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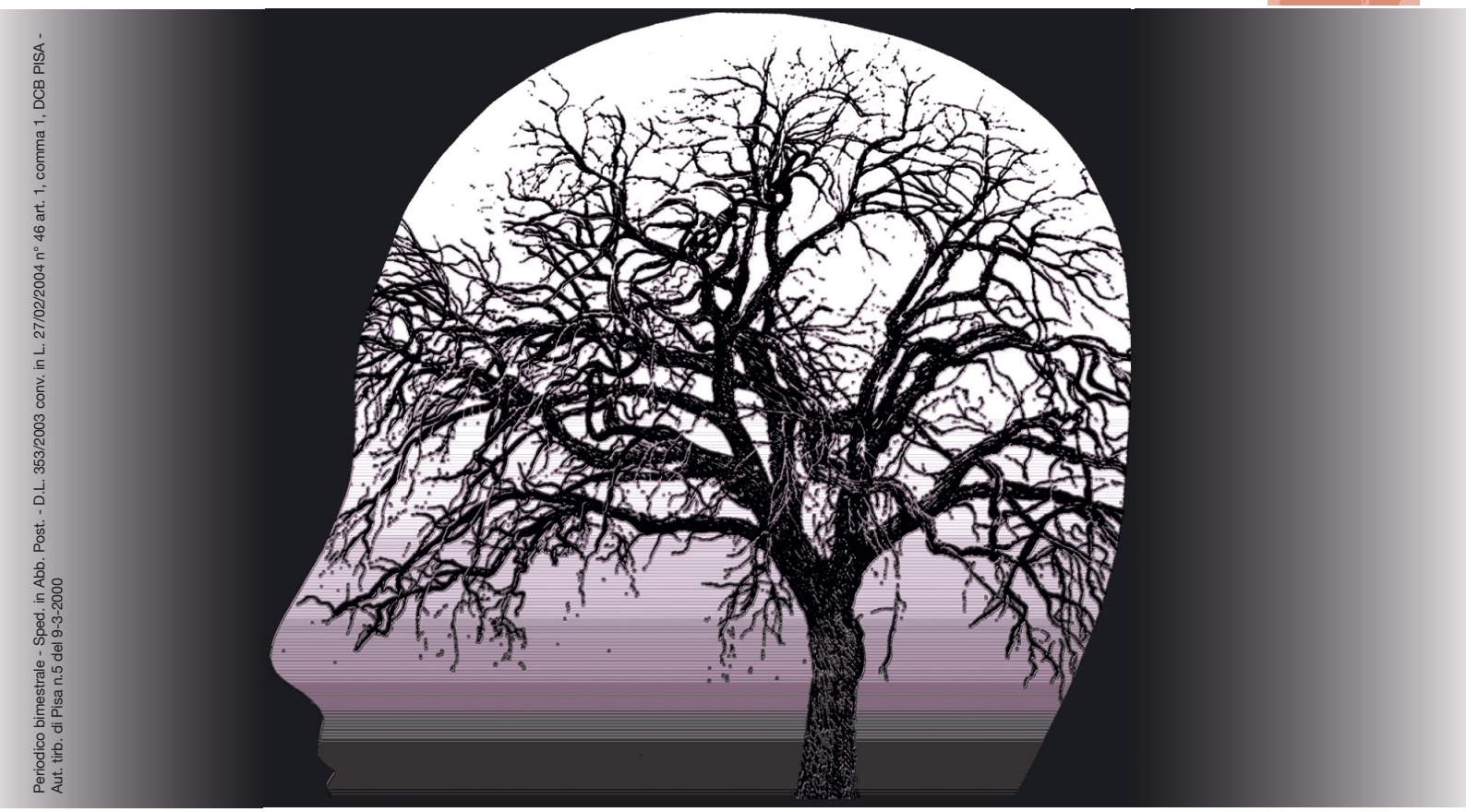

