Portuguese decriminalization of illicit drugs?" (PDF). *British Journal of Criminology*. Oxford University Press 10.1093/bjc/azq038. **50** (6): 1014. doi:10.1093/bjc/azq038. Archived from the original(PDF) on 21 August 2014.
5. Cardoso, Manuel; Santos, Ana Sofia; Duarte, Óscar (2009). "New Development, Trends and in-depth information on selected issues" (PDF). *Portuguese Focal Point report (2008 data) to the EMCDDA*. Lisbon, Portugal: Institute for Drug and Drug Addiction (IDT, I.P.).
6. Hughes, Caitlin; Stevens, Alex (21 July 2010). "What can we learn from the Portuguese decriminalization of illicit drugs?" (PDF). *British Journal of Criminology*. Oxford University Press 10.1093/bjc/azq038. **50** (6): 1014. doi:10.1093/bjc/azq038.
7. United Nations Office on Drugs and Crime (UNODC), "World Drug Report 2009," (Vienna: United Nations Office on Drugs and Crime, 2009).
8. International Federation of Red Cross and Red Crescent Societies, Statement to the United Nations Commission on Narcotic Drugs, 55th Session).
9. See Caitlin Elizabeth Hughes and Alex Stevens, "What Can We Learn from the Portuguese Decriminalization of Illicit Drugs?," British Journal of Criminology 50, no. 6 (2010): 999.
10. Caitlin Elizabeth Hughes and Alex Stevens, "A Resounding Success or a Disastrous Failure: Re-Examining the Interpretation of Evidence on the Portuguese Decriminalisation of Illicit Drugs," Drug and Alcohol Review 31, no. 1 (2012).
11. Balsa, C., Vital, C. and Urbano, C. (2013) 'III Inquérito nacional ao consumo de substâncias psicoativas na população portuguesa 2012: Relatório Preliminar', CESNOVA – Centro de Estudos de Sociologia da Universidade Nova de Lisboa, p. 59.
12. European Monitoring Centre for Drugs and Drug Addiction (2013) op. cit., pp. 65-67.
13. European Monitoring Centre for Drugs and Drug Addiction (2014) 'Data and statistics'.
14. Ari Rosmarin and Niamh Eastwood, "A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe," (London: Release, 2012).
15. Lee, David S., and Justin McCrary. 2005. Crime, Punishment, and Myopia. Cambridge, MA: National Bureau of Economic Research.
16. Loo, Mirjam Van Het, Ineke Van Beusekom, and James P. Kahan. 2002. Decriminalization of Drug Use in Portugal: The Development of a Policy. Annals of the American Academy of Political and Social Science 582 (1): 49–63.

17. Sede del Ministro, Produzione nazionale e distribuzione". The official website of the Italian Ministry of Health.
18. Allen, L, Trace, M & Klein, A (2004), Decriminalisation of drugs in Portugal: a current overview, DrugScope and The Beckley Foundation, London
19. Reuter, Peter, and Mark A. R. Kleiman. 1986. Risks and Prices: An Economic Analysis of Drug Enforcement. Crime and Justice 7:289–340.
20. Room, Robin. 2013. Legalizing a Market for Cannabis for Pleasure: Colorado, Washington, Uruguay and Beyond. Addiction 109 (3): 345–51.
21. Saguy, Abigail C., and Forrest Stuart. 2008. Culture and Law: Beyond a Paradigm of Cause and Effect. Annals of the American Academy of Political and Social Science 619 (1): 149–64.
22. Secret, Mosi. 2013. Outside Box, Federal Judges Offer Addicts a Free Path. New York Times, March 2. http://www.nytimes.com/2013/03/02/nyregion/us-judges-offer
23. Vastag, Brian. 2009. 5 Years After: Portugal's Drug Decriminalization Policy Shows Positive Results. http://www.scientificamerican.com/article.cfm?id=portugal-drug-decriminalization (accessed October 5, 2013).
24. Werb, Dan, Greg Rowell, Gordon Guyatt, Thomas Kerr, Julio Montaner, and Evan Wood. 2011. Effect of Drug Law Enforcement on Dr
25. World Health Organization. 2000. Guide to Drug Abuse Epidemiology. In Department of Mental Health and Substance Dependence Noncommunicable Diseases and Mental Health Cluster World Health Organization & U.S. National Institute on Drug Abuse. Geneva, Switzerland: WHO.
26. "Sì alle unioni civili, libertà di coscienza per la #StepchildAdoption". Beppegrillo.it/. Archived from the original on 14 March 2016. Retrieved 22 March 2016.
27. ^ Bordignon & Ceccarini, Fabio & Luigi (2015). "The Five-Star Movement: a hybrid actor in the net of state institutions". Journal of Modern Italian Studies. **20** (4): 454–473. doi:10.1080/1354571X.2015.1066112.
28. (EMCDDA, 2019) http://www.emcdda.europa.eu/countries/drug-reports/2019/italy/public-expenditure_en
29. Tiger, Rebecca. "Judging Addicts: Drug Courts and Coercion in the Justice System." New York: NYU Press, 2012. 88 Schaub, Michael et al. "Predictors of Retention in the 'Voluntary' and 'QuasiCompulsory' Treatment of Substance Dependence in Europe." European Addiction Research, 17. No. 2 (2011).
30. Schaub, Michael et al. "Comparing Outcomes of 'Voluntary' and 'Quasi-Compulsory' Treatment of Substance Dependence in Europe." European Addiction Research, 16. No. 1 (2010). McSweeney, T et al. "Twisting Arms or a Helping Hand: Assessing the Impact of 'Coerced' and Comparable 'Voluntary' Drug Treatment Options." British Journal of Criminology, 47. No. 3. (2006).
31. Gossop, Michael. "Drug Misuse Treatment and Reductions in Crime: Findings from the National Treatment Outcome Research Study." National Treatment Outcome Research Study. 2005. 89 United Nations Office on Drugs and Crime, World Health Organization. "Principles of Drug Dependence Treatment: Discussion Paper." 2008. https://www.unodc.org/ documents/drug-treatment/UNODC-WHO-Principles-of-Drug-DependenceTreatment-March08.pdf.
32. Esser, Marissa B et al. "Prevalence of Alcohol Dependence Among U.S. Adult Drinkers, 2009-2011." Preventing Chronic Disease, 11(2014).

