

TOXICOMANIA AS DESOCIALIZATION: SOME COMMENTS ON TREATMENT PROBLEMS RELATED TO THE SOCIO-CULTURAL ASPECTS OF DRUG ABUSE

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1. A DEFINITION OF THE STATE OF TOXICOMANIA

In the Western world there is, at the moment, a considerable number of hypotheses on the most suitable methods to deal with the problem of treating toxicomania. These hypotheses have increased in number during the last few years together with the growth of the social importance of the problem of treatment, a growth in turn dependent on the spread of antisocial or more simply asocial behaviour connected with drug use. The macroscopic differences existing between the various methods indicated are readily revealed, since the intervention perspectives refer, for example, according to case, to treatment of a medical type aimed at the cure of physical symptoms, of a psychiatric type by pharmacological means, of a psychotherapeutic type by various methods, of a social type by various techniques to rehabilitate the addict, and of a purely penal nature by various repressive measures.

This profusion of anything but coordinated hypotheses could lead to confused perspectives which can only be overcome on the basis of an understanding of the state of toxico-

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mania (1) (in its most significant sense, in social terms, as the habitual use of a drug, in the presence of a psychological and social condition of dependency on the use of the drug and the group of addicts), essential for a global comprehension of the phenomenon. Without a definition capable of embracing, in the broadest sense, the very meaning of the toxicomania phenomenon, it is of course impossible to formulate a shared point of view on any treatment calculated to have a precise effect on the state of toxicomania. We therefore propose a definition of toxicomania which aims at an understanding of the constitution of the phenomenon and, at the same time, at an intervention aimed at treating the state of toxicomania through a modification of the processes which have led to its constitution.

Such a definition could be articulated in the following way: the state of toxicomania, understood as the continued and compulsive use of drugs (particularly « heavy » drugs), constitutes the final stage of a process of desocialization (2) vis-à-vis the framework of the dominant social models and associated values present in contemporary urban-industrial society. This final stage consists of a complete or, at least, substantial, rejection of the models and values of socialization (3), the abandonment of the struggle for self-satisfying

(1) By « state of toxicomania », as indicated above, reference is made, first of all, to addicted users of opiates and especially heroin, for whom there is the greatest danger of desocialization, anti-social behaviour, and physical self-destruction. Problems that are in some respects similar can sometimes arise also with habitual marihuana users; however, the use of this drug usually involves much more limited risks of anti-social behaviour, desocialization and physical consequences, also due to the lack of a physical dependency phenomenon. The use of drugs such as amphetamine and LSD can sometimes be related to anti-social behaviour. Cocaine use usually leads to even less risks from the social point of view. Hence, here as elsewhere in the paper, when discussing the social problems of toxicomania, it is especially the problems of addicted opiate users that are referred to.

(2) The term « socialization » denotes the process by which the member of a group acquires values, standards and models of behaviour already possessed by pre-existing group members by learning how to carry out tasks connected with the social roles (W. F. OGBURN, M. F. NIMKOFF, *A Handbook of Sociology*, London, Routledge & Kegan Paul, 1964, p. 159-160): « desocialization » is here used to denote, in turn, the process of severance from the framework described above, which is grafted onto the original condition of lack of socialization.

(3) Merton rightly underlines the characteristic of rejection and abandonment as essential for the understanding of the process of severance of the drug addict, but his hypothesis of a choice of drug addiction as an effect of the existence in the addict of values contrary to normal criminal behaviour, is contradicted by the vast number of addicts who commit even « common » crimes. (R. K. MERTON, *Social Theory and Social Structure*, New York, The Free Press, 1968, (1st Ed. 1949), Part II, Chapter 6.

roles within « normal » society and the acceptance of different models and values, concentrated above all on an opposition to the world of normal adjustment in a perspective which tends to favour the juvenile hedonistic aspects and the search for support from a « community-type » structure. The drug addict is a person who finds himself in a situation characterized by conflict and/or weakness vis-à-vis roles in society (1) and who is proved incapable of interiorizing models and values suitable for a form of adjustment acceptable to society and satisfactory to himself (2): faced by the requirements presented to him by society in late-adolescence, he is unable to find a balance between the level of gratification and that of frustration vis-à-vis the social models and dominating values (3).

It is important to note that the desocialization process is a global phenomenon which affects the entire range of the socio-cultural characteristics of an individual, i.e. a form of comprehensive inadequacy with regard to the socially-acceptable roles, which is due to the lack of interiorization of a series of models and values suitable for producing the willingness,

(1) As argued by C. WINICK, « A Sociological Theory of the Genesis of Drug Dependence », in C. WINICK (Ed.), *Sociological Aspects of Drug Dependence*, Cleveland, C.R.C. Press, 1974, p. 4 ff. Winick maintains that a further element characterizing the drug addict's socio-cultural background is the lack of negative prescriptions regarding the use of drugs: however, we feel that this should be considered not so much as a factor in itself, but rather as the product of the conflict and/or weakness vis-à-vis the roles in society referred to, and of the *reactive formation* process which involves the adoption of opposing models and values, as a response to his inability to adjust to legitimate social roles.

(2) On the difficulties pertaining to the interiorization process, see T. PARSONS, *The Social System*, Glencoe, The Free Press, 1951, Chapter VII.

(3) A. K. Cohen illustrated very well the progressive rejection of the dominant system by youths who are part of violent urban gangs, underlining that the main motive is the difficulty of finding a balance within a system of values which prescribes goals which are difficult to achieve and with a high frustration potential: *Delinquent Boys. The Culture of the Gang*, Glencoe, The Free Press, 1955. R. A. Cloward and L. E. Ohlin see, in particular, the adaptation to the world of drugs as an effect of the impossibility of finding a balance within the system of dominant values or in the subcultures of crime and conflict: *Delinquency and Opportunity: A Theory of Delinquent Gangs*, Glencoe, The Free Press, 1960. Both these authors and Cohen (as well as Merton), consider, however, this impossibility of finding a balance within the system of dominant values as something basically linked with the unequal distribution of chances among the various social classes, whilst the present drug use phenomenon is distributed similarly throughout all the social classes. The spread of drug use can be more correctly understood by analysing the impact of the pressures on the individual (and the difficulties of achieving a balance) produced by the cultural patterns of behaviour characteristic of his own social group: cf. E. M. Lemert, « Social Structure, Social Control and Deviation », in M. B. CLINARD (Ed.), *Anomie and Deviant Behavior: A Discussion and Critique*, New York, The Free Press, 1964.

the technical skills and capabilities for self-gratification which are essential to perform legitimate social roles.

On the other hand, it should be noted, since it is very important, that the state of the addict whilst obviously leading in the great majority of cases to a situation of inability to adjust to acceptable social roles, does however lead at the same time, normally, to a form of alternative socialization in the drug subculture milieu. The addict finds a kind of balance between costs and social gratifications in the alternative situation, that formed by groups of drug addicts. He is, therefore, unable to adjust to acceptable social roles, but at the same time able to adjust, in some way, to alternative social roles. Whilst the drug addict is desocialized vis-à-vis the dominant culture and society, he enjoys the support of other addicts, participates in their subculture and shares a social context which helps him and gives him gratification (1). This is a state of adjustment in which the balance between gratification and frustration is favourable to the addict.

2. THE PERSPECTIVE OF MEDICAL ACTION

What has so far been said can be used to clarify the problem of the treatment of the drug addict, both as regards treatments for patients who undertake it on a completely voluntary basis and treatments for patients whose decision has in some way been conditioned, as is the case, for example, of detained addicts or, at any rate, those who undergo compulsory treatment. The above definition of toxicomania serves to clarify the considerable confusion caused by the perspective of medical action, which has ended up by modifying the terms of the problem, posing as essential for the resocialization of the addict some treatments which may serve, according to each specific case, to improve the general health of the addict or to substitute one drug by another, or, at best,

(1) On this subject, for example, H. S. BECKER, «Becoming a Marijuana User», *American Journal of Sociology*, 1953, n° 59, p. 235 ff; and also D. MATZA, *Becoming Deviant*, Englewood Cliffs, Prentice-Hall, 1969; E. GOODE, *The Marijuana Smokers*, New York, Basic Books, 1970, and above all I. CHEIN et al., *The Road to H.: Narcotics, Delinquency and Social Policy*, New York, Basic Books, 1964.

to make an attempt at disintoxication, with however limited, and sometimes even non-existent, results in terms of his resocialization. There have been an extraordinary number of failures in toxicomania treatments and a good many of these were due, no doubt, to the fact that the addict was not seen as a case of desocialization, but merely as a sick person, someone intoxicated by harmful substances and in need only of disintoxication.

As a matter of fact, toxicomania is in itself neither a physical illness, such as T.B. for example, nor a mental illness, such as schizophrenia; the state of addiction is comparable, rather, to other phenomena of essentially social type such as school maladjustment or juvenile delinquency, to which moreover it is often related. It is basically a cultural and social phenomenon and only secondarily a medical problem.

Medical action may prove necessary to cure a whole series of illnesses which, in the great majority of cases, are determined in the drug addict due to his way of life — e.g. hepatitis, physical debilitation, venereal diseases — but in these cases it is obvious that it is not the toxicomania which is being cured but the consequences of a certain way of life linked to toxicomania above all by social and cultural reasons. Furthermore, an intervention of medical type, and more precisely of psychiatric type, is required when the addict shows signs of mental disturbances, especially of psychotic type but also of neurotic type, at least in its most serious forms: here again it is not the toxicomania that is being « cured » but merely particular conditions which can nevertheless be considered as an obstacle to the effective socialization of the patient and to a reasonable adjustment to society, and which could therefore have consequences also on the tendency to toxicomania.

Apart from this, medical action can prove necessary in cases of an acute crisis of intoxication, as occurs in overdose cases, where intervention is aimed, nevertheless, only at overcoming, the crisis itself. Furthermore, medical treatment can be very useful, though not strictly necessary, in cases of disintoxication of dependent addicts (usually on opiates): in this case, medical treatments can help to overcome the addiction phase, but certainly do not constitute therapy for toxicomania.

3. DISINTOXICATION OF THE ADDICT

Medical treatments do not, therefore, constitute in the last analysis a solution to the problem of toxicomania, but only a possible aid: the problem remains a social and cultural one and obviously any medical treatments cannot substitute actions in the social and cultural spheres. The empiric proof of this is found in the overall failure of programmes of treatment essentially based only on the concept of a medical treatment for toxicomania through disintoxication of the addict, either by decreasing doses of opiates, or by methadone, in the use of which more than thirty years experience has by now been accumulated. Such treatments fairly easily achieve a state of disintoxication, above all if the patient is prevented from continuing to use drugs by means of controls, as occurs in conditions of forced treatment, in prisons or other controlled environments. But the state of disintoxication, even if it constitutes a necessary step, is at the same time a minimal requirement which can also be achieved without great difficulty even in the absence of any special medical treatments, if necessary with the help of some tranquillizers, as innumerable experiences in prison and elsewhere have shown.

