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Crime issues in Substance Use Disorders: Need for a medically-based algorithm

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Summary

On political grounds, the liberalization and decriminalization of treatment instruments, as long as they are used for medical purposes, have become a priority in improving treatment standards. Scientifically based interventions should never be hampered by restrictive regulations targeting substance classes, let alone specific medical preparations. Pathways to recovery should also be made easier by lessening the restrictions on work and travel that are generally applied to substance users or offenders against laws on drugs. In other words, the figure of the patient should be allowed to prevail in legal contexts over that of the offender, as long as treatment can guarantee a positive outcome. For non-responders, alternative sanctions or 'decriminalization' may be considered too, although the need to prevent social harmfulness may justify restrictive measures. Decriminalization should stop being a substance-related matter, and become a diagnosis-related one. Categories of mentally ill patients (addiction being one main issue) should be decriminalized in so far as their offence can be considered a result of their addictive behaviour. Intoxication-related behaviour may, therefore, be decriminalized when it springs from addiction, and generically sanctioned when it is independent of addiction or other brain disorders. In terms of social security, decriminalization should be distinguished from depenalization. The person in question should not be charged with legal responsibility, as long as he/she is addicted or mentally ill, but restrictions may be applied when there is no other way of preventing social harm. The definition of categories of abuse, addiction and mental illness is a medical matter. One consequence is that the most reasonable way to allow 'pathologic' offenders to be given treatment is to check whether each offender belongs to a decriminalized category. The physician should become the central figure in assessing and handling social risk related to psychiatric disorders, because he/she is able to give medical criteria and knowledge priority over laws targeting generic substance use, trading in substances or substance-related crime.

Key Words: Criminality; decriminalisation; Substance Use Disorders; medically-based algorithm

1. Background

Since the earliest attempts at intervention against drug addiction, the reduction of addiction-related crime has remained a major objective. When methadone treatment was introduced, one of the main results of the narcotic-blockade approach was its impact on the social disruptiveness of addicts in general, and criminal addicts in particular [9].

On entering methadone treatment, heroin addicts begin to achieve a drastic reduction in criminal engagement, and that advantage is maintained across different programmes in different urban areas [4]. Moreover, the neutralization of proneness to crime by addicts is maintained in the long-term: at a one-year follow up, the level of criminal engagement does not reveal any resumption with respect to the short-term improvement [5, 11, 16].

In Italy, methadone treatment was formally introduced and organized during the early 1990's. Throughout that period, and continuing through the first decade of the 2000's, although the incidence of

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jailed addicts kept on increasing, the percentage of those being arrested while on treatment fell sharply. Thus it appears that the nationwide spread of methadone treatment protected addicts who had entered treatment from imprisonment, and society from crime [7].

The reduction of criminal activities is achieved before full remission, but it should be borne in mind that any improvement that may be achieved independently of remission has only a marginal impact. Addicts who fail to strictly follow the rules of a high threshold methadone programme may show a positive difference in showing higher rates for negative urine outcomes, but they have comparable rates of getting into new trouble with the law [6]. From these data, criminal activities seem to be a complication of addiction, rather than the expression of a natural disposition to break the law intrinsic to addicted people. On the other hand, a subgroup of addicts may continue to be involved in criminal activities, but what certainly dwindles during treatment programmes is the incidence of criminal acts (mostly unplanned and often clumsily carried out) that are brought on by craving and impulsive drug seeking [34].

High-dosage group patients, defined as taking 140 mg/day or more, had a zero percentage of recorded jail days during the previous 12 months, compared with 1.5% in patients taking less than 140 mg/day. A trend towards better results due to lower involvement in crime can therefore be expected from higher dosage patients, as long as dose increases take place in a programme that has a no dose ceiling policy. In any case, satisfactory results are obtained at average dosages; this confirms the hypothesis that there is a close relationship between the criminal stereotype, attributed to addicted people and the brain dynamics of their disease (Deglon, personal communication).

Based on such evidence, The United Nations Office for Drug and Crime has lately become engaged in treatment monitoring and the enhancement of treatment programmes, so as to lessen treatment demand, especially the demand coming from heavily addicted consumers [36].