33. United Nations Office on Drugs and Crime. "World Drug Report 2014." 2014. https://www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf. 90 Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. "Treatment Episode Data Set (TEDS) 2002-2012: National Admissions to Substance Abuse Treatment Services." July 2014. https:// www.samhsa.gov/data/sites/default/files/TEDS2012N_Web.pdf.
34. Joy, Janet Elizabeth et al. "Marijuana and Medicine: Assessing the Science Base." Washington, D.C.: Institute of Medicine, National Academies Press, 1999, 102. 74
35. Eric Single et al. "The Impact of Cannabis Decriminalisation in Australia and the United States." Journal of Public Health Policy. 2000. 75 National Research Council. "The Growth of Incarceration in the United States: Exploring Causes and Consequences." Washington, D.C.: National Academies Press, 2014.
36. European Monitoring Center for Drugs and Drug Addiction. "Video: What is decriminalization of drugs?" http://www.emcdda.europa.eu/video/2015/what-isdecriminalisation-of-drugs. 2
37. Walsh, C. "On the Threshold: How Relevant Should Quantity Be in Determining Intent to Supply?" International Journal on Drug Policy, 19. No. 6 (2008).
38. Hughes, Caitlin et al. "Legal Thresholds for Drug Trafficking: Evaluating the Risk of Unjustified Charge of Users as Traffickers in Six Australian States." http://www. issdp.org/conference-papers/2013/2013_papers/Hughes%20C%20-%20Legal%20 thresholds%20for%20drug%20trafficking.pdf.
39. Harris, Genevieve. "Conviction by Numbers: Threshold Quantities for Drug Policy." Series on Legislative Reform of Drug Policies. No 14. 2011.
40. Harris, G. "Expert Seminar on Threshold Quantities. 2011. https://www.tni.org/files/download/thresholds-expert-seminar.pdf. Hughes, B. "Topic Overview: Threshold Quantities for Drug Offences." Lisbon: European Monitoring Center for Drugs and Drug Addiction. 2010. http://www.emcdda.europa.eu/html.cfm/ index99321EN.html.
41. Werb, D., Kamarulzaman, A., Meacham, M. C., Rafful, C., Fischer, B., Strathdee, S. A., & Wood, E. (2016). The effectiveness of compulsory drug treatment: A systematic review. The International journal on drug policy, 28, 1–9. doi:10.1016/j.drugpo.2015.12.005
42. EMCDDA- Report found and downloaded at : http://www.emcdda.europa.eu/edr2019_en
43. Rebecca.wabwoba. (2012, October). United Nations Office on Drugs and Crime. Retrieved November 5, 2019, from
44. https://www.unodc.org/unodc/en/frontpage/2012/September/unodc-and-italy-launch-initiative-to-promote-international-standards-on-drug-use-prevention.html.
45. Kalunta-Crumpton, Anita. Drugs, Victims and Race. Waterside Press, 2006.
46. Unodc.org. Mr. Yury Fedotov (UNODC Executive director)
47. World Drug Report. "United Nations Office on Drugs and Crime." World Drug Report 2019: 35 Million People Worldwide Suffer from Drug Use Disorders While Only 1 in 7 People Receive Treatment, 2019, www.unodc.org/unodc/en/frontpage/2019/June/world-drug-report-2019_-35-million-people-worldwide-suffer-from-drug-use-disorders-while-only-1-in-7-people-receive-treatment.html.
48. Velasco, V., Griffin, K. W., Antichi, M., & Celata, C. (2015, March 20). A large-scale initiative to disseminate an evidence-based drug abuse prevention program in Italy: Lessons

learned for practitioners and researchers. Retrieved from https://www.sciencedirect.com/science/article/abs/pii/S0149718915000282?via=ihub.
49. United Nations Office on Drugs and Crime (2009). Confronting unintended consequences: Drug control and the criminal black market (PDF). World Drug Report. United Nations. p. 174. ISBN 978-92-1-148240-9.
50. United Nations Office on Drugs and Crime (2009). Confronting unintended consequences: Drug control and the criminal black market (PDF). World Drug Report. United Nations. p. 174. ISBN 978-92-1-148240-9.
51. Andragno, Politiche. “Italy Country Drug Report 2019.” UNODC, 2019, www.politicheantidroga.gov.it/media/2549/country-drug-report.pdf.
52. Werb, D., Kamarulzaman, A., Meacham, M. C., Rafful, C., Fischer, B., Strathdee, S. A., & Wood, E. (2016). The effectiveness of compulsory drug treatment: A systematic review. The International journal on drug policy, 28, 1–9.doi:10.1016/j.drugpo.2015.12.005
53. ECJED-http://www.chanvre-info.ch/info/IMG/PROG129.pdf European alternatives in drug policies, European Parliament,Brussels, 6-7 November 2006
54. Greenwald, Glenn (2 April 2009). "Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies"(pdf). Cato Institute. Retrieved 14 February 2015.
55. Tavares, C. and Thomas, G. (2008). "Statistics in focus: Crime and criminal justice". Eurostat. p. 3.
56. Easton, Mark. Decriminalization of Drug Use in Portugal: The Development of a Policy". JSTOR 1049733.
57. United Nations Office on Drugs and Crime (2009). Confronting unintended consequences: Drug control and the criminal black market (PDF). World Drug Report. United Nations. p. 174. ISBN 978-92-1-148240-9.
58. Vastag, Brian (7 April 2009). "5 Years After: Portugal's Drug Decriminalization Policy Shows Positive Results". Scientific American. Retrieved 14 February 2015.
59. Tavares, C. and Thomas, G. (2008). "Statistics in focus: Crime and criminal justice". Eurostat. p. 3.
60. Greenwald, Glenn (2 April 2009). "Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies"(pdf). Cato Institute. Retrieved 14 February 2015.
61. United Nations Office on Drugs and Crime (2009). Confronting unintended consequences: Drug control and the criminal black market (PDF). World Drug Report. United Nations. p. 174. ISBN 978-92-1-148240-9.
62. Prinz, A. (1997). Do European Drugs Policies Matter? Economic Policy, 12(25), 373-385. Retrieved from www.jstor.org/stable/1344684
63. United Nations Office on Drugs and Crime (2009). Confronting unintended consequences: Drug control and the criminal black market (PDF). World Drug Report. United Nations. p. 174. ISBN 978-92-1-148240-9.
64. Decriminalization of Drug Use in Portugal: The Development of a Policy". JSTOR 1049733.
65. Laqueur, Hannah (June 2015). "Uses and Abuses of Drug Decriminalization in Portugal". Law & Social Inquiry. 40 (3):746–781. doi:10.1111/lsi.12104.
66. Brown, C. (n.d.). How Europe's heroin capital solved its overdose crisis. Retrieved November 4, 2019, from https://www.cbc.ca/news2/interactives/portugal-heroin-decriminalization/.