If however one analyses, in terms of resocialization, the efficacy of treatments focussed on the concept of disintoxication (1), one realizes the almost total lack of significant positive effects in the majority of patients treated, whether by using decreasing doses of opiates, or by using methadone, whether in controlled environments (2) or in open environments (3); and this is in spite of the fact that for decades now disintoxication treatments have hardly ever been carried out without at least a minimum of collateral interventions of psychiatric, psychotherapeutical and social type. The reason for these failures is without doubt connected with the fact

(1) V. ANDREOLI, F. MAFFEI, G. TAMBURINO, *Il ciclo della droga*, Milan, Mondadori, 1982, p. 124.

(2) See, for example, B. J. LANGENAVOR, C. L. BOWDEN, « A Follow-up Study of Narcotic Addicts in the N.A.R.A. Program », *American Journal of Psychiatry*, 1972, CXXVIII.

(3) See, for example, A. D. MOFFETT, « Post-Treatment Behavior Following Ambulatory Detoxification », in C.D. Chambers, L. Brill (Eds.), *Methadone: Experiences and Issues*, New York, Behavioural Publications, 1973.

that disintoxication does not mean resocialization: after disintoxication, the ex-addict remains what he was before, i.e. a person unable to adjust adequately, due precisely to his unchanged state of inadequate socialization, and therefore one who returns almost invariably to the state of toxicomania. The very frequent phenomenon of the relapse of the addict to drug use (1), even after complete disintoxication, should be considered in the framework of the tendency of the addict, desocialized from the general social system, to return to the road of alternative socialization in the subculture of the drug milieu whenever he finds himself faced by situations for which he is unprepared and has no solution, and which he has already learned to cope with by recourse to drugs and its associated environment, the only one in which he succeeds in finding a form of adjustment that is favourable to him.

4. METHADONE MAINTENANCE

Whilst the use of methadone has been shown to be almost totally lacking in positive effects as far as resocialization is concerned, if used as part of a treatment aimed at the disintoxication of the addict, the use of methadone in maintenance therapy has been shown to produce much more complex effects, in terms of resocialization, but also effects which are broadly open to criticism. Since 1964, when treatment of addicts began with a gradual substitution of daily methadone doses for heroin (2), this method has continued to spread rapidly and a number of valid proofs have been gathered concerning the effectiveness (at least in part) of the method in terms of stopping the use of heroin, readmitting the addict to the labour market and the school system, and above all reducing criminal acts (3).

(1) It appears, for example, that in Italy the great majority of a sample of addicted inmates had already undergone, some even several times, treatment in hospital or other specialized structures: Ministero di Grazia e Giustizia, *Indagine su 371 tossicodipendenti detenuti, etc.*, Rome, Quaderni dell'Ufficio Studi, Ricerche e Documentazione, General Directorate, Penitentiary Institutes, 1982, p. 234 ff.

(2) See what was written by the authors of the method: W. P. DOLE, M. E. NYSWANDER, « A Medical Treatment for Diacetylmorphine (Heroin) Addiction », *Journal of the American Medical Association*, 1965, CXCIH.

(3) See the evaluation of the authoritative Methadone Maintenance Evaluation Committee, « Progress Report of Evaluation of Methadone Maintenance Treat-

However, these data on the « effectiveness » of methadone maintenance treatment should also be gauged in the light of other less optimistic considerations. First of all, those patients who have a « heavy » criminal record or who, more in general, have very serious problems at the level of socialization (1), are just those who react in a particularly negative way to methadone maintenance treatment. This therefore confirms the already mentioned hypothesis that is the subject of this paper: namely, that the problem of the addict centres on a condition of desocialization which is the cause, and not the effect, of the use of « heavy » drugs, even though the state of toxicomania in itself inevitably aggravates the state of desocialization.

On the other hand, the data which seem to show that the patients treated with the methadone maintenance therapy are subject to a much lower percentage of arrests than heroin addicts (2), should not however lead to the assumption that an improbable chemical-behavioural miracle has occurred thanks to the continued administration of methadone, but should rather point to more simple effects which concern the social situation of the addict.

The addict, who already has, as his basic characteristic, an acute desocialization background, is pushed towards anti-social or more specifically criminal behaviour precisely by his need to obtain opiates on the black market (3). If

ment Program », *Journal of the American Medical Association*, 1968, CCVIII. More recently, basically positive results were summarized by the official National Institute on Drug Abuse, *Effectiveness of Drug Abuse Treatment Programs*, Rockville, U.S. Government Printing Office, 1981, p. 6-9. However, there are studies which seem to ascertain considerably lower levels of effectiveness: see for example G. HAYIM et al., *Heroin Use and Crime in a Methadone Maintenance Program: An Interim Report*, Washington D.C., National Institute of Law Enforcement and Criminal Justice, 1973.

(1) D. G. LEVINE et al., « Personality Correlates of Success in a Methadone Maintenance Program », *American Journal of Psychiatry*, 1972, CXXIX.

(2) On this difference, see F. R. GEARING, « Evaluation of Methadone Maintenance Treatment Program », *International Journal of Addiction*, 1970, V.

(3) On the causal connection between drug addiction and criminal behaviour aimed at maintaining the abuse, see for example: National Commission on Marihuana and Drug Abuse, *Drug Use in America: Problem in Perspective*, Washington, D.C., U.S. Government Printing Office, 1973, p. 161-162; P. G. BARIDON, *Addiction, Crime and Social Policy*, Lexington, Lexington Books, 1976, p. 19 and 45; E. M. SCHUR, *Narcotic Addiction in Britain and America: The Impact of Public Policy*, London, Tavistock, 1963. A partly critical opinion on this thesis is expressed by J. MOTT, *L'abus de drogues et la criminalité*, Comité Européen pour les Problèmes Criminels, Strasbourg, Conseil de l'Europe, 1975, p. 100-102, who is of the opinion that the data collected in Europe are not a sufficiently sure basis to confirm such a thesis.

the illegal and highly expensive use of opiates is replaced by the legal and free-of-charge use of a substance with basically similar effects, such as methadone, a quite considerable reduction in the number of crimes associated with the stimulus to obtain the drug illegally can be achieved.

A comprehension of this reality, in itself rather simple, and above all its application in terms of social defence, has been hindered by persistent moral prejudices. On the basis of the assumption that it is morally impossible for the State to distribute a *drug* to a person who needs it not for therapeutic purposes, but due to an addiction to something that is, in the first place, a way of life, the other Western countries have avoided following the system chosen by Great Britain since the 1920s, by which opiates were distributed free of charge by the health service, on the basis of a recognition of the fact that the problem of the social effects of drugs is more important than that of the effects of the drugs on the addict himself (1). On the other hand, the choice of the legal and free distribution of opiates is not so very different essentially from the continuing «therapy» with an heroin-surrogate, such as methadone; just as it is not so very different from a certain way of applying the disintoxication therapy with methadone, which more or less everywhere now tends to become more like a continuing «therapy», since patients all too easily tend to repeat the disintoxication treatment several times, being practically always under methadone treatment, except during the intervals when they take heroin.

The «successes» of the treatment of addicts by a continuing methadone therapy, even though always partial, basically consist on the one hand in the reduction of criminal acts perpetrated in order to obtain the drug and, more generally, in the reduction of the pressures towards the dependence on the drug subculture milieu — even though this latter phenomenon is partial, since the dependence on the drug environment is linked to the complex situation of equilibrium that the addict finds there, as already mentioned, and not merely

(1) On the treatment of addicts practised in Great Britain, and its results, also in comparison with those obtained in other countries, E. M. SCHUR, *Narcotic Addiction in Britain and America: The Impact of Public Policy*, op. cit.; N. E. ZINBERG, J. A. ROBERTSON, *Drugs and the Public*, New York, Simon and Schuster, 1972; L. M. SOLIVETTI, *Controllo dell'antisocialità e trattamenti preventivi*, Milan, F. Angeli, 1981.

to the need to obtain the drug. On the other hand, the « successes » consist in the support effect resulting from a series of services (ranging from individual and family psychotherapy to vocational retraining and social welfare), which are made available to the addict at the same time as the methadone maintenance therapy (1).

It is just these services, only apparently collateral, that form the essence (together with the legal and free-of-charge distribution of methadone) of the treatment programme, since different doses of methadone used in the same treatment programme lead to the same number of successes and failures, whilst equal doses of methadone used within different programmes lead to very different results (2): even the continuing methadone therapy presents itself therefore as a mere chemical aid, valid above all in terms of social defence to control criminal acts prompted by the need to obtain drugs on the black market.

In terms of its ability to keep the addict away from the drug milieu, the methadone maintenance therapy has very limited success, since even though the therapy reduces dependence on the drug subculture environment, its success hinges to a great extent on factors extraneous to the therapy itself (3), i.e. on the resocialization process which the drug addict, with or without outside help, must undertake.

(1) National Institute of Drug Abuse, *The National Drug Abuse Treatment Utilization Survey*, Rockville, U.S. Government Printing Office, 1975.

(2) A. GOLDSTEIN, B. A. JUDSON, « Three Critical Issues in the Management of Methadone Programs », in P. G. Bourne (Ed.), *Addiction*, New York, Academic Press, 1974.

(3) The original hypothesis, proposed by Dole and Nyswander, laid emphasis, on the contrary, on the therapeutic capacity, in itself, of continuing methadone administration, which was supposed to correct a presumed metabolic imbalance — created by heroin use — which is the reason for a « craving » for the drug which would not have been eliminated by disintoxication, but which would go on indefinitely: « A Medical Treatment for Diacetylmorphine (Heroin) Addiction », op. cit. This hypothesis would not appear to be supported by sufficient empirical data, in spite of the existence of studies which would tend to demonstrate the presence of a « secondary abstinence » syndrome at a physiological level, even after disintoxication: W. R. MARTIN, « Commentary on the Second National Conference on Methadone Treatment », *International Journal of Addiction*, 1970, no. 5. Instead, there appears to be considerable proof of the pressure to relapse into drugs generated by the socio-cultural aspects already mentioned: the modification of the theoretical perspective subsequently proposed by Dole and Nyswander themselves does not therefore appear without motivation: they identified as the focus of the « methadone revolution » the emphasis placed on the concept of rehabilitation rather than on the concept of disintoxication: « Rehabilitation of Patients on Methadone Programs », in *Proceedings of the 5th Nat. Conf. on Methadone Treatment*, New York, 1973.

It should, moreover, be said that the methadone maintenance therapy is only effective in so far as one could call « effective » a « therapy » which substitutes the use of heroin with the use of another drug, with similar characteristics, whose success with addicts is based on the similarity of its effects compared to those produced by heroin (1). Therefore, whilst it is right and proper that methadone use should be taken into consideration — as a means not only for a dis-intoxication therapy, but also for a maintenance therapy — since it does lend itself to an important function in the sphere of the mere *defence* of society's interests, we must be aware of the inherent dangers of the possibility of spreading another drug instead of heroin, even if it has less devastating effects on society: it should be recalled, among other things, that heroin itself was originally proposed as an alternative and less dangerous drug than morphine. The chance of similar errors would appear to be anything but imaginary today, given the fact that in certain areas with a high concentration of drug addicts, such as New York, methadone addiction has already for some time now had a diffusion similar to that of heroin addiction (2).

