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

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Summary

On political grounds, liberalization of treatment, and decriminalization of treatment instruments, as far as used for medical purposes, is a priority for treatment standards to improve. Scientifically based interventions should never be hampered by restrictive regulations targeting substance classes, let alone specific medical preparations. Pathways to recovery should be encouraged also by abating restrictions to work, travel, which are generally applied to substance users or drug law offenders. In other words, the patient figure should lawfully prevail on the offender's figure, as long as treatment can guarantee a positive outcome. For non-responders, alternative sanctions or decriminalization may be considered as well, although the need to prevent social harmfulness may justify restrictive measures.

Decriminalization should stop being a substance-related matter, and become a diagnosis-related matter. Categories of mentally ill patients (addiction being one main issue) should be "decriminalized" as far as their offence is considered related to their addictive behaviour. Intoxication-related behaviour, therefore, may be decriminalized if borne by addiction, and generically sanctioned when independent of addiction or other brain disorders. In terms of social security, decriminalization may be distinguished by depenalization. The person may be not charged with legal responsibility, as long as addicted/mentally ill, but 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. Thereby, the most reasonable way to grant "pathologic" offenders with treatment, is to check the offender's belonging to decriminalized categories case by case. Physician should become a central figure to define and handle social risk 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.

Background

Since early attempts of intervention against drug addiction, the reduction addiction-related crime has been a major concern. When methadone treatment was introduced, one of the main results of the narcotic-blockade approach was represented by the impact on the social disruptiveness of addicts in general, and criminal addicts in particular {Dole, 1968 #368}.

Heroin addicts entering methadone treatment meet a drastic reduction of criminal engagement, which advantage is maintained across different programs in different urban areas {Ball, 1991 #422}. Moreover, the neutralization of proneness to crime by addicts is maintained in the long-term: at a one year's follow up the rate of criminal engagement does has not met any re-increase with respect to the short-term improvement {Gossop, 2005 #8906}{Bellin, 1999 #5061}{Keen, 2000 #5041}.

In Italy, methadone treatment was formally introduced and organized during the early 1990's. Across that period, and on through 2000's, although the rate of jailed addicts kept on increasing, the percentage of those being arrested while on treatment sharply decreased. Thereby, the nationwide spread of methadone treatment may have protected addicts who had entered treatment from imprisonment, and society from crime {Colombo, 1986 #5055}.

The reduction of criminal activities is achieved before full remission, and may be achieve despite remission is just partial. Addicts who fail to follow strictly a high threshold methadone program rules differ by the rate of negative urine outcome, but have comparable rates of new trouble with the law {Bianchi, 1992 #7802}. From these data, criminal activities seem to be a complication of addiction, instead of the expression of a natural disposition of addicted people to break the law. On the other hand, a subgroup of addicts may continue to be involved in criminal activities, but what certainly dwindles during treatment programs is that kind of criminal acts (mostly not organized and often clumsy) which are brought on by craving and impulsive drug seeking {Uchtenhagen, 1997 #5035}.

High-dosage group patients, defined as taking 140 mg/day or more, had a 0% percentage of last year's jail days, compared to 1,5% amongst patients taking less than 140 mg/day. Thereby, a trend towards better results upon criminal involvement is expected for higher dosage patients, as long as dose increase takes place in a programme with no dose ceiling politics. However, satisfactory results are obtained at average dosages, which confirm the hypothesis of a close relationship between the criminal stereotype of 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 engaged into treatment monitoring and enhancement of treatment programmes, in order to abate treatment demand, especially by heavy and addicted consumers {UNODC-WHO, 2008 #7939}.

The handling of substance-related crime and social danger borne by drug use should be inscribed within the larger issue of mental health-related crime. Prevention of social trouble brought on by mental disorders also includes the monitoring and risk-situations, or evaluating the stress level at work, school, or other social environments. Likewise, the concern about substance-related crime cannot avoid to deal with legal choices about free substance trading, circulation and possession, and policies about the lawfulness of encouragement or public approval of drug use.

Thus, addicted people, free users, drug traders are grouped together, and so are all psychoactive substances, including therapeutic ones. One possible resulting paradox is that the disease-treatment channel and the free consumption channel are not discriminated eventually. Such lack of segregation between the criminal justice and the health system pathways may increase the overlap between personal use and involvement in low-rank drug trading, or the street drug environment in general. On the other hand, it also may discourage ill people from entering treatment and enduring in 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 stand in case of drug addiction, while some others are there in the presumption that drug addicts are sensitive to punishment.