67. "EMCDDA | Statistical bulletin 2009: Table DRD-3: Number of drug-induced deaths recorded in EU Member States and Norway according to EMCDDA standard definition 'Selection B', 1995 to 2007".
68. Easton, Mark; Decriminalization of Drug Use in Portugal: The Development of a Policy". JSTOR 1049733.
69. Brown, C. (n.d.). How Europe's heroin capital solved its overdose crisis. Retrieved November 4, 2019, fromhttps://www.cbc.ca/news2/interactives/portugal-heroin-decriminalization/.
70. Bartlett, R., Brown, L., Shattell, M., Wright, T., & Lewallen, L. (2013). Harm reduction: compassionate care of persons with addictions. *Medsurg nursing : official journal of the Academy of Medical-Surgical Nurses*, *22*(6), 349–358.

End of references

Appendix:

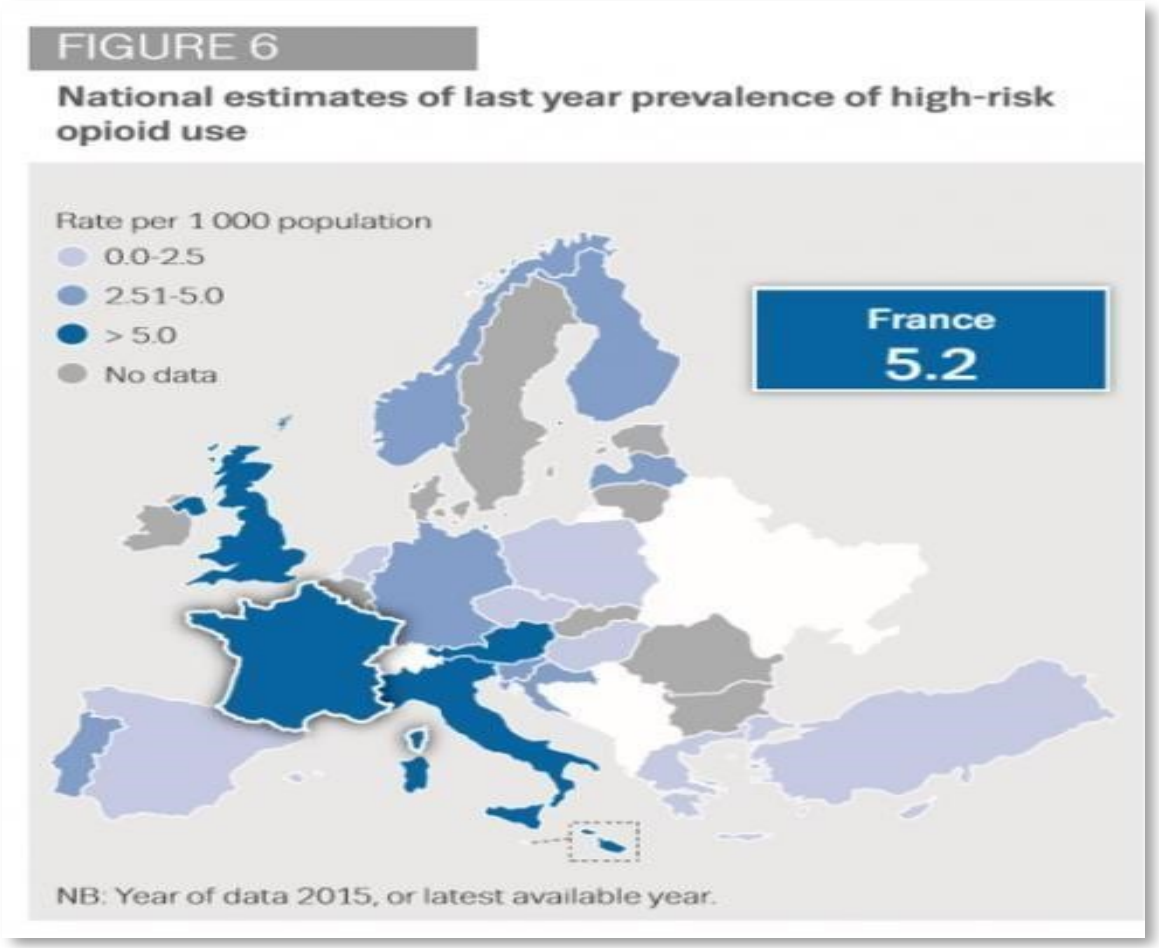


Figure 3: Past 30 days vs Lifetime Use of Drugs. Italy vs EU

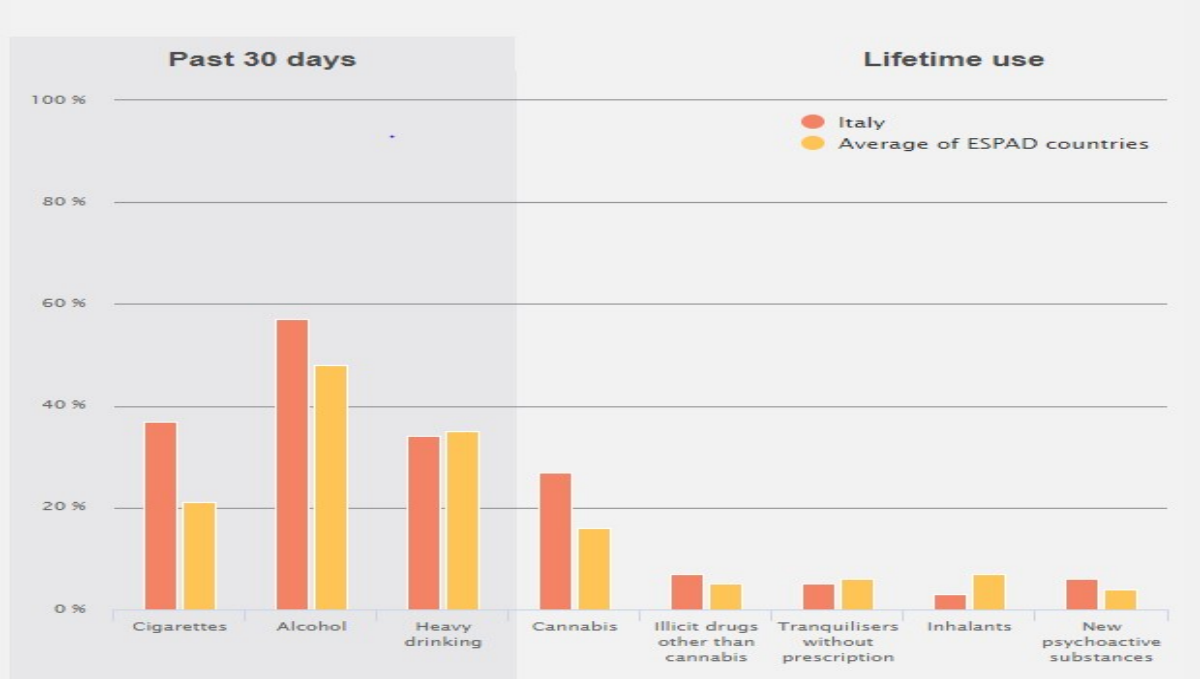
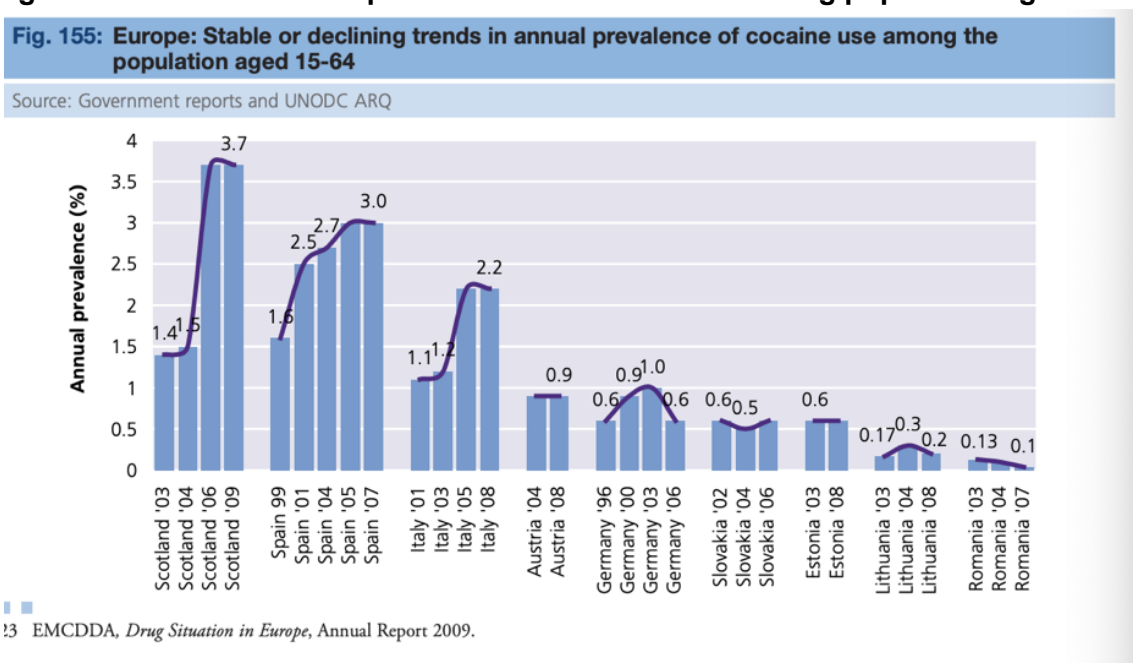
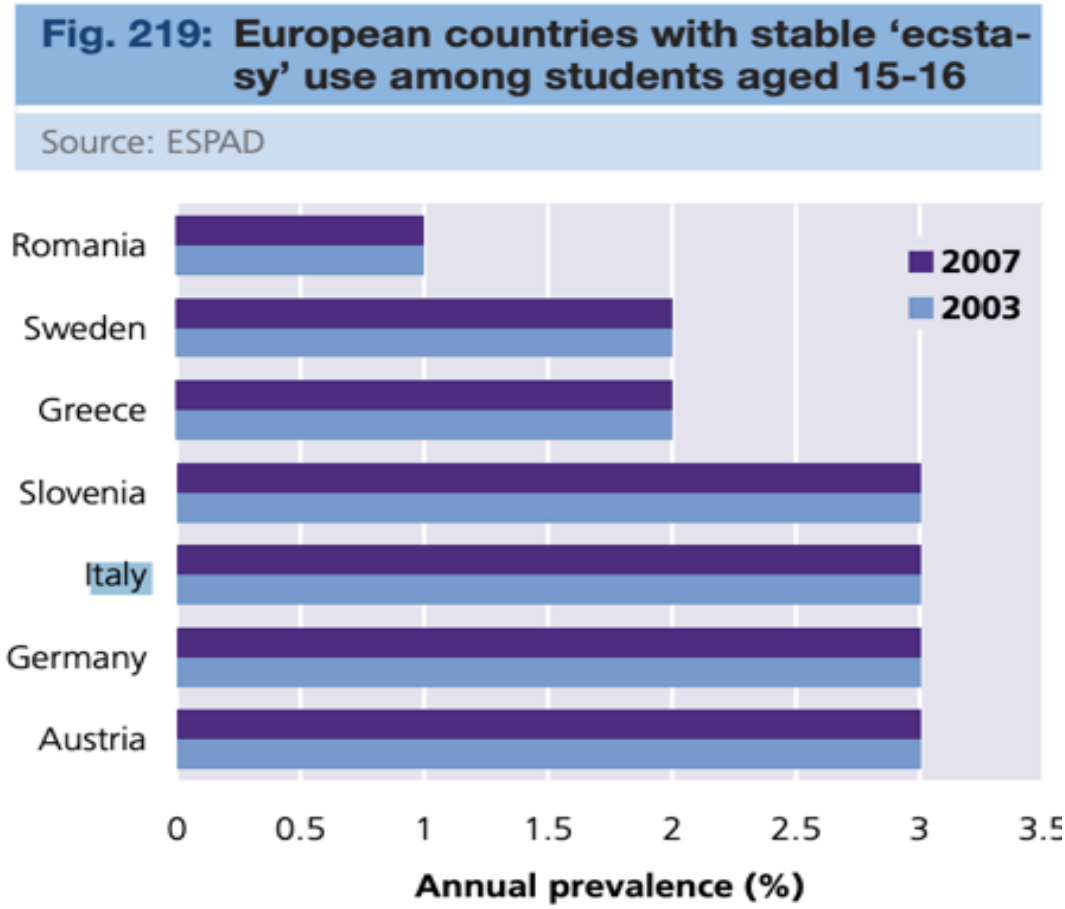