In the last analysis, it seems absolutely essential to find ways of intervention which can protect society from the reality of the enormous number of crimes committed by addicts in order to be able to buy drugs on the black market (it has been ascertained that, for example, in Italy half the male addicts in prison have committed crimes against property and nearly three-quarters of them (72 %) had criminal records, mainly for crimes against property, nearly always related to the need to obtain drugs (3). On the other hand, while the liberalization of the drug market is not considered suitable, for fear of a spread of habits considered at least *asocial* (4), the limits of an intervention based on the substi-

(1) On the similarity of effects and on the consequences which can derive from them, R. M. GLASSCOTE et al., *The Treatment of Drug Abuse*, Washington, D.C., Joint Information Service, 1972, p. 30-35.

(2) C. D. CHAMBERS, J. A. INCIARDI, « An Empirical Assessment of the Availability of Illicit Methadone », in *Proceedings of the 4th National Conference on Methadone Treatment*, New York, 1972.

(3) Ministero di Grazia e Giustizia, Ufficio Studi, Ricerche e Documentazione, *Indagine sul trattamento penitenziario dei tossicodipendenti*, Rome, 1982, p. 20 ff.

(4) L. RADZINOWICZ, J. KING, *The Growth of Crime*, Harmondsworth, Penguin Books, 1979, p. 130-131.

tution of the administration of alternative substances for heroin cannot be ignored.

If we recur to the real problems of the treatment, which are clearly connected with the causes (1) which led to addiction in the first place, the treatment can only be guided from the social point of view, by intervening on the addict in order to remove the conditions which caused the addiction. Now, methadone maintenance is a treatment which can lead to benefits in terms of a reduction of the pressures to resort to crime. It can also indirectly influence the addict's socialization, since the addict no longer needs to turn to the criminal and subcultural milieu of drugs to obtain his daily dose. But methadone maintenance cannot, in itself, have any effect on the resocialization of the addict, since the desocialization process — even if aggravated by the addiction — was essentially prior to addiction and was related to socio-cultural causes which obviously no chemical therapy can affect (2). It seems clear, therefore, that the success, as far as resocialization is concerned, of a methadone maintenance therapy depends on the efficiency of the parallel services of socio-cultural type, which are the only ones able to affect the addict's habitual state of desocialization.

5. UTILIZATION OF OPIATE ANTAGONISTS

The inadequacies of an essentially *pharmacological* conception of a problem which is essentially a *social* one — already underlined in the case of the methadone maintenance therapy — appears in a really macroscopic dimension in the case of attempts at a therapy of addiction by means of so-called heroin *antagonists*. These attempts are meaningful above all as further evidence of the serious limits of the *medico-pharmacological* approach, since their practical importance has always been quite limited. In fact, medicines

(1) On this subject, for an analysis of the various perspectives, C. FAZEY, *The Aetiology of Psychoactive Substances Use*, Paris, Unesco, 1977; in particular, on social and cultural factors, L. M. SOLIVETTI, *Perché la droga*, Milan, F. Angeli, 1980.

(2) See R. MILLER, « Towards a Sociology of Methadone Maintenance », in C. WINICK (Ed.), *Sociological Aspects of Drug Dependence*, op. cit., p. 178.

such as Cyclozocine, Naloxone and others are able to block the effects of an eventual dose of opiates and can therefore reduce to zero the addict's interest in the drug. However, it is obvious that in order to successfully continue taking such medicines, the addict must be impelled by a strong motivation to do so (1), a motivation presumably only present in those subjects who have effectively overcome social, cultural and psychological dependency on the drug. It should also be considered that an addict treated with antagonists does not even receive the « benefits » of effects similar to heroin, which are on the other hand felt by the addict under methadone treatment. It follows logically, therefore, that a large proportion of those who undergo treatment with antagonists can be expected to break off the treatment and return to heroin, as has indeed been ascertained by specific research (2).

6. LIMITATIONS OF PRISON AS A PLACE FOR TREATMENT

If the disintoxication and continuing therapy treatments normally organized by the health services give rise to the problems of effectiveness and suitability referred to above, it also becomes necessary to examine the effectiveness and suitability of such treatments, as well as that of others, within the institution which has during recent decades been entrusted with a considerable part of the control of the toxicomania phenomenon, i.e. the penal institution. Also as far as prisons are concerned, we will attempt to examine the meaning of the treatments adopted within these institutions in the light of the definition of toxicomania given above.

While nowadays it is, in general, virtually impossible to use the word « prison » without associating it with the word « crisis », it is more particularly impossible to consider prison as a suitable place for the treatment of drug addicts.

(1) National Commission on Marihuana and Drug Abuse, *Drug Use in America*, op. cit., p. 323-324; A. M. FREEDMANN, « Opiate Dependence », in A. I. KAPLAN et al. (Eds.), *Comprehensive Textbook of Psychiatry*, Baltimore, Williams & Wilkins, 3rd Ed., 1980, p. 1610.

(2) M. FINK et al., « Treatment of Heroin Dependence with Opiate Antagonists », *Current Psychiatric Therapy*, 1970, X. For a contrary view, see F. BRUNO, F. FERRACUTI, *Il controllo farmacologico e comportamentale degli stati di tossicodipendenza da oppiacei con il butorfanolo tartrato*, Rome, Università di Roma, 1979-80.

And this for several reasons. First of all, there is the reason of its negative labelling and its tendency to reinforce deviant behaviour (1): all phases of penal intervention against the addict (arrest, interrogation, trial (2)), but especially the imprisonment phase, constitute a very strong form of negative labelling. The effects of this are reflected in terms of a further loss of the ability to socialize: the addict, already characterized by an obvious deficiency of the ability to socialize adequately, also finds himself, after the experience of imprisonment, faced by new obstacles to the possibility of assuming « normal » roles in work, friendship, sentimental relations, etc., due to his social labelling as an « ex-prisoner ». The effect of all this, even if somewhat attenuated by the anonymity of present-day urban society, is still considerable on the state of desocialization and represents an inducement to seek refuge in the drug milieu again. But the greatest negative effect deriving from the prison labelling regards the addict's opinion of himself as a result of all this. The addict, who is already aware — sometimes excessively so — of his inadequacy vis-à-vis « normal » roles in society, will derive from the experience of imprisonment and the labelling connected with it an even deeper persuasion of his « diversity » and a stimulus to strengthen those deviant forms of behaviour which others consider as peculiar to him and which he too learns to accept as his own.

Secondly, prison constitutes for the addict a contact with the criminal subculture in the proper sense. In this regard, it should be recalled that the addict usually enters prison either because he has committed crimes, such as theft or armed robbery, motivated by his need to purchase the drug on the black market, or because he has committed crimes in connection with drug dealing: the addict is indeed already drawn into a subcultural milieu, but it is one in which crime is accepted as a function of the drug use. Through his experience of prison, on the contrary, the addict comes into contact with the real criminal underworld, in which crime

(1) On this subject, see E. M. LEMERT, *Social Structure, Social Control and Deviation*, op. cit.; D. MATZA, *Becoming Deviant*, Englewood Cliffs, Prentice Hall, 1969.

(2) SEE K. MENNINGER, *The Crime of Punishment*, Harmondsworth, Penguin Books, 1977, especially Chapter 3.

represents the fulcrum of the entire subculture. Through *differential association* (1) with elements from the subcultural milieu of real criminality, he is exposed to influence by anti-social values, which have a firm hold over him, due to his pre-existing state of desocialization also in cultural terms, as well as due to labelling which, imposed from outside, tends to encourage alliance among all those who are negatively labelled in a similar way. In particular, the existence of the typical values of the criminal subculture in the proper sense, which tend to label in a contemptuous way (*weak, ingenuous, unmanly, sold-out*) those who agree to undergo treatment and especially treatment for the addict's «resocialization», has extremely negative repercussions on the possibilities of a successful treatment of the addict (2). Faced by having to choose between the values of the treatment team and those of the group of inmates to which he belongs, the addict usually opts for the latter, because it is that group that he has to live with and adjust to.

But even if the addict, swimming against the stream, opts for the other choice and agrees to undergo treatment, he still has to face up to the problems which such a programme entails within a prison set-up: this set-up, since designed principally to keep order, tends implicitly if not explicitly to reject any change which could create «uncertainties» in the system and challenge the roles within it (3). In any case, the relations between staff and inmates in prison are mainly based on the principles of order and security (4) and this affects the entire feasibility and successful outcome of the treatment of addicts — as more in general of all inmates — since any conflict produced in the warder between the role of «protector of order» and «social worker» (5) would be

(1) E. H. SUTHERLAND, *Principles of Criminology*, New York, Lippincott, 1939.

(2) R. SMITH, *Drug Programs in Correctional Institutions*, Washington, D.C., National Institute of Law Enforcement and Criminal Justice, 1977, p. 10.

(3) For further information on the subject, L. RADZINOWICZ, J. KING, *The Growth of Crime*, op. cit., Chapter 9.

(4) R. H. MOOS, *Evaluating Correctional and Community Settings*, New York, J. Wiley, 1975, p. 15.

(5) On this point, D. CRESSEY, «Contradictory Directives in Complex Organizations: The Case of the Prison», *Administrative Science Quarterly*, 1959, June; M. POGREBIN, «Role Conflict among Correctional Officers in Treatment Oriented Correctional Institutions», *International Journal of Offender Therapy and Comparative Criminology*, 1978, no. 2.

resolved as a rule in favour of the former, whilst any possible activity carried out by personnel specialized in treatment would be reduced within the limits of the principles already mentioned above, by means of the organization of the penitentiary structure itself.

Apart from this, prison introduces further negative elements for the perspective of the addict's treatment, with its connotations of social and emotional deprivation which stimulate passivity, and with its general characteristic of coercion which tends to cancel out the volitional aspect: it is therefore not surprising that the treatment of addicts in prison does not seem to give very encouraging results (1).

7. THE PROBLEM OF PENAL LAW INTERVENTION

In the light of the aforesaid, it would appear difficult to support the suitability of treatment in prison for persons who were merely addicts. On the other hand, the problem of penal law intervention in the field of drug use has been amply debated, starting from the basic question of whether it is right and proper to punish penally a form of behaviour considered immoral – according to common ethical standards – and yet whose harmful effects fall mainly on the perpetrator (2).

The dilemma, even though it can in no way be considered as overcome, due also to the broad social effects dependent on the way it is dealt with, presents today a new and particular

(1) Apart from the above-cited B. J. LANGENAVOR, C. L. BOWDEN, « A Follow-up Study of Narcotic Addicts in the N.A.R.A. Program », see P.T. d'ORBAN, « Court Sentences in Female Narcotic Addicts », *British Journal of Addiction*, 1974, no. 2; D. M. PETERSEN, « Some Reflections on Compulsory Treatment of Addiction », in J. C. INCIARDI, C. D. CHAMBERS, *Drugs and the Criminal Justice System*, London, Sage, 1974. As far as structures for treatment based on a penitentiary model are concerned, see J. C. KRAMER, « The State Versus the Addict: Uncivil Commitment », *Boston University Law Review*, 1970, no. 1; A. R. LINDESMITH, *The Addict and the Law*, New York, Vintage Books, 1965.