In our opinion, the legal system should update to scientific knowledge, which closely concerns the prediction of human behaviour in case 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 from the pathway of penalty and imprisonment. Drug addicts represent a risk category in jails, which require special precautions and treatments, and are likely to lose any acquired advantage after discharge, due to predictable recidivism. The availability of addiction treatment has introduced a chance, both for addicts and the rest of society, to propose supervised treatment as an alternative to jail, so to make treatment (instead of environmental measures) works as means rehabilitation and control of social perniciousness {Maremmani, 2004 #5584}.

On the other hand, most law authorities miss to check the appropriateness of therapeutic interventions: treatment is considered as appropriate as long as delivered by an authorized

centre but little attention is dedicated to the ascertainment of what treatment consists of, and whether is sticks to the scientific standard for the therapy of that specific addiction.

Some addictions just have no standard and reliable treatment {Maremmani, 2003 #5363}, but a generic "rehabilitation treatment" involving 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 the "addiction" category as opposed to the free consumption, or the "abuse" patterns with no clear-cut signs of chronic-relapsing course.

In Italy, for instance, a rise (though of minor weight) in the rate of treatment demand for cannabis-use-problems was registered after the a law act, dating 2009, which introduced alternative measures for minor offenses, as long as due to a state of addiction. It is not difficult to hypothesize that a lot of people charged with cannabis-related offenses have claimed a state of cannabis addiction in order to be sentenced to rehabilitation. In such a dynamic, it is up to a physician to formulate a diagnosis with an automatic legal consequence, which finds most of them uncomfortable.

Furthermore, some kind of offenses are hardly reconsidered despite a confirmed diagnosis of addiction. For instance, it is very controversial whether driving under the effect of drugs may be judged according to the offender's diagnostic status. In most cases, penalties are sentenced out according to a toxicological status, with no deeper view into the chronological relationship between sampling, results and objective signs of intoxication, let alone tolerance {Pollini, 2015 #10771}.

General legal responsibility is another dilemma of all systems. On theoretical grounds, the absence of control upon one's mental functions, when those functions are impaired as a symptom or a result of addiction, should render individuals not chargeable with any offense. A distinction is usually made between the incapability to understand the consequences of one's own actions, and the incapability to ponder decision in a way that is consistent with one's own intention. In the Italian legal system, for instance, a persons cannot be charged with any penalty as long as missing either of the two capabilities. Nevertheless, it is unlikely that addicts get "absolved" along such a conceptual frame, especially if they were not "intoxicated" when committing the crime. Oppositely, claiming to have been "irresponsible" of one's deeds because of intoxication may elicit an opposite judgment, that is to be twice as much responsible, because of having intoxicated oneself, thus increasing the risk of committing crime.

1 Use and possession

It is surprising how most countries think that substance use should be punished by either fines or even imprisonment. We cannot make out whether it equals to a moral statement against the recreational use of drugs, or else it is meant to discourage people from using. Some countries explicitly aim at punishing public drug use (Croatia, Spain), while for others penalties are only featured for opium (table 1).

Out focus, however, is rather on the penalties for recidivism (of use) and use by addicted persons, which aspects are intermingled. A drug addict is likely to break use-related laws repeatedly. Most countries do not have specific law for use-offense by addicted persons. Nevertheless, intrinsic contradictions are possible. In Malta, for instance, addicts may be admitted to probation instead of jail, but recidivism rules out such a chance: 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 also, the court is obliged to send the new offender to a drug treatment commission, but has may choose not to do it again for already known offenders. Sanctions for addicts must be non-pecuniary. In these cases, free recreational users have greater chances to ask for treatment (which is not indicated), than addicts displaying as recidivists.

A few countries, which feature penalties for use, addicts are send to compulsory treatment. The paradox in countries, which do not feature penalties for use, is that addicts cannot be send to any compulsory treatment, since use is not regarded as an offense. The idea not to punish addicts for use is itself sensible, but addicts and recreational users should follow different legal pathways. 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 other drawbacks or interference with one's job and family status. On the other hand, the health system should engage in treating cases of addiction, regardless of how they come to its attention (which may also be for the accidental identification of non-punishable use).

2 Decriminalization of recidivism

Successful decriminalization has had two characteristics: 1) addiction (pathologic use in general) as a target; 2) the availability of treatment for that specific addiction. Needless to say, successful decriminalization has concerned opiate addiction. A similar concern has not targeted alcoholism, although it is a main health and social issue. Given the legal status of alcohol in

most countries, no penalties are featured for use, possession and making it available to other, either for free or by selling (except when underage subjects are involved).