The handling of substance-related crime and the social dangers that spring from drug use should be viewed in the context of the wider issue of crime related to mental health. The prevention of social issues brought on by mental disorders should include the monitoring of risk situations, besides the evaluation of stress levels in work, school, or other social environments. Likewise, the concerns that are felt about substance-related crime cannot avoid the legal choices that arise in dealing with permitted substance trading, circulation and possession, and policies about the lawfulness of encouraging or publicly approving drug use.

Thus addicted people, free users and drug traders are grouped together, as happens with all psychoactive substances, including therapeutic ones. One possible resulting paradox is that the disease-treatment channel and the free consumption channel end up by not even being properly differentiated. Any such lack of segregation between the criminal justice system and health system pathways may increase the overlap between personal use and individual involvement in low-rank drug trading, or the street drug environment in general. On the other hand, it may also discourage ill people from entering treatment and enduring throughout long-term rehabilitation.

The current legal algorithm is based on legal categories (use, possession, trading), to which exceptions are allowed in certain cases, such as being affected by addiction. One major flaw in such an array is that certain categories just do not retain their validity in cases of drug addiction, while with some others there is the dubious presumption that drug addicts are sensitive to punishment.

In our opinion, the legal system should be updated to keep pace with scientific knowledge, which closely concerns the prediction of human behaviour in cases of drug addiction. In fact, interventions against drug addiction originated – in different countries and across different historical periods – because of the need to shift drug addicts away from the domains of penalty and imprisonment. In jails, drug addicts make up a special risk category that calls for special precautions and treatments; after being discharged they are likely to lose any acquired advantage, due to predictable recidivism. The availability of addiction treatment has created an opportunity, both for addicts and the rest of society, to propose supervised treatment as an alternative to jail, so as to make treatment (rather than environmental measures) work as a means of rehabilitation and of keeping control over social perniciousness [21].

As things stand at present, most law authorities miss the opportunity to check the appropriateness of therapeutic interventions: treatment is only considered as appropriate as long as it is delivered by an authorized centre, but little attention is dedicated to ascertaining what that treatment consists of, or whether it sticks to the scientific standard for the therapy of that specific addiction.

Some addictions simply have no standard or

reliable treatment [19], but a generic 'rehabilitation treatment' involving various different professional figures is enough to give the impression that it is an acceptable therapeutic proposal.

On the other hand, diagnoses may be skipped, with no clear identification of what is meant by the 'addiction' category as opposed to habitual free consumption, or of 'abuse' patterns that fail to show any clear-cut signs of a chronic-relapsing course.

In Italy, for instance, a rise (though of minor degree) in the demand for treatment to solve cannabis use problems was registered after the law, passed in 2009, which introduced alternative measures for minor offences, as long as they were due to a state of addiction. That prompts the hypothesis that a lot of people charged with cannabis-related offences have claimed a state of cannabis addiction in order to be sentenced to rehabilitation. In this dynamic, it is up to a physician to formulate a diagnosis with an automatic legal consequence – a predicament that makes most physicians feel uncomfortable.

Furthermore, some kinds of offences are hardly ever reconsidered, despite a confirmed diagnosis of addiction. For instance, one very controversial issue is whether driving under the influence of drugs may be judged according to the offender's diagnostic status. In most cases, penalties are meted out in a sentence based on the offender's toxicological status, with no deeper inquiry into the chronological relationship between sampling, results and objective signs of intoxication, let alone tolerance [30].

General legal responsibility is another dilemma that dogs all systems. On theoretical grounds, the absence of control over one's mental functions, when those functions are impaired as a symptom or as a result of addiction, should render individuals exempt from being charged with any offense. A distinction is usually drawn between an incapability to understand the consequences of one's own actions, and an incapability to ponder decisions in a way that is consistent with one's own intention. In the Italian legal system, for instance, no one can be charged with any penalty as long as either of these two capabilities is missing. On the other hand, it is unlikely that addicts will get absolved within this conceptual frame, especially if they were not 'intoxicated' when committing the crime. In fact, any claim to have been no longer 'responsible' for one's deeds because of intoxication may elicit an opposite judgment, that is, the offender should be considered to have twice the responsibility, because of having intoxicated oneself, so increasing the risk of committing a crime.

2. Use and possession

It is surprising that most countries should take the view that substance use should be punished by fines or even by imprisonment. It is hard to make out whether this is equivalent to a moral statement against the recreational use of drugs, or else is meant to discourage people from using them at all. Some countries explicitly aim at punishing public drug use (Croatia, Spain), whereas elsewhere penalties are only applied for opium use (Table 1).