(2) The discussion has concentrated above all on the opposing theses of H. L. A. HART, *Law, Liberty and Morality*, London, Oxford University Press, 1963, and P. DEVLIN, *Enforcements of Morals: Seven Essays*, London, Oxford University Press, 1968. See also Y. H. SKOLNICK, « Coercion to Virtue: The Enforcement of Morals », *Southern California Law Review*, 1968, 41; T. DUSTER, *The Legislation of Morality: Law, Drugs and Moral Judgement*, New York, The Free Press, 1970.

perspective. This is because Western countries have already made progress in the depenalization of drug use for personal consumption, either by a formal depenalization (as in the case of Italy) or through a *de facto* quasi-depenalization, achieved by the use of a simple warning (Switzerland), by the omission of penal sanctions (Germany), by treating it as a simple deed punishable by fine (Austria, Sweden, Holland), by suspending the penal action if therapeutic treatment is accepted (France), and by applying a minimum penalty, and suspending even it by recourse to probation, usually on condition that some form of therapeutic intervention is accepted (Great Britain, USA) (1).

8. THE DRUG ADDICT AS PERPETRATOR OF «COMMON» CRIMES AND SPECIFIC CRIMES

In Western countries prison is, therefore, no longer at the present time the place assigned for the detention and treatment of drug addicts as such — as usually occurred until a few years ago — but only the place for the detention and treatment of addicts as perpetrators of «common» crimes or those crimes generically defined as drug «dealing» (2). To ask the question, therefore, of whether prison is a suitable place for the treatment of addicts no longer has the meaning it previously possessed. Today, on the contrary, it is much more meaningful and relevant to ask the same question

(1) On the differences between the various legislations, see V. ANDREOLI, F. MAFFEI, G. TAMBURINO, *Il ciclo della droga*, op. cit., VI.

(2) The moderate theses on the use of the penal instrument in cases of personal use — as expressed in the Interim Report of the Canadian Government Commission of Inquiry, *The Non-Medical Use of Drugs*, Harmondsworth, Penguin Books, 1971, especially p. 324 ff — have therefore prevailed. It should, however, be noted that the application of the substantial depenalization for possession of drugs for personal use has inherent contradictions that are anything but insignificant: an assessment of the actual use of the drugs possessed is very often based merely on the quantity in possession, consequently punishing those who possess quantities greater than a minimum established on a rigid and *a priori* basis. This approach tends effectively to penalize those who have laid in a stock of their particular drug in order not to be (too) dependent on the black market, whose defeat is the natural goal of the penal law. On the other hand, the same substantial depenalization of personal use constitutes indirectly a stimulus to the maintenance if not to the enlargement of the black market, since those who have recourse to it are no longer punished. At the same time, this non-punishment often enables real drug dealers to elude the law by pretending to be mere users.

with regard to addicts who have committed « common » crimes or crimes connected with drug dealing.

An exhaustive answer to this question would entail reference to a whole series of considerations which would require more space than is available here. However, at least two considerations should be mentioned. The first concerns the control of addicts who have committed « common » crimes: for them — even if the link between the need to obtain drugs and the pressure towards criminal behaviour, present in most of them (1), must not be undervalued — the fact that some intervention to defend society is required cannot be ignored. Now, the defence of society can best be ensured through the resocialization of addicts rather than just by segregating them from society for varying lengths of time. It is, however, obvious on the other hand that, particularly for cases of serious « common » crimes, the addict cannot simply be *offered* the choice of undergoing outside treatment or not: the *obligatory nature* of the treatment itself and the control of the subject, in defence of society, need to be guaranteed, in view of the fact that it is just those addicts with bad criminal records who react less positively to any attempt at treatment (2). And this cannot be achieved without some form of coercion, represented by prison or some other form of compulsory treatment, albeit with the painful awareness of the contradiction between all this and the principle of a free adhesion to the treatment, which is so important for its success.

The second consideration concerns the control of those addicts who have committed crimes of drug « dealing » alone (3). For this category, criminal behaviour is normally even more closely connected with the personal use of the drug than are the « common » crimes committed by other addicts. Besides, the drug addict-dealer does not usually accept the values which are particularly conducive to the perpetration of

(1) Obviously, apart from the addicts who are perpetrators of criminal deeds in connection with their state of toxicomania, there are also addicted criminals whose antisocial behaviour bears no essential relation to their state of toxicomania: what is said here about the former does not apply to the latter.

(2) C. W. HORNICK et al., *Measurement of Post D.A.R.P. Outcomes*, Fort Worth, Texas Christian University, 1977.

(3) But also, obviously, crimes of import, cultivation, manufacture, etc., of quantities greater than those considered necessary for personal consumption.

criminal acts (1), shared by those addicts who commit « common » crimes. In spite of all this, it should be pointed out that in any case the penal measure of detention cannot, it seems, be completely eliminated so long as any liberalization of drug dealing is considered inopportune, on the basis of the fear of a still stronger wave of desocialization (2). If the international community does not change its opposition to the legalization of drug trafficking, the addict-dealer will continue to be punished by the penal law and put in prison: the provisions of the most recent international agreements on this matter authorize the replacement (or supplementation) of the penal sanctions of detention by mere treatment measures if the perpetrators of the presumed criminal acts are also addicts (3). But the substitution of mere treatment for the penal measure of detention is logically only possible if the violation of the drug laws is, in essence, directly connected with personal use, because if such a substitution were to be applied to any form of violation of these laws, the result would be a depenalization of the international heroin trade, so long as it is carried on by addicts (4), which is obviously in contradiction of the said international agreements. There exists today legal scope for the application of treatment measures under conditions of freedom even to the addict guilty of « small-time » dealing, and it is probable moreover that this scope will also be extended to other categories of addicts-law-breakers; but prison will still continue to serve as a means of social control for addicts who perpetrate violations, considered serious, of the drug laws. For this category, the use of the measures of detention would appear to depend on considerations of social defence similar to those mentioned earlier with regard to the obligatory nature of the intervention

(1) Or rather a cultural structure in which there is more room for self-justification techniques vis-à-vis moral issues arising from criminal behaviour. On these techniques, see G. M. SYKES, D. MATZA, « Techniques of Neutralization: A Theory of Delinquency », *American Sociological Review*, 1957, XXII.

(2) This fear appears to be shared by the great majority of scholars in the field. There are, however, some dissentient voices: on the thesis in support of the legalized sale of heroin, see P. C. BARIDON, *Addiction, Crime and Social Policy*, op. cit., Chapter 5.

(3) Art. 22, Para. I of the *Convention of Psychotropic Substances*, Vienna, 1971.

(4) Apart from those addicts who are also dealers and who commit other violations of the drug laws in connection with their state, there are addicts whose crimes in the field of drug laws basically have nothing to do with their state in itself.

on addicts who perpetrate « common » crimes, with the difference that what is of concern here is defence against the spreading of drugs.

9. SOCIO-CULTURAL ASPECTS OF DISINTOXICATION WITHIN A DETENTION SET-UP

Rebus sic stantibus, treatment in prison of the particular types of addicts mentioned above presents special problems — over and above those already mentioned — as far as the use of intervention methods usually adopted outside prison is concerned.

The first point to be considered is that relating to disintoxication. Disintoxication is normally an almost automatic consequence of the addict's entry into prison. While the « normal » addict's curriculum is peppered with disintoxication attempts, undertaken on a personal basis or with the help of outside structures, and never concluded or followed within a very short span of time after conclusion by a relapse into drug use, the experience of imprisonment actually represents for many an opportunity for real disintoxication and an effective break with the drug milieu (1).

All this cannot simply be explained by mere reference to the coercive element connected with the state of being a inmate. The withdrawal crisis without a doubt consists, at least in part, of a series of physical disturbances of varying intensity connected with the state of typical dependency determined by the continued use of certain drugs (mainly opiates) (2). The withdrawal crisis cannot, however, be understood without reference also to the personal problems (3) which are established in the addict together with toxicomania: such personal problems are closely connected with the social and cultural aspects of toxicomania. When the use of drug is

(1) M. M. GLATT, « Treatment of Drug Dependency in Treatment Centres, In-Patient Units and Prisons in the London Area », *The British Journal of Addiction*, 1972, no. 2; see also Comité Européen pour les Problèmes Criminels, *Conclusions Générales*, Séminaire sur *Les Drogues et la Prison*, Messina, 1962, p. 6.

(2) Interim Report of the Canadian Commission of Inquiry, *The Non-Medical Use of Drugs*, op. cit., p. 44-44.

(3) See *Bulletin of the World Health Organization*, 1965, no. 32.

broken off after a long period of addiction, together with physical disorders, the series of problems connected with the addict's awareness of his own inadequacy vis-à-vis « normal » society, his desocialization, and his social and cultural insecurity recur with even greater intensity. At the same time, the addict expresses the anxiety of losing the fundamental help constituted by the use of drugs, with its artificial Nirvana, the support of the subculture of addicts and the alternative equilibrium derived from all this. It is owing to this complex situation that the period of the withdrawal crisis represents, for the addict involved in the conflictual reality of the subculture, a terrifying experience and an almost insurmountable obstacle to the achievement of resocialization. It is an indisputable fact that the addicts who live outside detention set-ups perceive this crisis as *per se* a determining factor for the perpetuation of the state of addiction.

Within a detention set-up, the crisis takes on different aspects. Imprisonment represents a phase of isolation both with regard to the problems of desocialization vis-à-vis « normal » society and with regard to the problems posed by the abandonment of the subculture's equilibrium. Cut off from the conflicts inherent in his *outside* life, the addict, during the crisis period, no longer seems to show those dramatic symptoms which are feared as well as experienced outside prison. Disintoxication takes place without particular problems (1). Research in this field would appear to indicate a considerable number of cases in which no evident withdrawal symptoms are presented, whilst in 70 % of the cases in which a crisis appears, this may be considered modest in scale (2). This is all the more significant if one considers that the treatments of the internal health services rarely consist of decreasing doses of opiates; they consist more frequently of methadone, and even more frequently of the mere administration of tranquillizers and sedatives, whilst it is not rare – also due to disorganization – for the addict to receive no type of specific therapy at all.

(1) K. BJERVER, *The Correctional Treatment System – Treatment or Detention of Drug Abusers*, paper presented to the Seminar on *Les Drogues et la Prison*, op.cit.

(2) Ministero di Grazia e Giustizia, *Indagine su 371 tossicodipendenti detenuti*, etc., op. cit., pp. 244-248.

10. ASPECTS OF METHADONE MAINTENANCE WITHIN THE SAME SET-UP

As far as the continuing methadone therapy is concerned, it seems that this treatment is not capable of having a similar significance in prison than outside. As we have already seen, methadone maintenance is a therapy aimed at providing the addict with a heroin substitute on a continuing basis. This is in order to remove the pressure to seek the drug on the black market, the connected need to commit crimes to finance it and the dependence on the subcultural milieu of drug addicts. However, from the moment an addict enters prison, the pressure to seek drugs on the black market and all the social problems connected with it are removed by the substantial impossibility of continuing in their habitual use (1). Consequently, a lot of society's interest in this type of treatment fades, since it is aimed in the first instance not so much at improving the addict's situation, as at defending society by trying to achieve not a drug-free condition, but a dependence on a socially less-dangerous drug.