Figure 4: Trends in annual prevalence of cocaine use among population aged 15-64



23 EMCDDA, *Drug Situation in Europe*, Annual Report 2009.



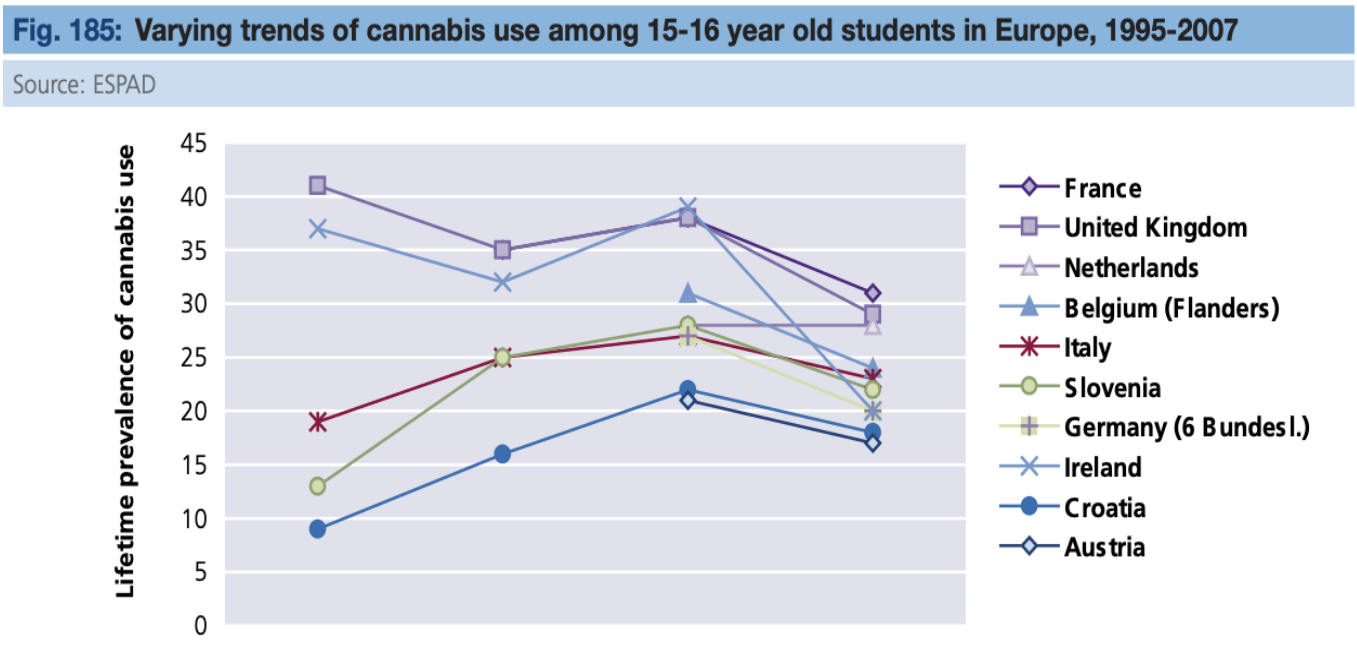


Figure 5: Life time use of cannabis in Italy for population 15-64

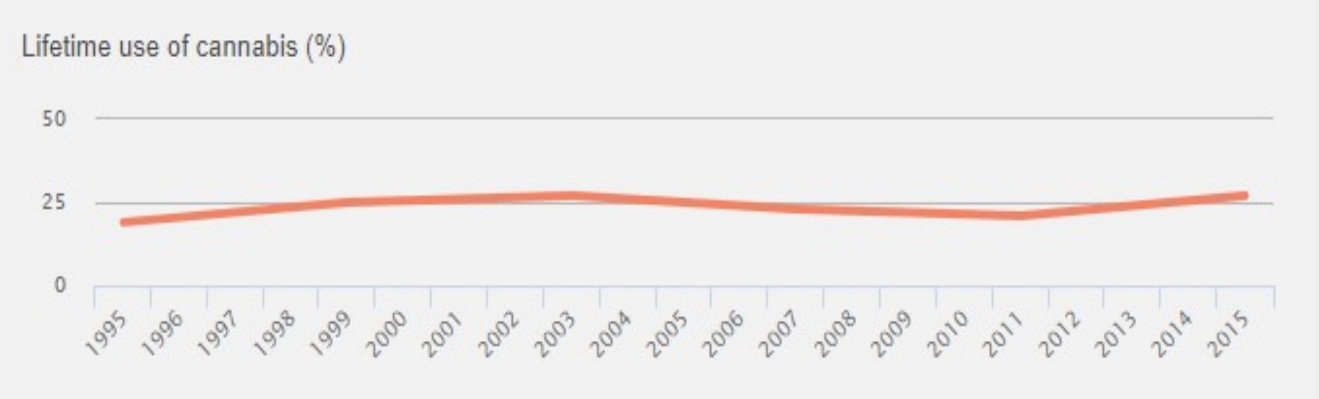
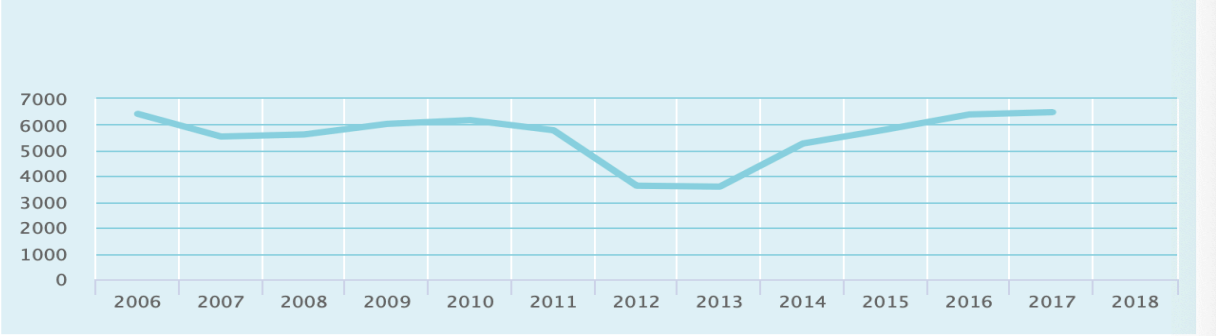