Our focus, however, has to stay fixed on the penalties for recidivism of use, and use by addicted persons, whose aspects are intermingled. A drug addict is likely to break use-related laws repeatedly. Most countries do not have any specific laws for use-offence by addicted people. Even so, intrinsic contradictions are possible. In Malta, for instance, addicts may be admitted to probation instead of jail, but recidivism

Table 1. Penalties in Europe

Countries with variations of penalties in case of addictive use
Greece (no penalty)
Ireland (treatment instead of penalty)
Malta (probation instead of penalty, and treatment)
Portugal (treatment instead of penalty, non pecuniary and pecuniary sanctions)
Countries with variations of penalties in case of repeated offense
Luxembourg
Cyprus
France
Hungary: no alternative to penalty in case of recidivism
Latvia: penal instead of civil responsibility
Malta: no chance to be granted with probation

rules out any such solution: addicts are regarded as justifiable the first time, as if they were a category of people who are prone to experimental use, but will stop after the first sanction.

In Portugal too, the police is obliged to assign to one of the Drug Dissuasion Commissions any offender which has with him/her quantities of illegal drugs not considered as trafficking (decriminalization of consumption). But it is not uncommon for the offender not to be sent to the Commissions, or being sent does not attend it. Ther are 22 Drug Dissuasion Commissions in Portugal (mainland and islands).

Each Drug Dissuasion Commission may choose to send or not to send the consumer to a treatment facility. Sanctions for addicts should be non-pecuniary. It's possible to pay money or to do some activity for the community.

Free recreational users have the chance of being sent to Treatment Centre (which is not indicated).

In a few countries, which feature penalties for use, addicts are sent to compulsory treatment. The paradox, in countries that do not apply penalties for use is that addicts cannot be sent to any compulsory treatment, since use is not regarded as an offence. The idea of not punishing addicts for use is itself sensible, but addicts should follow different legal pathways from recreational users. Use may not be sanctioned in either case, but the identification of users as addicts should be followed by semi-compulsory treatment solutions. On one hand, treatment is not a sanction, and should not be accompanied by stigma or by other drawbacks or interference with one's job and family status. On the other hand, the health system should become involved in treating cases of addiction, regardless of how they come to its attention (which may also be due to the accidental identification of non-punishable use).

3. Decriminalization of recidivism

Successful decriminalization has had two characteristics: 1) Making addiction (and pathological use in general) a target; 2) Ensuring the availability of treatment for each specific type of addiction. Needless to say, successful decriminalization has been closely focused on opiate addiction. No similar concern has targeted alcoholism, although it is a major health and social issue. Given the legal status of alcohol in most countries, no penalties are foreseen for its use, or possession, or for making it available to others, either for free or by selling it (except when underage subjects are involved).

Despite the social problems to be faced, the way alcohol-related crime is handled has changed by introducing a decriminalizing philosophy. Offenders who abuse alcohol should be assessed and then referred to treatments, or at least be left free to choose whether to protect themselves from penalties by acquiring a certified in-treatment status. Alcohol abusers, who are not relapsing in an automatic way, but may be led to experiencing single abuse episodes by a variety of factors, may be advised about how to prevent further abuse episodes, and, possibly, be referred to specific treatments. It should always be kept in mind that penalties are among the factors that often carry weight in determining a patient's decision to avoid excessive consumption. In cases where alcohol abusers suffer from mental disorders, psychiatric treatment should be considered.

A clear separation should exist between the legal handling of addictions (alcoholism included) and non-addictive abuse. For addictions, treatment should be proposed as the only alternative to handing out a penalty, and penalties should not be considered in a rehabilitative perspective, since rehabilitative efforts in the absence of treatment have a poor outcome. There is always the danger that limitations on freedom and the loss of family rights, or even rehabilitative opportunities (e.g. jobs) may function as drawbacks that induce addicts to reject the option of treatment.

For non-addicted abusers, penalties may be suspended, but recidivism should be followed by the proposal of treatment or monitoring as an alternative to the application of penalties.

Recidivism should increase the likelihood of treatment for addicts, without increasing the likelihood of a penalty (at least pecuniary sanctions, otherwise imprisonment). For non-addicted abusers, the likelihood of a penalty being applied should increase in parallel with the opportunity to avoid it by accepting specific interventions (varying on the basis of the kind of risk factors that can be identified).