Consequently, the use of methadone maintenance within a detention set-up can, in the opinion of the writer, assume a significance only in the perspective of a mere control of the situations of conflict in prison or of a preparation for a continuation of the therapy outside, after release.

As regards the first perspective, nevertheless, the principle of a continual administration of a drug to inmates does not seem ethically acceptable if it is merely in order to reduce their attitude of conflict towards their condition of detention and thus to obtain less « problematic » prisoners. A prison structure should be able to control the inmates kept in it

(1) It is known that some drug use within closed set-ups such as prison exists (cf. H. REMSCHMIDT, « Traitement et réadaptation des délinquants pharmacodépendants et consommateurs de drogues », in Comité Européen pour les Problèmes Criminels, *L'Importance des stupefiants par rapport à la criminalité*, op. cit., p. 148 and 155). However, the phenomenon of the entry of drugs into prison, since limited both from the quantitative point of view and in terms of continuity of time, does not permit the development, except in rare cases, of a use similar to that possible outside prison and the consequent state of dependency.

without needing to have recourse to a drug (1). Moreover, the possibility of using methadone maintenance as a means of controlling tension seems to be clearly incompatible with the rehabilitation aims of present-day detention systems (2). These rehabilitation aims cannot exclude the aspects of awareness and willingness mentioned above, which would be subverted by the use of a drug, even if « legal ».

As regards the use of continuing therapy in prison, as a preparation period for a subsequent similar treatment outside, it must be said that this is only superficially better founded. In fact, whilst it is important to develop contacts between the penal institutions and outside society as far as possible, in order to prevent prison remaining — what it has in essence been to date — *a world apart*, and whilst it is particularly desirable that this should happen for the benefit of drug addicts, whose desocialization vis-à-vis the outside world is especially acute, it is not at all clear how a continuing therapy might constitute a valid and necessary *trait d'union* between prison and society. Even if the theory of a policy of methadone maintenance outside prison were accepted (3), the usefulness of undertaking such a therapy in prison still remains to be proved, for the subject would not thereby be obliged to continue with the therapy outside prison once free again.

The paradox of the hypothesis of the continuing methadone treatment in prison lies precisely in the fact that, on the one hand, it has no sense if seen from the perspective of the purely *internal* point of view of the prison, and on the other it does not have much more sense if seen from the *external* perspective, as the continuing treatment inside cannot logically be seen as a suitable *training* for a continuation of the same therapy

(1) Since, in contrast to the situation outside, it is certainly possible in prison to control people without making them methadone addicts, the continued use of methadone does not seem acceptable. The fact that there certainly exists in prisons an abuse of medicines (above all tranquillizers and sedatives), often essentially in order to control internal tensions, in no way authorizes this practice to be considered acceptable, still less the substitution of these medicines by the more effective methadone.

(2) See, on this subject, U.N., *Ensemble des règles minima pour le traitement des détenus*, 1955, in part. Art. 65-66.

(3) And even recognising the fact that it would be possible to identify inside the prison those addicts who — due to mental disorders, due to their psychopathic characters or due to their long-standing criminal experience — should constitute the ideal patients for an unlimited methadone treatment.

outside. The acceptance of such a continuing therapy outside depends exclusively on the personal will of the addict: such a will cannot be influenced by the methadone maintenance treatment undergone in prison, in positive social terms, since the subject who has become dependent on methadone can of course easily return to heroin use as soon as he is free. At the same time, this will is influenced, in negative social terms, by the therapy undergone, since if the addict really wanted to free himself of the drug habit, he would have to face up to his methadone dependency, which is substantially similar to that of heroin (1). The will to avoid a relapse into the drug world on release — or the will to undergo possible methadone maintenance outside prison in order to escape at least the subcultural-criminal milieu of drugs — can be conditioned in positive terms only by a treatment that, already in prison, aims at a progressive reversal of the state of desocialization which is at the root of the drug use. For all these reasons, a spread of the methadone maintenance therapy inside closed institutions does not appear desirable: the eventual use of methadone just for the disintoxication therapy appears much more desirable. This is, besides, the approach most widely followed so far, even though some countries are using the continuing therapy for a limited number of patients, for whom different treatments do not seem to offer much hope (2).

11. ADDICT'S MINIMAL BALANCE IN A SPECIAL SET-UP

If the hypothesis of an overall resocialization treatment remains, even in prison, or rather above all in prison, the only chance of intervening on the state of addiction — since medico-pharmacological therapies cannot be sufficiently relied upon

(1) For an opposing view see, V. P. DOLE et al., « Methadone Treatment of Randomly Selected Criminal Addicts », *New England Journal of Medicine*, 1969, June, whose study appears to have given positive results for the therapy in question; the group studied was, however, so limited that no important conclusions can be drawn from it.

(2) That is the case of Holland: J. M. VAN DER VAART, *Examination of the Theme from the Social Workers' Point of View*, paper presented to the Seminar on *Les Drogues et la Prison*, op. cit. It does not however appear to be easy to limit methadone treatment to a few special patients ignoring the pressures which would be made by the other addicted inmates.

— it must at the same time be stated that the treatment which the users of heavy drugs normally receive in prison is not able to change the overall phenomenon of the global inadequacy of the subject to adjust to acceptable social roles. The limited opportunities for work offered to him, as well as the minimum of education, some forms of medical assistance, some attempts at individual short-term psychotherapy, as well as group psychotherapy, and some religious help provided for him (1), are not calculated to overcome his situation of global inadequacy vis-à-vis normal social roles. Naturally, far more could be done than has been to date. However, it has to be borne in mind that the problem cannot be reduced to that of increasing both human and technical resources, even supposing that the present crisis of development were to permit this increase.

The possibility of a resocialization treatment in prison and the obstacles it would seem to pose, are in the first place linked, as has already been said, to the prison structure itself and the addict's state within it. Paradoxically enough, despite all the limitations already mentioned, the prison set-up does not have entirely negative effects on the addict: within the prison walls the addict, in the majority of cases, manages to find what we could call a *minimal balance*, which is different from that of his normal adjustment to the roles of outside society (2), but also different from the balance an addict can achieve in the drug culture underworld. This minimal balance is the consequence of the type of social organization within the institution. The addict is unable to adjust to an outside reality — that of society today — which presents characteristics of high selectivity, very strong competitiveness, the progressive marginalization of broad strata

(1) On the limitations of treatment in prison, L. RADZINOWICZ, J. KING, *The Growth of Crime*, op. cit., Chapter 9. In underlining the overall inadequacy of the treatment of addicts in prison, my intention has been to refer first of all to the basic limits of such a treatment due to the organizational characteristics of prisons, underlined *passim*; only in the second place has it been my intention to refer to the lack of technical and human resources. In this regard it should be stated that in the USA, according to recent estimates, about 10,000 adult inmates (4 % of total) are participating in drug addict treatment programs (though compared with 21 % of inmates considered as former habitual heroin-users) at a cost of many millions of dollars and involving a large number of specialists: National Institute on Drug Abuse, *Drugs Abuse Treatment in Prison*, Rockville, U.S. Government Printing Office, 1981.

(2) For the same perspective see also K. BYERVER, *The Correctional Treatment System*, op. cit.

of the population, continuous stress and deep frustrations. However, the addict, at the same time, is very often able to find a balance within a closed institution, such as prison, where competitiveness is very low, where the daily goals established by the organization are within everybody's reach, and above all where the daily routine is ordered, as in any total institution, by a rigid system of rules which support the individual because they regulate every moment of his day, thus enabling him to avoid difficult personal decisions and too arduous requirements.

This does not mean that the drug addict, on leaving prison, is in some way ready to face up to normal outside life, precisely because there are such enormous differences between the roles in outside and inside society (1). We therefore find ourselves faced by this paradoxical situation: during the present historic phase in which imprisonment is seen essentially as a means for resocialization vis-à-vis the roles in outside society (2), prison acts on the contrary mainly as a defence of society through the segregation of the addict and as a place for the realization of a form of integration that is valid almost exclusively *inside* prison.

12. THE PROBLEM OF PROGRESSIVE RECONSTRUCTION

The chance for the drug addict to find a minimal balance within a detention institution constitutes, therefore, almost always only an intermission in his process of desocialization. Yet this phenomenon can be useful to understand some of the shortfalls in the forms of the treatment of addicts practised in non-detention conditions. The limited balance which most addicts achieve in prison seems to indicate that any attempt at treatment should necessarily pass through a progressive reconstruction of a socialization model, progressive in the sense that the subject must be gradually prepared to respond to rising levels of society's requirements, starting at a level where the difficulties are very limited and the require-

(1) On this subject, R. SMITH, *Drug Programs in Correctional Institutions*, op. cit. p. 41.

(2) On this subject, B. WOOTTON, *Crime and the Criminal Law*, London, Stevens & Sons, 1963.

ments reduced — as occurs within prison — and continuing until the same level in terms of difficulty is attained as exist in « normal » life in today's society.

However, even the perspective of progressive reconstruction presents by no means negligible obstacles. The addict, as has been seen, forms part of the drug subculture milieu, where he has found some sort of adaptation and balance, even though in a role alternative to the dominating culture. The addict, like any other human being, is striving to find an adjustment which, in a calculation between the rewards and frustrations, offers a positive balance. The attempt therefore to extricate him from his dependency is bound to fail if one supposes it is possible to deprive him of the advantages of this balance and to offer him in exchange only the frustrations that he will receive from an incongruous attempt to adjust.

Behind the failure of most of the attempts to achieve the adjustment of addicts to society there is a misunderstanding of the problem of transition from a situation of drug addiction, which represents in some way a sort of adjustment, to the opposite situation of a drug-free condition, which could represent a complete maladjustment in terms of balance. In order to prevent this transition from the status of addict to that of (potential) « normal » citizen resolving itself into frustrations such as to lead to the abandonment of the attempt and the reconfirmation of his belonging to the drug milieu, a resocialization treatment must be organized which not only gradually prepares the subject to face increasingly demanding social tasks, up to a level similar to that present in « normal » social reality (1), but which also ensures gratifications able to compensate the individual for the gradually growing efforts asked of him. It is inconceivable that the ex-addict will be able to face *ex abrupto* all the difficulties of normal adult life unless he is first taught how to face some minor difficulties and is constantly rewarded, at a faster than normal rate, in a milieu in which he receives steady and prompt gratifications

(1) For a similar view, as regards the specific problem of employment, see H. R. LAMB, C. MCKOTA, « Using Work Therapeutically », in R. E. HARDY, J. G. CULL (Eds), *Drug Dependence and Rehabilitation Approaches*, Springfield, C. C. Thomas, 1973, p. 165.

capable of sustaining him in his progress towards social adjustment.

This gradual process, through progressive levels of social requirements and coordinated gratification levels, cannot be undertaken by the drug addict without some help, since society asks him *hic et nunc* too much, in the light of the level of his desocialization vis-à-vis the standards of normal life. Just as it would be inconceivable to ask an effective social adjustment of a child without putting him under the control of institutions — like the family or the school — specialized in the task of determining such an adjustment through a form of education which presents characteristics of progressive socialization and parallel gratifications, it is equally inconceivable to expect of an addict — who presents as his background a condition of incomplete or distorted socialization — a readjustment in the absence of structures suited to achieve this through a socialization treatment presenting the same characteristics.