Figure 8: Cannabis users entering treatment facilities in Milan, Italy over 2006-2017



Quadro 29 - Resultados de Estudos: Prevalências do Consumo de Cocaína ao Longo da Vida (%)
2010-2015

Estudos		Consumos	2010	2011	2012	2014	2015
População Geral	INPG	Pop. Total (15-64 anos)	_	_	1,2	_	_
		Pop. Jovem Adulta (15-34 anos)			1,4		
	DDN	18 anos	_	_	_	_	4,6
Pop. Reclusa	INCAMP		_	_	_	38,9	_
População Escolar	ESPAD	16 anos	_	3	_	_	2
	HBSC/OMS	6.º/ 8.º/10.º ano	1,9	_	_	2,4 a)	_
	ECATD	13 anos	_	2,0	_	_	1,2
		14 anos	_	2,6	_	_	2,2
		15 anos	_	3,8	_	_	2,4
		16 anos	_	3,4	_	_	2,2
		17 anos	_	3,9	_	_	2,5
		18 anos	_	3,4	_	_	2,4
Pop. Jovem Internada em Centros Educativos	INCACE	14-20 anos	_	_	_	_	19,4

Figure 15: Public expenditure related to illicit drugs in Italy, EMCDDA

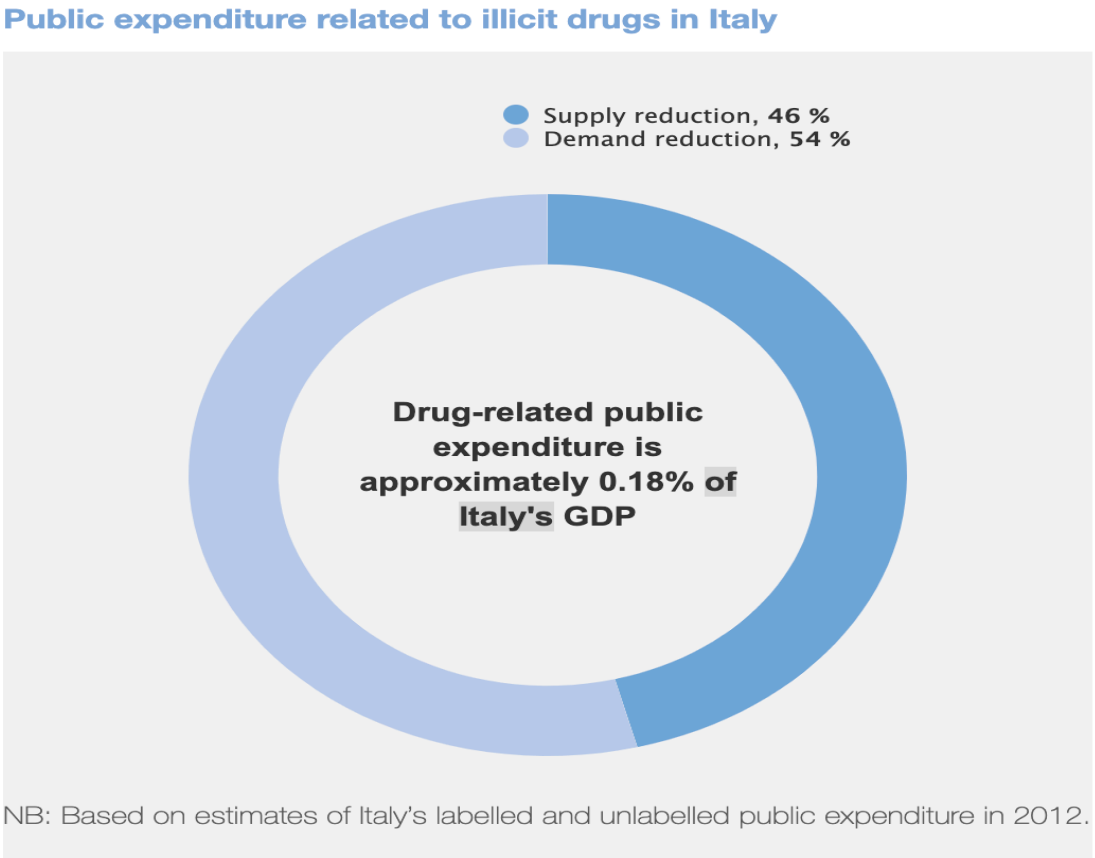
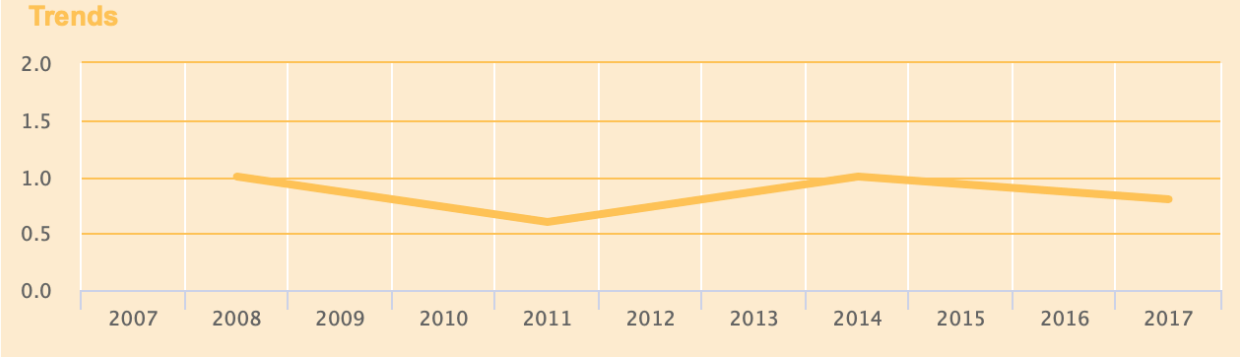


Figure 17: Supporting statements to Alternative 1 via evidence-backed research to predict future trends should status quo remain.