It is only reasonable to admit that alternative measures may be suspended or revoked if they prove to be ineffective. On the other hand it always takes time before it can be claimed that a treatment is reliably effective, or can be presumed to be ineffective. Legal authorities often seem to allow alternative measures for people they judge to be reliable, or those who seem truly willing to change their lifestyle. In this case, the law fails to speak the language of addiction. The simple availability of, and/or the individual’s willingness to undergo some treatment programme is a good starting point, but these pre-

conditions do not predict the outcome at all. Good outcomes are possible when that person is obliged to get treatment, and bad outcomes are always possible despite good intentions.

Thus the legal decision should be weighed on the basis of the most likely outcome, while the opportunity to benefit from an alternative measure or from depenalization should be primarily founded on the diagnostic status, to be supplemented by the availability of any documented treatment option, or any structured experimental treatment.

During that 'trial' period, that individual should not be considered as if 'on probation', susceptible to arrest and to withdrawal of all benefits if there is recidivism or the violation of any rule. Responding to treatment is an outcome, not a rule, and cannot be controlled by the patient. Relapsing, and doing so with associated criminal behaviour, should, in fact, be regarded as a confirmation of the diagnosis as defined, rather than a contradiction of that person's acceptance of treatment.

4. Depenalization

To date, no legal system has ever superseded the dilemma of quantity and modalities of use. In other words, drug-addicted people may not be sentenced to jail, but the depenalization of drug-smuggling is not considered admissible, even if the offence arises from the need to supply oneself with money or drugs as a direct consequence of one's addictive condition. Moreover, penalties may change, and be made milder or converted into supervised rehabilitation or treatment, but the original charges are not cancelled, anyway. To date, allowing possession and free trading below a certain threshold is bound to bring in its wake new trends in the area of non-punishable drug trafficking.

4.1. A comparison between two European Countries: Portugal and Italy

The Portuguese legal system underwent a change in 2001, by allowing problematic drug users to be evaluated by a commission, and be sent to treatment instead of being jailed and legally sanctioned [31]. This political decision which has joined the increase of Harm Reduction Programs and the exponential previous increase in Treatment Programs and facilities, (since late 80ties to 2000) including Opiate Maintenance Programs (High and Low Threshold Programs) was an answer to the 2000 opiate-related health emergency [28].

The reduction of crime rates, HIV seroconversion, and addictive behaviours stands as a breakthrough in the history of opiate addiction treatment [35].

People in Italy continue to debate the respective merits of the liberalization or legalization of drug use, the latter looming as more viable on political grounds. Nevertheless, some parties have invariably taken a strong position against any tolerance to drug use, raising major criticism over the distinction between light and heavy drugs. Portugal is usually mentioned as an example of successful legalization policy, mostly in support of the idea that the decriminalization of light drug use has led to no rise in the consumption of light drugs, and probably to the alleviation of drug-related harm attributable to more responsible and aware drug use.

But in Portugal really the decriminalization of consumption (2001) has been done for all illegal drugs. But no illegal drugs have been legalized. So no drug user has the right to have any illegal drug with him/her (even for personal use). In practice, in the face of a drug user non-trafficker (having small quantities), the police seize the drugs, or invites the owner to destroy it, or make as if he/she didn't saw nothing. In the last 12 years in Portugal heroin consumption has stabilized, but cannabis, cocaine, syntetic drugs and alcohol have gradually and significantly increased. The Portuguese Harm Reduction Law (also from 2001) legalized the activity of Testing and the Consumption Rooms, among other innovative measures. However, aseptic consumption rooms (fixed or mobile units) are still not being created and drug testing programs remain unconfined [28].

The first thing to be noted is the intrinsic paradox of that view (i.e. the decriminalization of drug use supposedly yields the advantage of reducing involvement in drug use – a view that itself implies the assumption that such use is indeed harmful). Apart from that, the status of the Portuguese 2000 law differs little from the Italian one dating back to 2009. Drug use was decriminalized, apart from cases in which possession is proved to be aimed at selling or handing over drugs, no matter if that happens on a presumably free basis. A quantitative threshold is resorted to as a criterion for presuming the aim of possession, whether for personal use or with the aim of selling/delivering drugs to others. Although use itself is not considered an offence, it may enhance the severity of any penalties that are handed down, as a sign of voluntary risk-taking behaviour or harmful

empowerment of one's criminal potential. Addicted people are considered to belong to a special class, and may lodge a request to avoid imprisonment as long as they declare they are willing therapeutic programmes. For major offences, judges usually accept residential treatment or house arrest as an alternative to prison.