13. THE NEED FOR A GLOBAL MODEL OF SOCIALIZATION

There is therefore a need to provide specialized structures aimed at the resocialization of the addict and of a very different type than the normal medico-psychiatric structures: the real problem is not, in fact, to «cure» drug addiction but overcome the inadequate socialization which is at its root. Unfortunately, not only is there a serious shortage of structures set up for the resocialization of addicts, but there are also grave shortcomings even in those public or private bodies which concentrate their work on the aspect of the addict's socialization, rather than on the «medical treatment» for toxicomania. These bodies are expected to convert addicts to other forms of adjustment — other than that of the drug sub-culture — which have to be both gratifying for them and in conformity with society's needs. But, in order to achieve this, such bodies must be able to help the subjects treated to interiorize complex social models, i.e. *coordinated sets* of socio-cultural-psychological characteristics, suitable for the adjustment aimed at.

Faced by this enormous task, the action of the bodies set up to deal with resocialization tends normally to be limited to an attempt to piece together the specific fragments within a framework which is however inadequate as a whole. The action of these structures for resocialization usually takes the form of an attempt to teach the ex-addict the necessary techniques to carry out a job, to improve his general knowledge, to make him aware of his personal problems, and so on.

Now, the importance of rebuilding specific aspects of the framework of socialization cannot be denied. In particular, the acquisition of the technical skills needed to enter the labour market must above all be stressed due to the importance it has, particularly nowadays in a society which requires a high level of specialized training for employment. But, at the same time, the specific fragments of socialization do not allow the rebuilding of a global model of socialization. The global model goes far beyond the individual specific aspects — and also the sum total of them — since it concerns, among other things, the acceptance of values on which in turn depend both the motivations which lead to the acceptance of the individual specific aspects of socialization and the ability for self-gratification in their application, in social terms. It is, for example, to a great extent a waste of time to teach an ex-addict to be a bricklayer or a book-keeper or to improve his general knowledge, if he is incapable of finding a social meaning for all this (1), unable as he is to use these aspects within a social role actually performed in society: knowing how to do a job is — to use the same example — an entirely different matter than finding social achievement through it.

The state of desocialization of the addict may be understood precisely as an inability to connect the individual specific aspects within a global model which is effectively suited to the achievement of social adjustment. The global model provides for the interiorization of the coordinated sets of

(1) The importance of the motivation, in the specific sphere of employment, is underlined by D. N. NURCO and M. LERNER, « Occupational Skills and Life-Styles of Narcotic Addicts », in C. WINICK (Ed.), *Sociological Aspects of Drug Dependence*, op. cit., p. 269.

socio-cultural-psychological characteristics, but these sets cannot, by their very nature, be interiorized through a simple process of learning specific bits of knowledge on the basis of imitation, but only through the acceptance of a global model represented by an interactive subject, on the basis of an identification of affective type (1).

14. THE IDENTIFICATION WITH AN INTERACTIVE SUBJECT

It is precisely the identification with another interactive subject, in a relationship in which feelings of esteem, affection and loyalty predominate, which allows the interiorization of *values*, and thereby the establishment of a global model in which the values themselves operate as cement for the separate specific aspects of socialization. As far as the drug addict is concerned, it is precisely the global model which needs to be reconstructed and it is only possible to achieve this through a slow process of identification with interactive subjects able to represent global models for resocialization. But this process of identification cannot be achieved if the addict is not willing to cooperate in it: if the treatment and contacts with the interactive subject were just the result of a mere obligation on the addict's part, then the scope for those feelings which are at the basis of the process of identification would be sharply reduced, if not eliminated altogether. In contrast to what happens in the early years of life, during the basic process of socialization, when the affective relationship with the parents is an unavoidable fact since it is substantially the only channel of contacts with the outside world, in an adult who needs in some way to be resocialized a tie of affection with a suitable model can only be established by free will. This is because an obligation from outside cannot condition the subject's affective availability, if there are other alternative models — particularly those belonging to the drug subculture — which already exert a deep influence on him.

In view of all this, the possibility of obtaining successes within a resocialization treatment based on a compulsory

(1) T. PARSONS, *The Social System*, op. cit., Chapter VI.

element is very limited: prisons and all other structures within which treatments largely characterized by a basis of coercion are carried out (1), have limited possibilities of establishing a bond between the addict and valid models for resocialization (2).

15. THE THERAPEUTIC COMMUNITIES

The possibility of achieving the interiorization, by the addict, of a suitable model for his resocialization is much greater in those structures in which the model is presented within the framework of a relationship based on the principle of the voluntary acceptance of it by the addict himself. Exemplary, in this regard, is the Synanon type of therapeutic community (3), which was originally set up for alcoholics but later extended to drug addicts. This type of treatment structure is based on the following principles: a) not only must the addict voluntarily undergo treatment, but he must undertake actively to prove his will to change by self-criticism and confession of his own inadequacies; b) the only aim of the treatment is the drug-free state, and not that of dependency on another surrogate substance: the addict's interests in freeing himself of his addiction is considered as predominant rather than society's need to find some sort of solution to defend itself, as with methadone maintenance; c) disintoxication is carried out by trying to avoid the recourse to pharmacological therapies; d) the treatment usually involves a fairly long-term stay in a community residential structure together with other addicts; e) the treatment aims at resocializing the subject, through the reconstruction of suitable social, cultural and personality qualities: group psychotherapy is widely used as a means to alter inadequate

(1) Those centres are referred to in which the addict has to undergo treatment: under the threat of imprisonment: J. C. KRAMER, «The State Versus the Addict: Uncivil Commitment», op. cit.

(2) M. M. Glatt states, however, that also a treatment under coercive conditions, within structures such as prison and the like, can give positive results since it is possible to create a motivation for treatment in the subject: «Treatment of Drug Dependency in Treatment Centers, In-Patient Units and Prisons in the London Area», op. cit.

(3) See S. CASRIEL, *So Fair a House: The Story of Synanon*, Englewood Cliffs, Prentice Hall, 1963; R. M. GLASSCOTE et al., *The Treatment of Drug Abuse*, op. cit.

characteristics; f) subjects treated are in constant and direct contact with the « older » members of the community — often ex-addicts themselves (1) — who represent the model figures with whom the addict can identify.

On the whole, in comparison with the alternatives actually carried out, this type of treatment must be considered today as the most advanced hypothesis for the resocialization of the addict (2): of the number of those who have concluded the period of treatment, the percentage of those who have remained drug-free, who have not been re-arrested and who manage to hold down a job, is very high (3).

However, this does not mean that the method does not present criticizable aspects or that it cannot be improved. In particular, it should be pointed out that the success rates of the treatment are conditioned by the pre-selection which the treatment itself involves: only a small number of addicts are willing to undergo long-term residential treatment: many of those entering a community drop out after a short while (4). In particular, long-term residential treatment is not accepted as a rule by those addicts who have their own family; who are part of a well-knit subcultural group; who have cultural and personality difficulties in accepting submission to authority and who possess characteristics which make them unsuitable for community life. It is evident, moreover, that, except for the first case, the individuals who tend to refuse

(1) On the importance which the ex-addict model represents, see C. L. BOWDEN, G. F. MADDUX, « Clinical and Counselling Problems in Drug Dependence », in R. E. HARDY, J. G. CULL (Eds.), *Drug Dependence and Rehabilitation Approaches*, op. cit., p. 133-134; G. GEIS et al., « The Use of Ex-Addicts in a Rehabilitative and Educational Program », in C. WINICK (Ed.), *Sociological Aspects of Drug Dependence*, op. cit., p. 241.

(2) This seems also to be the opinion of many prison authorities, since the therapeutic community model has even spread inside detention structures: in the USA, for example, more than 40 % of the inmates who undergo treatment for toxomania participate in programs based on this model: National Institute on Drug Abuse, *Drug Abuse Treatment in Prisons*, op. cit., p. 8. Obviously the fact that such treatment is undergone in prison, radically alters the model's substance for the reasons mentioned above.

(3) W. V. COLLIER, *The 1971 Profile/Statistical Report on the Therapeutic Community Program of Daytop Village*, New York, Satellite Co., 1972; R. M. GLASSCOTE et al., *The Treatment of Drug Abuse*, op. cit., p. 83 ff.; G. NASH, « The Sociology of Phoenix House: A Therapeutic Community for the Resocialization of Narcotic Addicts », in C. WINICK (Ed.), *Sociological Aspects of Drug Dependence*, op. cit., p. 199 ff.; National Institute on Drug Abuse, *Effectiveness of Drug Abuse Treatment Programs*, op. cit.

(4) R. M. GLASSCOTE et al., *The Treatment of Drug Abuse*, op. cit., p. 40.

this treatment are just the ones who constitute the most serious cases of desocialization and who are the source of the greatest danger for society. In addition, the principle of the therapeutic community as an *organization in itself*, separate from society raises some doubts: while it does offer undeniable advantages as regards the graduality of the resocialization process and the possibility of interiorizing a new model on the basis of a continuing and exclusive contact, it must equally be admitted that life in the therapeutic community always remains characterized by diversity vis-à-vis « normal » life outside, since it has the typical characteristics of the *small group* and more particularly of a surrogate of the family institution. This does not occur by chance, since the aim is to reproduce conditions similar to those in which socialization takes place during childhood. But the consequence is that there is a tendency to produce in those who have undergone treatment a greater capacity to achieve adjustment within the community itself than outside it, i.e. in « normal » society (1), where the mechanisms of social relation are quite different.

This is why those subjects who have completed the treatment tend to continue to remain tied to the community and often stay on as « group leaders » for the new arrivals.

16. A PROPOSAL: HYPOTHESIS FOR A MIXED-TREATMENT MODEL

Faced by these contradictions, we are of the opinion that an approach to be attempted is that of the feasibility of combining some of the basic characteristics of the Synanon model (aimed at a drug-free state, reconstruction of the socio-cultural-personality aspects, and constant and direct contact with the model) with the characteristics of a form of service to society's advantage. The performance of such a service — the actual carrying out of which could be monitored by a public or private body — should be concretely carried out through assistance to hospital patients, to the elderly, to the

(1) See G. NASH, *The Sociology of Phoenix House: A Therapeutic Community for the Resocialization of Narcotic Addicts*, op. cit., p. 214.

blind, to the handicapped, or also (preferably in a second phase), through work in various fields, for example restoration of buildings, road repairs, etc., always to the benefit of the general community. This type of service would permit the gap between the small community group and the world outside to be bridged and at the same time offer the opportunity to interiorize a global work model (1): the fact of being enabled to carry out an activity capable of producing direct and immediate socialization could considerably reduce the anomie, the alienation and the sense of frustration normally associated with the addict's life-style.

The chance — which would be offered to the subject by this type of treatment — of being involved in an activity useful to the community (and, in the case of work with the handicapped, etc., in a activity with humane aspects that could deeply involve him), of winning the esteem and respect of others, and of learning new forms of integration by working alongside the model consisting of the social workers, should constitute factors valid for overcoming his state of desocialization. Furthermore, the possibility of carrying out a job under special conditions, i.e. with the help of social workers, in a less competitive context and one more tolerant towards his inadequacies in work, would create the necessary conditions for the gradual process of development up to the levels of skills normally required in society: without this gradual process, success in terms of readjustment cannot, as has already been emphasized, be expected.