Among students aged 15-19 years old, cannabis was reported as the most used substance. 1/3rd of this demographic also reported having used cannabis at least once in the last calendar year. Another study conducted by the Sewage Analysis Core Group Europe (SCORE), which was a part of the Europe-wide annual wastewater campaign, uncovered data regarding stimulants and their leftover metabolites found in wastewater.

This was used to gauge illicit drug use levels within city perimeters. For example, in the city of Milan the results showed a considerable increase between 2015 and 2018 in cocaine and MDMA metabolites detected in the city's waste water (See figure 6 below for trends)[40]

Fig. 6 EMCDDA Graph showing MDMA usage for young adults between 15-24 years old.



(Y-axis shows percentage of adults who reported using the drug every calendar year)

[40] EMCDDA Graph delineates MDMA Usage for young adults aged 15-24 based on EMCDDA reporting in Italy

Figure 18: Worst case scenario:

Drug rates begin skyrocketing: One of the risks with decriminalization and with the provision of substitutes for drugs as a method of treatment, is increased drug use. There is the risk that decriminalization allows for the population to be able to purchase narcotics legally and possibly overdose, making it so that many more people are likely to become drug users or to experience drug-related illnesses or deaths.

The same can occur with the implementation of methadone supplies in treatment clinics. Substitutes can lead people who are otherwise not addicted, to become further addicted to certain narcotics. If these people end up being unable to attend treatment clinics for whatever reason, they are likely to recidivate into drug use again.

It becomes too costly: Policy implementation could be very effective and many people could start coming to treatment clinics to rid themselves of drug use, however, if the demand exceeds the supply of treatment facilities then new measures will have to be imposed and supplies will have to be increased. This could lead to millions of government funds going towards this policy, which would cause the policy itself to lose a lot of support from decision makers and stakeholders (such as the Ministry of Interior) and end up potentially bankrupting the government's extraneous funds.

The most important one to acknowledge is the skyrocketing drug rates: The government in coalition with UNODC/EMCDDA/UNICRI needs to monitor the levels of drug use after it is potentially decriminalized and substitutes become available because the worst thing that can happen is the policy creates more of a drug abuse problem.

Figure 19: Discussion of Portugal's drug policy for Alternative 2

Below are two EMCDDA graphs depicting drug usage in Portugal over the time period 2007-2017. Rates had already dropped from a much higher level (around 8.5%pm) since policy implementation in 2001, and around 2007 they were close to nearing 0%pm (EMCDDA)

Figure 10 shows amphetamine usage over 2007-2017 for individuals aged 15-64. What began at 0.4pm (per million people) decreased until it hit nearly 0%. It is important to note that treatment clinics had been established since 2001, and the initial number of drug users in 2001 was significantly higher. (EMCDDA)[6]

Figure 10: Amphetamine usage from 2007-2017 in Portugal for age group 15-64

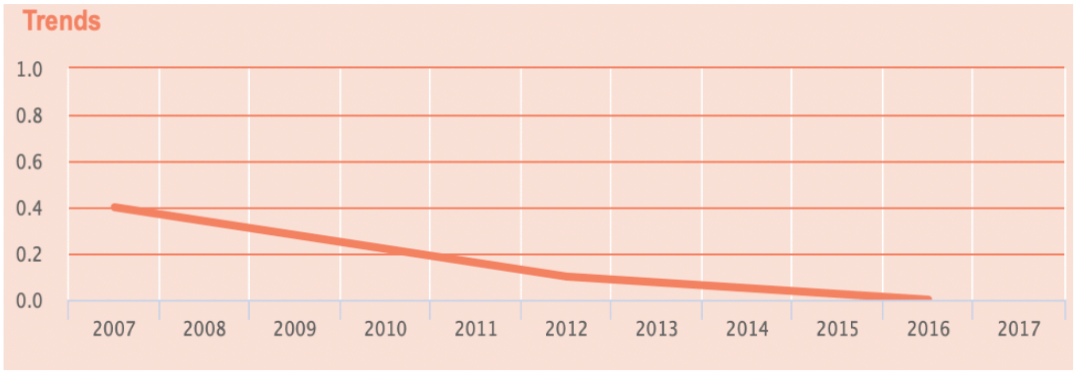
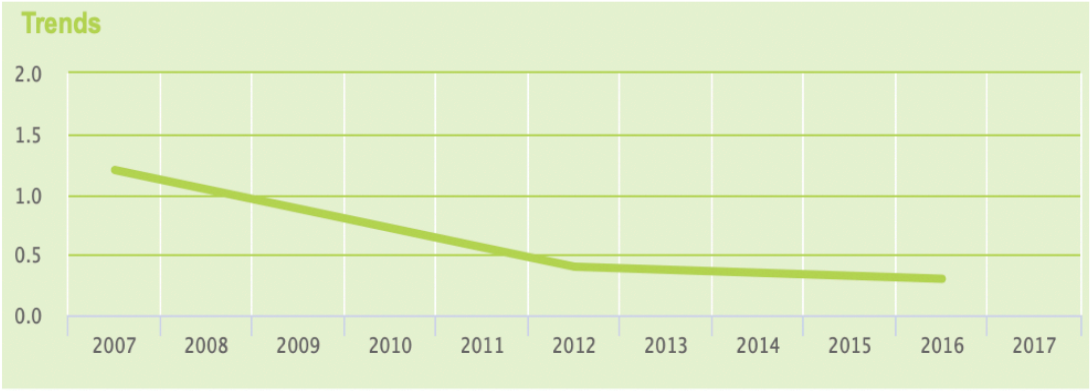


Figure 11 below shows Cocaine usage in Portugal over 2007-2017 for individuals aged 15-64. What began at 1.4pm (per million people) decreased until it stabilized around 0.4pm. It is equally important to remember that treatment clinics had been established since 2001, and the initial number of drug users in 2001 was significantly higher, at around 1.2%. We cannot be certain if the policy produced additional benefits in 2015, nor do we know if individuals substituted it with another drug. (source: EMCDDA)