In Italy, the 2009 law contained some changes with respect to the previous one (1990), and was meant to avoid the overcrowding of prisons by drug addicts, on one hand; and implement the healthcare system for people with pathological drug abuse, by favouring semi-coercive treatment programmes, on the other. To tell the truth, we cannot state that drug possession in Italy is no longer a legal problem, although it is no longer officially an offence in itself. People who are found to possess drugs may be arrested before the quantities and types of substances have been ascertained, and may be treated as presumed sellers on the basis of vague features (e.g. travelling with drugs, or the pool-buying of drugs by a group of friends, or buying on behalf of others). By contrast, it often happens that cases of drug abuse follow the path of treatment instead of imprisonment, without there being any clear diagnostic status referring, for instance, to "cannabis dependence" or "the pathological use of cannabis as a drug". The transition from the DSM-IV category "dependence" to the quantitative grading of "substance-use problems" that was introduced in DMS-5 is not helpful in clarifying the nature and prognosis of clinical pictures, and thus paves the way for the indiscriminate use of the word "pathologic" to label any drug use that has legal complications [1, 2].

Moreover, the Portuguese law tends to rule out punishment for offenders, but allows judges to punish drug-using offenders in cases of recidivism. Since recidivism is the rule for addicts, although not exclusive to them, addicts seem to be the category most subject to punishment in the long term.

On the whole, we conclude that no legal system has yet accepted or theorized the fact that addicted people are not conditioned by punishment, as far as addiction-related offences are concerned, whereas non-pathological drug users may be. The standard approach to serial offences is still to keep on increasing the level of punishment, even when that is offered as an alternative to imprisonment. In general, first-time offenders who prove to have a drug problem may not undergo any financial penalty, or be sentenced to compulsorily undergo treatment, but may be sent to prison, and afterwards may not be given the same kind of opportunities as other offenders in cases of recidivism.

5. Driving and work licences

Among penalties inflicted on drug users, the rejection or withdrawal of licences (to do a certain type of work, or to drive) is not to be underrated, especially from a rehabilitative viewpoint.

Usually, public officers who are responsible for licencing citizens cannot base their judgement on anything but a table of non-compatible substances. In other words, the idea of compatibility should not refer to an individual's status, whether pharmacological or clinical, but to toxicological analyses. Moreover, tables of monitored substances are often compiled to include therapeutic agents, such as methadone or buprenorphine [8, 13, 30, 33]. Any exceptions to be made, are, in principle, part of the officer's responsibility.

The pharmacological status of a drug is unlikely to be investigated or have any weight, beyond the single feature of dose quantification. For instance, a threshold for legal driving after drinking alcohol has been defined, and has been changed over the years, but the weight of pharmacodynamic and environmental tolerance does not influence the presumption of 'driving under the influence' of alcohol. In the case of road accidents, it is quite likely that drug users must face trial on the basis of a positive urinalysis result, with no further evidence of current mental abnormality. Opposition to the standard charges made in this kind of situation is possible, but that requires assistance by a lawyer, covering the whole duration of a regular trial.

6. Can prisons offer a chance to start treatment?

To date, alternative measure for addicts have been intended to avoid imprisonment. Nevertheless, one major issue of free attendance programmes is attrition, which is a natural limit to the rate of response to treatment, often defined as absolute resistance [20]. On the other hand, data about compulsory treatment, or parole based on compliance with treatments, shows that results tend to be better when patients are not left completely free to decide whether to enrol or not. By enrolling for non-therapeutic purposes, they find themselves achieving better therapeutic results. From a medically centred perspective, that kind of datum is not hard to explain: since an addict's brain does not lead to functional behaviour, including a range of pro-therapeutic choices, situations in which patients are

persuaded to undergo treatment because of the legal advantages to be gained by doing so is a good way to overcome their resistance, prevent dropout and avoid premature treatment termination through the achievement of results [35].

Prisons may be organized in such a way as to include addiction-treatment units, so aiming at initiating treatment while remaining closely linked to external facilities [10, 14, 15, 18, 27, 29, 38].