In addition to the work aspect, the need for the presence of valid models with whom to establish affective relationships, and the need for a *graduality* in the process of readjustment to an acceptable social role, would be guaranteed by the element of *community*, while contacts with the outside world would represent the essential element for an effective readjustment to « normal » society.

A treatment characterized in this way, by its inherent pressure towards integration, could reduce the need for long-

(1) In order to make such a model more realistic and gratifying, some sort of payment should also be envisaged for the activity carried out, though it should be borne in mind that this should be low, since the subject who is working is also enjoying at the same time the benefits of a complex treatment.

term *residential* care — thereby recuperating those clusters of addicts who find it difficult to accept this particular aspect — whilst the series of services usually provided could carry out their function possibly on the basis of a organization of « day-centre » type.

The mixed-treatment model, as described above, could also be used for those addicts who have committed common crimes in connection with their state, and even more so for those who has committed crimes of drug trafficking, again directly tied to their state of addiction (1).

Naturally, the provision of this kind of treatment for drug addicts who have committed crimes would have to pass through the selection of subjects by the usual techniques of prediction, to establish the degree of danger to society and the tendency to recidivism. This would be aimed at striking the right balance between, on the one hand, the humane interest in the resocialization of the addict and the social interest in the same goal and, on the other hand, the need to control the social risks involved by a measure applied under conditions of substantial freedom (2).

The treatment in question would appear to have several advantages over the application of prison sentencing for criminal addicts. The service in favour of the community would represent a form, at least partial, of *restitution*, in the sense that the community would be compensated in some way for the damages incurred by the addict's antisocial behaviour, which is not the case with a prison sentence. There would be a minimum aspect of punishment, since the treatment, while offered as an alternative to imprisonment, would entail, even though in a limited fashion, some punitive aspect, through an imposition to work hard to the advantage, at least in part,

(1) Moreover, a type of social service as an alternative measure to imprisonment — though without the community assistance background here indicated — has been used for several years now in Great Britain for adults sentenced for crimes, with positive results: J. B. COKER, « Community Service in Hampshire (England) », *International Journal of Offender Therapy and Comparative Criminology*, 1977, no. 2.

(2) The selection of suitable subjects could be organized even during a brief initial period of detention, in case it is felt that the utilization of some form of detention structure cannot be avoided for security reasons. Besides, whilst a prison sentence in itself does not produce significant effects, a brief stay in a detention structure, followed by a period of treatment on parole outside, seems to give good results in terms of achievement of the drug-free condition: G. E. VAILLANT, « A 20-Year Follow-up of New York Narcotic Addicts », *Archives of General Psychiatry*, 1973, 29.

of the community; this should satisfy all those who believe that society can defend itself only if those responsible for anti-social acts be *punished* in some way. At the same time, the punitive elements would not be such as to generate frustration and resentment in the person undergoing treatment — thus impeding his identification with the new models with whom he comes into contact — because it would not be a question of a cold and impersonal punishment, but of an involvement in a social activity; the subject would not be cut off from « normal » society — with all the consequent negative effects — but would undergo a treatment whose final objective of overcoming the state of desocialization would be achieved by daily integration into social reality.

The proposal of new forms of intervention in the field of the treatment of addicts does not, however, imply any claim that this social scourge can be defeated and eliminated *rebus sic stantibus*. Drug abuse is by now an established reality in the social organization of the Western world: we should deduce from this — according to Durkheim's lesson (1) — that it is a « normal » phenomenon, in the sense that it has its roots in the very structure of this type of social organization. Within certain limits, the levels of failure of toxicomania treatment can be considered as an effect of the same pressure to drug use which this type of society produces: the forms of treatment represent an attempt to counter-balance the pressure to drug use whose origin lies in causes up-stream. The fact that the average percentage of treatments completed successfully is estimated at around 15 %, with maximum peaks of 23 % in the case of therapeutic communities (2), is not therefore merely the result of inadequacies in the treatment programmes.

This is not to deny, however, that many of the types of treatment hitherto used were effectively deficient and inadequate in terms of the objective of the addict's resocialization and readjustment. Particularly in the case of treat-

(1) E. DURKHEIM, *Les règles de la méthode sociologique*, Paris, F. Alcan, 1895, Chapter III.

(2) National Institute on Drug Abuse, *Follow-up Evaluation of Drug Abuse Treatment: A Summary Report*, Rockville, U.S. Government Printing Office, 1978. For an overall review of the results of the different treatments, see National Institute on Drug Abuse, *Effectiveness of Drug Abuse Treatment Programs*, op. cit.

ment through medicinal drugs or imprisonment, we usually find ourselves faced merely by a form of « encapsulation » of the phenomenon: in these cases, the « success » — if it can be called such — of the treatment is entrusted to a great extent to the end of the natural addiction cycle. In effect, after an average period of 8–9 years, the forms of drug addiction tend to be self-extinguishing (1), though many cases register maximum periods of much longer duration (2). Between the ages of 35 and 40, nevertheless, we usually see the re-absorption of the addiction on the conclusion of an *adolescent* period already artificially prolonged well beyond its normal limits.

Even if this is true, we cannot, however, continue merely to limit ourselves to the « encapsulation » of the phenomenon whilst waiting for the conclusion of the natural cycle in order to count the number of victims.

(1) C. WINNICK, « The Life Cycle of the Narcotic Addict and of the Narcotic Addiction », *Bulletin on Narcotics*, 1964, vol. 16, no. 2; see also L. BRILL, *The De-Addiction Process*, Springfield, C. C. Thomas, 1972, which provides an analysis of the phases of the detachment from the drug world as well as data on the length of the addiction cycle.

(2) G. E. VAILLANT, « A 20-Year Follow-up of New York Narcotic Addicts », *op. cit.*

RIASSUNTO

La confusa differenziazione attuale di ipotesi di trattamento nei confronti del fenomeno della tossicomania costituisce lo specchio di una contraddittorietà esistente a livello della stessa definizione del fenomeno.

Per superare questo ostacolo fondamentale, l'Autore propone una definizione di tossicomania — funzionale alla comprensione eziologica del fenomeno — come « uso continuato e coatto di droga, quale stadio terminale di un processo di desocializzazione rispetto al quadro dei modelli sociali dominanti presenti attualmente nelle società urbano-industriali ».

Viene sottolineato come questo processo di desocializzazione si sviluppi sulla base di una situazione caratterizzata dalla conflittualità e/o debolezza dei modelli sociali con cui il soggetto è venuto a contatto, e di un complessivo squilibrio tra il livello di gratificazione ed il livello di frustrazione connessi con l'accettazione dei modelli sociali stessi.

Il processo di desocializzazione costituisce un fenomeno globale che ha effetto sull'intero quadro delle caratteristiche socio-culturali dell'individuo, cioè una inadeguatezza complessiva nei confronti dei ruoli socialmente accettabili, dipendentemente dalla mancata interiorizzazione della serie di modelli e valori idonei a produrre la disponibilità, le capacità tecniche e le capacità di gratificazione essenziali per lo svolgimento dei ruoli sociali legittimi.

Il processo di desocializzazione prevede, come « soluzione » per la situazione di tensione creatasi nel rapporto individuo-società, il rigetto dei modelli e valori dell'inserimento e l'adesione a modelli e valori diversi, centrati sulla contrapposizione rispetto al *mondo dell'inserimento*: aspetto essenziale di questa creazione di una contrapposizione è la socializzazione alternativa all'interno della comunità sottoculturale dei tossicomani.

Attraverso quest'ultima, il tossicomane — desocializzato rispetto alla cultura e alle società dominanti — gode comunque dell'appoggio di suoi pari, partecipa della loro sottocultura, è inserito in un contesto sociale che lo sostiene e lo gratifica.

Da una definizione della tossicomania nei termini sopra indicati, consegue che la prospettiva dell'intervento medico sul tossicomane non può che essere considerata come un qualcosa *non* in grado di incidere sul cuore del fenomeno della tossicomania, ma soltanto eventualmente su aspetti indiretti o secondari di esso: la tossicomania è infatti, in sè, un fenomeno culturale e sociale, assimilabile ad altri

fenomeni come il disadattamento scolastico o la delinquenza minorile, e rappresenta solo secondariamente un problema medico.

Sostanzialmente per gli stessi motivi, un intervento sulla tossicomania centrato sulla disintossicazione dell'*addict* si dimostra nei fatti inadeguato in termini di risocializzazione, in quanto quasi privo di significato nei confronti di questa.

Effetto di questa inadeguatezza è il generalizzato ripercorrere — da parte del tossicomane — le strade della socializzazione alternativa nel mondo della droga, anche dopo esperienze di completa disintossicazione.

Per quanto riguarda invece, la terapia di mantenimento con methadone, si sottolinea come attraverso questa si ottengono effetti positivi, almeno parziali, in termini di cessazione dell'uso di eroina, reinserimento lavorativo e scolastico, riduzione degli atti di criminalità legati al bisogno di procurarsi la droga, emancipazione dell'*addict* dall'ambiente sottoculturale ruotante intorno al mercato nero della droga.

L'Autore rivela, tuttavia, come i parziali successi ottenuti non siano comunque attribuibili alla terapia farmacologica in sè — come sostenuto in origine da alcuni autori — essendo semplicemente gli effetti sociali del fatto di poter disporre *legalmente* e *gratuitamente* di un surrogato degli oppiacei, senza che ciò comporti d'altra parte un intervento effettivo sulla condizione di desocializzazione di base del tossicomane.

La terapia continuata con methadone viene ritenuta pertanto dall'Autore un semplice aiuto chimico, valido soprattutto in termini di difesa sociale, per contenere gli atti di criminalità originati dal bisogno di procurarsi la droga sul mercato nero e per ridurre la dipendenza dell'*addict* dall'ambiente sottoculturale fornitore di droga.

In termini di capacità di allontanare il soggetto dal mondo della droga, la terapia di mantenimento con methadone avrebbe una efficacia del tutto relativa, in quanto il suo successo dipenderebbe da cose estranee alla terapia stessa, e cioè dal processo di risocializzazione che il tossicomane deve intraprendere.

D'altra parte, si sottolinea come la terapia di mantenimento con methadone può essere ritenuta *efficace* solo all'interno di una prospettiva che si propone di sostituire l'uso di eroina con l'uso di un altro farmaco con caratteristiche largamente simili: pertanto, anche se non deve essere sottovalutata la funzione di *difesa sociale* connessa a questo trattamento, non si devono neanche sottovalutare i pericoli connessi con la prospettiva di diffondere un'altra droga, anche se produttrice di effetti sociali meno devastanti rispetto all'eroina, senza alcuna speranza di poter incidere con una terapia chimica su quelle cause socio-culturali da cui dipende la stessa *addiction*.

Viene successivamente affrontato il problema dei limiti della struttura detentiva come luogo per il trattamento dei tossicomani.

Si fa notare come, a livello internazionale, vi è stata una evoluzione delle leggi penali in materia di stupefacenti, che ha comportato una tendenza netta alla depenalizzazione formale o sostanziale dell'uso personale di droga: si è passati quindi da una utilizzazione del carcere

allargata anche ai semplici consumatori di droga, ad una utilizzazione ristretta ai soli consumatori che siano anche spacciatori o autori di reati « comuni ».