Figure 11: Cocaine usage in Portugal over 2007-2017 for age group 15-64



[6] Figures derived from EMCDDA, ESPAD, and UNODC graphics which are comprised of data from Drug Policy studies

The number of drug users in 2001 was significantly higher, at around 1.2%. We cannot be certain if the policy produced additional benefits in 2015, nor do we know if individuals substituted it with another drug. (source: EMCDDA)

Figure 20: Foreseeable outcomes should Decriminalization occur

In terms of what we foresee occurring in Italy should the decriminalization of narcotics occur- we look to the long-term effects that have been recognized in Portugal since its respective decriminalization of narcotics

- Substance abuse and addiction were cut in half since 2001 (when policy was implemented) (Hughes)
- Violence related to drug trafficking was greatly reduced (Hughes)
- The countercultural essence of drug use is changed when society regards it as a disease and not a crime (Cardoso)

There are also several long term benefits associated with the decriminalization of drugs (sources from: UNODC)

- Addiction treatment and rehabilitation is less expensive than incarceration
- Individuals with substance abuse problems are more likely to recover in rehab than in jail
- People completing treatment can become productive members of society more easily than convicted felons
- Courts are free up for other important work.

However, there are several negative implications associated with the decriminalization of drugs, which became apparent throughout Portugal's decades with decriminalization. (UNODC)

- Individuals with a biological predisposition toward addiction may be more likely to experiment with drugs if they do not fear legal prosecution.
- Existing treatment resources aren't enough to handle the influx of millions of new addicts
- If decriminalization leads to an increased supply of drugs in the community, prices will fall and millions of new people may be tempted to experiment.

Based on evidence from SICAD (and subsequently, EMCDDA) drug use among adolescents decreased for several years following decriminalization. This suggests that removing criminal penalties for personal drug possession did not cause an increase in levels of drug use. Additionally, the number of newly diagnosed HIV cases stemming from people who inject drugs declined from 1016 to 56 between 2001 and 2012. (EMCDDA).[8]

Figure 21: Further effects of decriminalization from Portugal UNODC study

The below graph from SICAD shows that since 2009, and 8 years since the decriminalization of drug usage in Portugal, the amount of numerous types of illicit drugs reported to have been used by drug users dramatically decreased. This data was gathered by treatment clinics and self-reporting surveys for individuals aged 15-64, and it was conducted by SICAD in conjunction with EMCDDA.

Ano / Tipo de Droga [a]	2009	2010	2011	2012	2013	2014	2015
	Grama						
Haxixe [b]	22 965 577	34 773 666	14 632 884	18 314 067	8 688 998	32 877 460	2 411 978
Liamba	5 044 569	40 079	107 873	49 390	95 712	108 372	223 726
Cocaína	2 697 083	3 244 350	3 678 217	4 019 866	2 439 719	3 715 151	6 028 656
Heroína	128 073	46 947	72 908	65 541	55 457	38 691	97 273
	Comprimido						
Ecstasy [c]	8 987	48 370	7 791	73 887	14 554	7 169	50 934

Haxixe = Cannabis: in 2009, for people aged 15-64, nearly 30 million grams of Cannabis were reported to have been used. In 2015, that number dropped to 2 million grams in 2015 (worth noting, however, that spikes occurred in 2014 and 2010).

Heroind= Heroine: in 2009, for people aged 15-64, nearly 130,000 grams of heroin were reported to have been used. That number dropped to as low as 38,000 grams in 2014, despite a spike in 2015. Regardless of the spike, the general level of heroin use dropped altogether.

While this may not constitute as a causal effect in terms of whether the decriminalization of drugs directly lowered the levels of drug usage among populations, it provides solid statistical evidence to show that there is a relationship between the policy's implementation in 2001 and the statistical decrease of drug usage over the ensuing years.

Figure 22: Prevalence, Male vs Female, Italy vs rest of Europe

Lifetime prevalence of cocaine usage was also found to be higher among males than females (UNODC & ESPAD, 2007). Regarding treatment, the number of clients entering drug treatment with cocaine as the primary drug being used has been increasing in many European countries for several years. Between 2002 and 2007, large proportional increases among new clients were reported by Greece, Portugal, Spain and Ireland (ESPAD, 2007). Italy remains one of the last countries to experience a proportional increase among new clients checking into treatment facilities. This means that while cocaine usage is increasing in Italy, there is not a proportional increase of Italians seeking treatment for their drug abuse (EMCDDA, 2009).

Figure 23: ***How budgeting affected drug policies***

In terms of political budgeting, The *European Coalition for Just and Effective Drug policies* found that Italy spends 7.8 billion euros on policing and 2.9 billion on prisons (SIULP, 2016), whereas The Netherlands and Switzerland spend around 1.07 euros and 1.4 billion Swiss francs, respectively, on policing (Jurisdiche Neerlande, 2003 & Schweiz aktuell, 2016). The Netherlands spends around 712 million euros on its prison system and Switzerland spends around 400 million Swiss Francs on its prison systems (ECJED, 2006 & Rijksoverheid, 2013 & Federal Statistical Office of Switzerland, 2015).

While Italy maintains a high prison and policing budget, the lower government expenditure for The Netherlands and Switzerland allows the countries to allocate more funding for clinics, counselors, and harm reduction treatments. ECJED also identified that EU countries save 15 euros, on average, in police/health costs for each euro invested in drug education and counseling (ECJED, 2006). The rates of drug usage in The Netherlands and Switzerland have either plateaued or decreased, with overdose rates continuously decreasing.

Italy has suffered from budget cuts to harm reduction services over the past decade, due to lack of funding, which risks further augmenting the number drug users (EMCDDA, 2019). In 2012, drug-related public expenditure was estimated at approximately 0.18 % of gross domestic product (GDP), indicating a gradual decline since 2010 (0.25 % of GDP in 2010 and 0.2 % of GDP in 2011) (see figure 15 in appendix)

It is also more costly to continually enforce higher policing and prison maintenance, with the other option of creating clinics and counseling options for users coming at a lower cost. It is not only more effective in terms of reducing overdose rates and lowering the rate of drug users to pursue a harm reduction policy but more cost-efficient. [41]

[41] This was all discerned under oversight by UNODC, ECJED and European Department of Anti-Drug policies, and the rates are confirmed as reliable and effective to date.