In a way different from what is likely to happen at present, heroin addicts currently under agonist treatment should not be detoxified or discharged without receiving at least their previously prescribed dose; on the opposite hypothesis – of heroin addicts currently receiving no treatment, they should be required to start or resume agonist treatment, and discharge may be planned only after the induction phase has been completed, by linking patients up with external facilities.

Drug use in prison, violent behaviours and recidivism can then be expected to diminish, whereas a subpopulation of otherwise incurable addicts may find their way towards remission if long-term ongoing treatment is attached to personal freedom by paroling.

Unfortunately, some programmes have had no impact on either recidivism or substance abuse outcomes [3].

7. Bridging social security and individual health

Allowing the spread of toxic substances in a state's environment has never been considered acceptable. The best compromise between the citizen's freedom to use drugs and the need to limit the toxic effects of drugs on a state's population has taken the form of fixing a quantitative threshold discriminating between possession for personal use, and the presumption of drug trading in the background. Nevertheless, that compromise did not overcome the conceptual contradiction between the preservation of the individual's freedom and the protection of the individual's health.

As long as the spread of, and exposure to drugs is tolerated, a State should still be responsible for the treatment of drug-induced problems, at least in those cases which go beyond the limits of self-determined and controlled consumption.

On the other hand, the social perniciousness of drug-related behaviour is maintained, when not enhanced, in cases of addictive use. In this sense, a solution is imperative to give society the necessary protection from addictive behaviours, and give addicts themselves protection from their disease they are suffering from.

On psychopathological grounds, it should be remembered that addicted users are not prone to enter and stay in treatment in the absence of emergency conditions. Getting an addicted patient into long-term treatment is quite awkward, although motivational treatment and concurrent problems may favour earlier and longer-lasting engagement.

Newman summed up this concept in the forceful phrase: “we'll make them an offer they can't refuse” [25]. The patient complies with treatment because of an expected improvement or the prospect of advantages, or to avoid further harm, long enough for treatment to change his/her brain. Before this change actually happens, no really proactive attitude should be expected, but the patient is somehow tricked into healing by overcoming the anti-therapeutic behaviour that arises from addiction.

8. Harmfulness of substances: the common ground between decriminalization and prohibitionism

The implication of decriminalization is the awareness of the harmlessness of certain substances which were previously stigmatized as toxic or pernicious due to cultural positions or prejudice, rather than along medical knowledge. We cannot ignore the ideological paradox by which prohibitionism and decriminalization overlap on a common ground: some substances are considered dangerous [26], and their legal room is made narrow. The greatest controversy is that about some drugs, so called “light”. On political grounds, it seems that argumenting about the legal status of a generic substance class (cannabinoids) is easier than introducing the concept of legal purposes. In Italy, for instance, the authorization of cannabis use for therapeutic purposes has come along a cultural campaign for free cannabis, although medical criteria for the choice of safe therapeutic marijuana were respected. The therapeutic use of opioids for addiction treatment is possible, but failed to receive any major political support. Surely, there has been greater interest for the authorization of free heroin to heroin addicts in the last year, that there has been for the increase of freedom in the use of medical methadone and buprenorphine during the last 30 years [12].

On the whole, decriminalization and prohibitionism should not be seen as antithetic, since opposite position may be equally sensible if applied to

different substances, or different purposes.

When only one ideology is accounted for, the above-mentioned paradox is bound to emerge. Let us consider the case of marijuana.

Model finds gathered marijuana-related hospital data from 1975 to 1978 for 21 metropolitan statistical areas in the Drug Abuse Warning Network (DAWN) [24]. His study supplies abundant data on the consequences of the decriminalization of the possession of small amounts of marijuana by 11 US states between 1973 and 1978. This historic change presumably reduced the full price of marijuana.

It has been reported that the legal status of cannabis is related to higher levels of declared use. Such survey-based studies, in our opinion, fail to produce any evidence a priori. A positive correlation might, in fact, do no more than mirror an increase in users' confidence in reporting the truth about their personal marijuana usage, without any fear of legal consequences; whereas a negative result might be due a reasonable reluctance to do the same, regardless of the official legal status. In other words, results may be useful to illustrate a cultural change towards cannabis use by users, or the perceived legal risk of self-reporting drug use, but cannot clarify trend of actual drug exposure.