Nonostante ciò, il carcere è una agenzia alla quale viene ancora affidata una parte notevole del controllo del fenomeno delle tossicomanie.

Ora, le caratteristiche dell'istituzione penitenziaria la rendono assai poco idonea ad un trattamento di risocializzazione dell'*addict*: in particolare, risultano particolarmente negativi sotto questo profilo il contagio con la sottocultura criminale caratteristica dal carcere — che definisce in modo negativo anche il semplice sottoporsi ad una forma di trattamento di risocializzazione — la percezione negativa del sè che il tossicomane — già portatore di un marchio di *diversità* — ricava dall'esperienza carceraria, la caratteristica generale di coercitività che tende ad annullare l'elemento volitivo, etc.

Scendendo nel particolare della distinzione tra il tossicomane autore di reati « comuni » e quello autore di reati specifici, si osserva che nel primo caso, pur dovendosi dare il giusto peso al collegamento tra bisogno di procurarsi la droga e pressione verso il comportamento criminale — collegamento che costituisce il normale *leit-motiv*, in questo caso — il principio di difesa della società non permette che ci si limiti, specialmente nei casi di gravi reati, ad offrire semplicemente al tossicomane la scelta di sottoporsi o meno ad un trattamento esterno.

È necessario garantire un controllo del soggetto o una obbligatorietà del trattamento stesso, le quali cose non possono prescindere da qualche norma di coercizione, rappresentata dal carcere o da altre modalità di trattamento coattivo, pur con la dolorosa consapevolezza degli aspetti anche negativi che tali modalità di intervento presentano, specialmente rispetto al principio della libera adesione al trattamento, così importante per l'efficacia del medesimo.

Per quanto riguarda il caso del tossicomane autore di soli reati « di droga », si fa notare come, pur essendo qui il reato ancora più legato di regola all'uso personale di droga, non sembra che l'intervento penale-restrittivo possa essere completamente eliminato sino a che si ritiene inopportuna la liberazione del commercio di droga.

Mentre è probabile che vi sarà in futuro uno spazio maggiore per l'applicazione di trattamenti in libertà anche per il tossicomane che si è reso colpevole del cosiddetto *piccolo spaccio*, la sostituzione della detenzione con il trattamento in libertà non sembra possibile per gli altri reati specifici più gravi, perché altrimenti si assisterebbe alla sostanziale depenalizzazione del traffico internazionale di droga, purché fatto da tossicomani.

Venendo al problema specifico del trattamento del tossicomane nell'istituzione detentiva, l'Autore ritiene che la prospettiva di una terapia continuata con methadone non abbia ragione di essere, in quanto questa terapia, essendo finalizzata non tanto al miglioramento della condizione dell'*addict* quanto piuttosto alla difesa della società, risulta non necessaria in una struttura che dovrebbe offrire di per sè garanzie almeno di una difesa passiva della società.

Del resto, l'ipotesi di una terapia continuata con methadone all'interno della istituzione, come momento di preparazione per una successiva terapia simile esterna, non appare fondata, in quanto la eventuale volontà nel tossicomane di ricorrere a questa terapia all'esterno — per sfuggire almeno all'ambiente sottoculturale-criminale della droga — non può essere determinata da esperienze nello stesso senso fatte all'interno della istituzione, ma eventualmente solo da un trattamento che si indirizzi ad un rovesciamento progressivo della condizione di desocializzazione che è alla base dell'uso della droga.

A proposito dell'intervento su questa condizione di desocializzazione, l'Autore afferma che — mentre la istituzione detentiva non è in grado, normalmente, di modificare il fenomeno complessivo della inadeguatezza del soggetto ad inserirsi in ruoli sociali accettabili, a causa degli aspetti negativi della istituzione stessa — il tossicomane riesce tuttavia nella maggiore parte dei casi a trovare all'interno della istituzione un *equilibrio minimale*: questo dipende dal fatto che il tossicomane — incapace di inserirsi nella realtà esterna, per via delle caratteristiche di selettività, competitività, marginalizzazione, frustrazione, ecc., tipiche di questa ultima — può invece trovare un *equilibrio minimale* in una istituzione nella quale la competitività è estremamente bassa, le mete quotidiane alla portata di tutti, la vita regolata, come in ogni istituzione totale, da un sistema rigido di norme che sostengono l'equilibrio, determinando le attività ed evitando al tossicomane difficili scelte di tipo personale.

Queste considerazioni possono essere utilizzate per una analisi delle caratteristiche indispensabili ad un trattamento sulla tossicomania in qualsiasi condizione (non-detentiva o detentiva) esso si svolga, affinché esso sia produttivo di effetti positivi.

Tra tali caratteristiche ci deve essere quella della ricostruzione *progressiva* di un modello di socializzazione: all'origine del fallimento di gran parte dei tentativi di reinserimento dei tossicomani vi è la non-comprensione del fatto che ad essi si chiede assurdamente di passare di colpo da una condizione che è comunque di adattamento, anche se alternativo, ad una di completo disadattamento di fronte alla società « normale ».

Bisogna dunque abituare il soggetto a rispondere a livelli crescenti di richieste provenienti dalla società, cominciando da livelli che presentano difficoltà assai limitate e frustrazioni ridotte.

Un'altra caratteristica essenziale è quella della presenza di un modello *globale* di socializzazione.

Il tossicomane è carente sotto questo profilo globale e poco vale tentare di ricostruire aspetti specifici ma isolati (capacità lavorative tecniche, istruzione, conoscenza del sè, etc.), se non si ricostruisce il modello globale: quest'ultimo va ben oltre i singoli frammenti specifici — e anche la loro somma — in quanto riguarda, ad esempio, motivazioni che sono a monte della accettazione dei singoli aspetti specifici, capacità di autogratificazione, etc.

D'altra parte, la ricostruzione di un modello globale non può passare attraverso l'apprendimento, su base imitativa, di frammenti

di cultura, ma solo attraverso la adesione ad un modello rappresentato da un soggetto interagente, con cui vi sia una identificazione di tipo affettivo.

Questa ulteriore caratteristica, indispensabile ad un trattamento, presuppone la libertà della disponibilità affettiva del soggetto e quindi la mancanza di un obbligo esterno.

Rileggendo alla luce delle considerazioni di cui sopra le esperienze delle *Comunità terapeutiche*, si osserva come esse da una parte presentino aspetti largamente apprezzabili (ad es., trattamento non-farmacologico, condizione di *drug-free* come finalità, ricostruzione delle qualità socio-culturali-caratteriali, rapporto con una figura « modello », etc.), mentre dall'altra presentano difetti quali la separazione tra comunità e società e la tendenza a produrre nei soggetti trattati più capacità di inserimento all'interno della comunità che nella società normale all'esterno.

Per superare questa *impasse*, l'Autore propone un modello misto di trattamento, in cui accanto a caratteristiche essenziali del modello di *comunità* vi dovrebbero essere attività di servizi a vantaggio della società.

Le attività a vantaggio della società dovrebbero permettere sia il superamento della frattura tra piccolo gruppo e società esterna, sia il superamento della condizione di desocializzazione attraverso nuove occasioni di integrazione esterna.

Il fatto di poter svolgere una attività capace di produrre una socializzazione diretta e immediata potrebbe ridurre notevolmente la anomia, la alienazione e il senso di frustrazione legati al modello di vita del tossicomane.

Un trattamento misto del genere potrebbe essere applicato anche a tossicomani autori di reati specifici o « comuni », anche eventualmente dopo un breve periodo in detenzione, necessario per l'accertamento dei rischi affrontabili in termini di pericolosità sociale e propensione al recidivismo.

Rispetto alla pena del carcere presenterebbe vantaggi tra i quali l'esistenza di una forma di restituzione sociale, l'esistenza di un minimo ma non nullo aspetto di *pena*, la prevalenza dell'aspetto risocializzativo attraverso una integrazione quotidiana nella realtà sociale esterna.

RESUME

La différenciation actuelle et confuse d'hypothèses de traitement de la toxicomanie est seulement le reflet d'une contradiction au niveau de la définition du phénomène.

Pour éviter cet obstacle fondamental, l'auteur propose une définition de la toxicomanie « comme usage continu et forcé de drogue, dernier stade d'un processus de désocialisation par rapport au cadre

des modèles sociaux dominants présents actuellement dans la société industrielle urbaine ».

L'auteur souligne que ce processus de désocialisation se développe sur la base d'une conflictualité ou faiblesse des rôles sociaux intériorisés et d'un équilibre d'ensemble entre le niveau de gratification et celui de frustration liés à l'acceptation des modèles sociaux: le processus prévoit le rejet du *monde de l'intégration* et une socialisation alternative dans la communauté sous-culturelle des toxicomanes.

En partant d'une telle définition, on nie toute validité substantielle à la perspective de l'intervention médicale, et on conteste la validité d'une intervention sur la toxicomanie centrée sur la désintoxication de l'« addict ».

On passe donc au problème du méthadone en thérapie de maintien (*methadone maintenance*), en soulignant que ce type de traitement permet d'obtenir certains résultats positifs comme la réduction des infractions liées au besoin de se procurer de la drogue illégale et l'émancipation de l'« addict » de la sous-culture tournant autour du marché noir de la drogue; toutefois, un tel succès n'est pas dû à la thérapie pharmacologique en soi mais aux effets sociaux du fait de pouvoir disposer légalement et gratuitement d'un succédané des opiacés, sans que cela comporte une intervention effective sur la condition de désocialisation de base du toxicomane.

Ensuite est abordé le problème des limites de la structure détentive comme lieu pour le traitement des toxicomanes.

Après avoir souligné les différentes caractéristiques de l'institution pénitentiaire qui rendent extrêmement difficile la resocialisation de l'« addict », on met en évidence l'évolution au niveau international des interventions restrictives sur le toxicomane, tendant à frapper seulement l'auteur d'infractions de « commerce » ou de « droit commun ».

Pour les toxicomanes traités à l'intérieur de la structure détentive, on examine les problèmes de la crise d'abstinence, des traitements avec méthadone et des traitements de resocialisation: à ce propos, on affirme que la prison, bien que n'étant pas positive en général pour la resocialisation de l'« addict », permet cependant à ce dernier d'atteindre un niveau d'équilibre *minimum*, conséquence de l'organisation sociale proposée par l'institution globale.

Ainsi sont individualisés, comme aspects essentiels du traitement de resocialisation de l'« addict » — dans n'importe quel milieu — la resocialisation *progressive* des capacités de socialisation et la nécessité d'un modèle *global* de socialisation pour l'apprentissage d'aspects techniques et de fragments spécifiques de culture.

On analyse ensuite la capacité des communautés thérapeutiques à mettre en oeuvre les aspects essentiels du traitement, en soulignant les qualités et les défauts de ce type d'intervention.

Pour éviter les principaux défauts de cette méthode, l'auteur propose un modèle mixte de traitement dans lequel, à côté des caractéristiques typiques des communautés, il faudrait développer surtout les aspects d'une activité de services en faveur de la collectivité.