Nevertheless, the handling of alcohol-related crime does deserve a change by a decriminalizing philosophy. Alcohol-abusing offenders should be evaluated and addressed to treatments, or left free to choose whether protect themselves from penalties by a certified in-treatment status. Alcohol abusers, who are not relapsing in an automatic way, but may be lead to single abuse episodes by different factors, may be advised about how to prevent further abuse episodes, and possibly addressed to specific treatments. However, penalties are included amongst the factors which may themselves weight on the patient's decision to avoid excessive consumption. For alcohol abusers who suffer from mental disorders, psychiatric treatment should be considered.

A clear difference 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 penalty, and penalties should not be conceived in a rehabilitative perspective, since rehabilitative efforts in the absence of treatment have a poor outcome. On the other hand, freedom-limitations and the loss of family rights, or rehabilitative chances (e.g. jobs) should stand there as drawbacks for 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 penalty (at least pecuniary sanctions and imprisonment). For non-addicted abusers, the likelihood of penalty should increase parallel to the possibility to avoid it by specific interventions (varying on the basis of the kind of identifiable risk factors).

Reasonably, alternative measures may be suspended or revoked if they reveal to be ineffective. Nevertheless, it takes time to either claim a treatment is reliably effective, or presumably ineffective. Legal authorities often seem to allow alternative measures for people who they judge as reliable, or to those who seem truly willing to change their lifestyle. In this case, the law fails to speak the language of addiction. The simple availability and acceptance to undergo some treatment program is a good point to start, but does not predict the outcome at all. Good outcomes are possible when the person is obliged to get treatment, and bad outcomes are possible despite good intentions.

The eventual decision should then be pondered on the basis of the outcome, while the opportunity to benefit from alternative measure or depenalization may be just based on the

diagnostic status, and the availability of any documented treatment option, or any structured experimental treatment.

During that "trial" period, the person should not be considered as if "on probation", susceptible to arrest and withdrawal of all benefits due to recidivism or 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 be rather regarded as a confirmation to the defined diagnosis, than a contradiction with the availability to be treated.

3 Depenalization

No legal system, to date, has overcome the dilemma of quantity and modalities of use. In other words, drug addicted people may not be sentenced to jail, but depenalization of drug-smuggling is not conceived, even if due to the need to supply oneself with money or drug due to one's addictive condition. Moreover, penalties may change, and be milder or converted into supervised rehabilitation or treatment, but charges are not cancelled anyway. To date, allowing possession and free trading below a certain threshold is bound to also bring together some trend to non-punishable drug trafficking.

3.1 A comparison between two European Countries: Portugal and Italy

The Portuguese legal system would undergo a change in 2001, allowing problematic drug users to be evaluated by a commission, and be sent to treatment instead of being jailed and legally sanctioned {Pombo, 2016 #10782}. This political decision was an answer to the opiate-related health emergency, and its success is easily explainable along previous experiences. The reduction of crime rates, HIV seroconversion, and addictive behaviours by semi-compulsory treatment, is a sound piece of knowledge in the history of opiate addiction treatment {Uchtenhagen, 2008 #10770}.

People in Italy are debating about either liberalization or legalization of drug use, the latter looming as more viable on political grounds. Nevertheless, some parties have always made a statement against any tolerance to drug use, raising major criticism upon the distinction between light and heavy drugs. Portugal is usually mentioned as an example of successful legalization policy, mostly to support the idea that decriminalization of light drug use has led to no rise in the consumption of light drugs, and possibly reduced drug-related harm due to more responsible and aware drug use. To be noted, firstly, is the intrinsic paradox of such a view (the decriminalization of light drug use would produce the advantage to reduce the engagement into drug use, which implies the assumption that such use is itself harmful). Apart from that, the Portugal 2000 law status is not dissimilar from the Italian one dating back to 2009. Drug use is decriminalized, apart from cases in which possession is proved to be aimed at selling or handing