In states with medical marijuana laws, marijuana use is more likely, as well as episodes of abuse. However, current marijuana use presenting as abuse or dependence is the same as frequent as in states with different legal status. Apart from the possible link between increased use and medical use, rates are just slightly higher. Episodes of abuse can be said to be more likely, with no clear distinction between isolated episodes of abuse or chronic relapsing abuse (dependence), Abuse is related to a higher rate of exposure to cannabis [23, 32].

In California, drivers testing positive for THC at random or targeted controls have not increased during the years of legalization. Nevertheless, a rising trend of cannabis-positive cases in lethally injured drivers has been found. It is not clear whether these cases accounted for an increase in lethal accidents and were thus attributable to cannabis exposure, or they just accounted for a higher rate of cannabis use by drivers who are predisposed to lethal accidents for other reasons (e.g. alcohol abuse). We may state that a subgroup of drivers who died in accidents was also more likely to have been exposed to cannabis, although this finding was not enough to delineate any causal relationship [30].

In a legal cannabis sanctuary, The Netherlands, cannabis use trends seem to develop independently of changes in cannabis policy. Recently, concerns about a reconsideration of the legal status of cannabis have been expressed because of a change in local cannabis quality (its higher THC content) [17].

Decriminalization of marijuana does not seem to reduce declared cannabis use, but is likely to increase initiation of use by naive individuals (youths), while experienced consumers may not be influenced at all, although favoured in managing their consumption habit. Across different countries, the prevalent effect of decriminalization seems to be an increase in regular use, at least once five years have passed after a policy change [37].

Probably the only feasible way forward is aprohibitionism [22]. According to Michelazzi, what is needed is a qualitative more forward, one that goes beyond their confrontation, and beyond the stances either of anti-prohibitionism or prohibitionism. We need a standpoint specifically different from these two – prohibitionism and anti-prohibitionism, keeping them at a safe distance and distancing itself from them, while stripping them of their 'raisons d'etre' and their opposition.

We prefer to talk about aprohibitionism, where a distancing effect can be perceived at first sight – coming to us from the signifier. In practice, this means there is a need to devise ways of thinking that go beyond the logics either of prohibitionism or anti-prohibitionism. This requires us to think up a procedure that does not legalize drugs with the aim of making them marketable. It means thinking up a procedure that makes it possible to cope with needs beyond their immediate expression, and beyond enforced medical treatment, but also beyond any possible increase in the supply of psychoactive drugs. It means viewing the potential consumption of desired substances in a way that aims to keep them outside markets where they can be bought and sold. It means stripping a particular kind of goods of their most conspicuous features, so allowing both the lawfulness of what stands outside the any commercial type of logic, and a distancing from any course of action that can be evaluated directly in terms of public consumption. To achieve this, we believe that we must distinguish between substances according to their specific noxiousness, on the grounds of the degree of dependency they induce, but also in terms of their actual toxicity and the degree of alteration they produce in states of consciousness.

9. Conclusions

On political grounds, the liberalization of treatment, and the decriminalization of treatment instruments, as far as these are directed to medical purposes, is a priority in attempting to improve treatment standards. Scientifically based interventions should never be hampered by restrictive regulations targeting substance classes, let alone specific medical preparations. Pathways to recovery should also be made attractive by alleviating restrictions on work and travel, which are generally applied to substance users or offenders against drug laws. In other words, the figure of the patient should always be made legally prevalent over that of the offender, as long as treatment can guarantee a positive outcome. For non-responders, alternative sanctions or decriminalization may be considered too, although the need to prevent social harmfulness may justify restrictive measures.

Decriminalization should stop being a substance-related matter, and become a diagnosis-related one. Categories of mentally ill patients (addiction being one main issue) should be 'decriminalized' as far as their offence is considered to arise from their addictive behaviour. Intoxication-related behaviour, therefore, may be decriminalized if it is derived from addiction, but generically sanctioned when independent of addiction or other brain disorders. In terms of social security, decriminalization should be distinguished from depenalization. The accused person may be not charged with legal responsibility, as long as he/she is addicted/mentally ill, but forms of restriction may be applied when no other means are available to prevent social harm.

The definition of categories of abuse, addiction and mental illness is a medical matter. On this foundation, the most reasonable way to deliver treatment to 'pathologic' offenders, is to check whether they belong to a decriminalized category on a case by case basis. The physician should become a central figure in defining and handling the social risks related to psychiatric disorders, by placing medical criteria and knowledge at a higher hierarchical level than laws targeting generic substance use, or trade- or substance-related crime.

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