over, no matter if on a presumed free basis. A quantitative threshold is resorted to as a criterion to presume the aim of possession, whether for personal use or selling/delivering to others. Although use itself is not considered an offence, it may enhance the severity of penalty, as a sign of voluntary risk-taking behaviour or armful empowerment of one's criminal potential. Addicted people are ruled apart, and may ask to avoid imprisonment as long as they accept to follow therapeutic programs. 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 overcrowding of prisons by drug addicts, on one side; and implement the healthcare system for people with pathological drug abuse, by favouring semi-coercive treatment programs. To tell the truth, we cannot state that drug possession in Italy is no longer a legal problem, although it is not officially an offence itself. People who are found to hold drugs may be arrested waiting for quantities and types of substances to be ascertained, and may be treated as presumed sellers on the basis of vague features (e.g. travelling with drugs, or pool-buying of drugs between friends, or buying on behalf of others). On the other hand, it is likely that several cases of drug abuse may follow the path of treatment instead of imprisonment, without any clear diagnostic status regarding, for instance, "pathologic drug cannabis" or "cannabis dependence". The transition from DSM-IV "dependence" category to the quantitative grading of "substance-use problems" of DMS-5 is not helpful in clarifying the nature and prognosis of clinical pictures, and thus paves the way for indiscriminate labelling of "pathologic" of any drug use with legal complications {A.P.A., 1994 #3118}{A.P.A., 2013 #9733}.

Moreover, the Portugal law would rule out punishment for first-time offenders, but allows judges to punish drug-using offenders in case of recidivism. Since recidivism is the rule for addicts, although not exclusive of them, addicts would be more subjects to punishment in the long term.

On the whole, we conclude that no legal system has yet accepted and theorized the fact that addicted people are not conditioned by punishment, as long as addiction-related offences are concerned, whereas non pathologic drug users may be. Serial offence is still approached by an increase in the level of punishment, although it is also offered an alternative to imprisonment. Thereby, first-time offenders who prove to have a drug problem may not undergo any penalty, or be sentenced to treatment, but may go to prison, or not given the same kind of chance in case of recidivism.

4 Driving and work licenses

Among penalties inflicted to drug users, the rejection or withdrawal of licenses (work, driving) is not to be underrated, especially in a rehabilitative view.

Usually, public officers who are responsible for licensing citizens cannot base their judgement on anything but a table of non compatible substances. In other words, the compatibility is not referred to the person's status, be it pharmacological or clinical, but on toxicological analyses. Moreover, tables of monitored substances also include therapeutic agents, such as methadone or buprenorphine {Smiley, 1981 #2701;Dittert, 1999 #7294;Hauri-Bionda, 1998 #7295}{Pollini, 2015 #10771}. Any exception to be made, is, basically, under the officer's responsibility.

The pharmacological status is unlikely to be investigated or have any weight, beyond the unique feature of dose quantification. For instance, a threshold for legal driving after drinking alcohol has been defined, and changed through the years, but the weight of pharmacodynamic and environmental tolerance do not influence the presumption of "driving under the influence" of alcohol. In case of road accidents, it is not unlikely that drug users must face a trial on the basis of a positive urinalysis result, with no further evidence of current mental abnormality. Opposing to charging in such a condition is possible, but it requires assistance by a lawyer, along the time term of a regular trial.

5 Can prisons be a chance to start treatment?

To date, alternative measure for addicts have been meant 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, also defined as absolute resistance {Maremmani, 2009 #605}. On the other hand, data about compulsory treatment, or parole based on adherence to 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. In a medically-centred perspective such a datum is not difficult to explain: since an addict's brain does not lead to functional behaviour, including pro-therapeutic choices, being made to choose to undergo treatment due to legal advantages is a good way to overcome patient's resistance, prevent dropout and premature treatment termination after the achievement of results {Uchtenhagen, 2008 #10770}.

Prisons may be organized as to include addiction-treatment units, aiming at initiating treatment and closely linked to external facilities {Galander, 2014 #352;Kastelic, 2007 #146;Hennebel, 2005 #94;Pisec, 2003 #72;Yakoub, 2001 #40}{Lamanna, 2007 #143}{Parrino, 2000 #4705}.

Differently from what is likely to happen currently, heroin addicts should not be detoxified or discharged with less or no methadone going on: oppositely, those who are not in treatment should be started back onto agonist treatment, and discharge may be planned after the induction phase has been completed, linking patients up to external facilities.

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

Unfortunately some programmes had no impact on either recidivism or substance abuse outcomes {Anglin, 2002 #10781}.

6 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 limitation of their toxic effects upon a state's population has been represented by a quantitative threshold discriminating between possession for personal use, and presumption of drug-trading. Nevertheless, such a 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 and exposure to drugs is tolerated, a State should be in charge for the treatment of drug-induced problems, at least in those cases which go beyond self-determined and controlled consumption.

On the other hand, the social perniciousness of drug-related behaviour is maintained, when not enhanced, in case of addictive use. Thereby, a solution is needed to grant society with the protection from addictive behaviours, and addicted people with protection from their disease.

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

Newman summed up this concept by the phrase "we'll make them an offer they can't refuse" {Newman, 1973 #5765}. The patient complies with treatment because of a certain improvement or advantages, or to avoid further harm, long enough for treatment to change his brain. Before this change has happened, no real collaborating attitude should be expected, but the patient is somehow tricked into healing by overcoming the anti-therapeutic behaviour borne by addiction.

7 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 {Nutt, 2007 #7932}, 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 {Guelfi, 2007 #6820}.

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 that marijuana-related hospital data from 1975 to 1978 for 21 metropolitan statistical areas in the Drug Abuse Warning Network (DAWN) {Model, 1993 #10783}. This study capitalizes on the decriminalization of the possession of small amounts of marijuana by 11 U.S. states between 1973 and 1978. This presumably reduced the full price of marijuana.

It is 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. In fact, a positive correlation may just mirror the increase confidence in reporting the truth about oneself without legal consequences; whereas a negative result may 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 {Miech, 2015 #10774}{Shi, 2015 #10776}..

In California, drivers testing positive for THC at random or targeted controls did not increase across the legalization years. Nevertheless, a higher rate of cannabis-positive cases in lethally injured drivers was found. It is not clear whether this 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 disposed to lethal accidents for other reasons (e.g. alcohol). 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 is not enough to delineate any causal relationship {Pollini, 2015 #10771}.

In a legal-cannabis sanctuary (The Netherlands), cannabis use trends seem to develop independently of changes in cannabis policy. Recently, some concern about reconsidering the legal status of cannabis has been rising due to the change in local cannabis quality (higher content in THC) {Korf, 2002 #10772}.

Decriminalization of marijuana does not seem to reduce declared cannabis use, but is likely to increase initiation of use by naive individuals (youth), while experienced consumers may be not influenced at all, although favoured in managing their consumption habit. Across different countries, the prevalent effect of decriminalization seems an increase in regular use, at least after five years after policy change {Williams, 2014 #10773}.

Probably only the aprohibitionism is a feasible way {Michelazzi, 2000 #4133}. According to Michelazzi, a qualitative more forward is necessary, one that goes beyond their confrontation, and beyond the stances both of anti-prohibitionism and 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 of aprohibitionism, where a distancing effect can be perceived at first sight – in the signifier. In practice, this means there is a need to devise ways of thinking that we must go beyond the logics of prohibitionism and anti-prohibitionism. This requires us to think up a procedure, which does not legalise drugs in order to make them marketable. It means thinking up a procedure that makes it possible to cope with needs beyond

their immediate expression or enforced medical treatment, but also beyond any possible increase in their supply. It means viewing the potential consumption of desired substances in a way that will aim to keep them outside the exchange market. It means stripping a particular type of goods of their most conspicuous features, so allowing both the lawfulness of what stands outside the production-reproduction 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 of their actual toxicity and the degree of alteration to states of consciousness they produce.

8 Conclusions

On political grounds, liberalization of treatment, and decriminalization of treatment instruments, as far as used for medical purposes, is a priority for treatment standards to improve. Scientifically based interventions should never be hampered by restrictive regulations targeting substance classes, let alone specific medical preparations. Pathways to recovery should be encouraged also by abating restrictions to work, travel, which are generally applied to substance users or drug law offenders. In other words, the patient figure should lawfully prevail on the offender's figure, as long as treatment can guarantee a positive outcome. For non-responders, alternative sanctions or decriminalization may be considered as well, although the need to prevent social harmfulness may justify restrictive measures.

Decriminalization should stop being a substance-related matter, and become a diagnosis-related matter. Categories of mentally ill patients (addiction being one main issue) should be "decriminalized" as far as their offence is considered related to their addictive behaviour. Intoxication-related behaviour, therefore, may be decriminalized if borne by addiction, and generically sanctioned when independent of addiction or other brain disorders. In terms of social security, decriminalization may be distinguished by depenalization. The person may be not charged with legal responsibility, as long as addicted/mentally ill, but 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. Thereby, the most reasonable way to grant "pathologic" offenders with treatment, is to check the offender's belonging to decriminalized categories case by case. Physician should become a central figure to define and handle social risk 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.

Table 1.

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 (non 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