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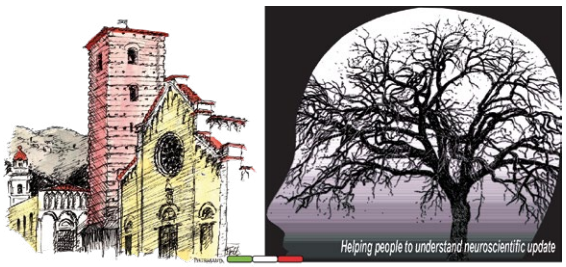

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Addiction as a chronic illness. Treatment, stabilisation and the limits of punitive approaches in substance use disorders within international human rights frameworks

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Summary

Background: Substance use disorders continue to occupy an ambiguous position between healthcare and criminal justice systems. Despite increasing recognition of addiction as a chronic condition, responses frequently oscillate between treatment and punishment, generating inconsistencies in clinical practice and potential conflicts with international human rights principles. **Methods:** This perspective analyses addiction through a clinical and conceptual framework integrating contemporary knowledge on the developmental and chronic nature of substance use disorders with legal and ethical considerations derived from international human rights instruments. Particular attention is given to the distinction between physiological dependence and addiction, the progressive impairment of behavioural control, and the implications for treatment, responsibility and clinical decision-making. **Results:** Addiction emerges as a chronic behavioural illness characterised by a transition from voluntary substance use to impaired control, requiring long-term treatment and stabilisation rather than punitive responses. The persistence of hybrid models in which therapeutic pathways remain intertwined with penal mechanisms risks reinforcing stigma, therapeutic omission and structural discrimination, while alignment between medical practice and human rights frameworks supports treatment-oriented approaches based on continuity of care, proportionality of intervention and protection of individual dignity. **Conclusions:** Recognising addiction as a chronic behavioural disorder is essential to reconcile clinical practice with human rights principles. Effective responses require prioritising care over sanction and reaffirming the responsibility of healthcare systems to provide evidence-based treatment consistent with the rights and protections afforded to other chronic medical conditions.

Key Words: Automatic Behaviour; Loss of Control; Substance Use Disorders; Human Rights Protection; Clinical Responsibility

Substance use disorders occupy a complex and often contradictory position within contemporary health and legal systems. Individuals affected by addiction frequently move between two opposing frameworks: one that recognises their condition as requiring care, and another that interprets the same condition through categories of control, sanction or social danger. This oscillation generates practical, ethical and clinical tensions that influence access to treatment, the organisation of services, and the recognition of fundamental rights.

The present text seeks to examine these tensions from a clinical and conceptual perspective, with particular attention to the implications arising from the recognition of addiction within the broader framework of disability and human rights. Substance use disorders continue to be managed within systems in which therapeutic pathways are often intertwined with penal mechanisms, where treatment may occur under

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explicit or implicit legal pressure, and where residential or rehabilitative settings are sometimes employed as alternatives to detention rather than as components of a medically defined therapeutic process.

Within this context, international human rights principles – particularly those concerning the rights of persons with disabilities – introduce an additional level of reflection. These principles invite reconsideration of autonomy, legal capacity and self-determination in individuals whose behavioural control may be compromised by illness, while at the same time affirming the need to protect physical and mental integrity on a basis of equality with others. The tension between protection, care and autonomy remains insufficiently explored in relation to addiction, despite its direct relevance to everyday clinical and institutional practice [2, 4].

The purpose of this essay is therefore not to advance new theoretical models, nor to provide a strictly legal analysis, but to clarify the conceptual foundations necessary for a coherent understanding of addiction as a chronic condition. By examining the distinction between dependence and addiction, the developmental nature of the disorder, and the limits of punitive or hybrid responses, the text aims to contribute to a reappraisal of how treatment systems may better align clinical knowledge with respect for individual rights.

1. Dependence and addiction: A necessary distinction

A major source of misunderstanding in both clinical and public discourse arises from the failure to distinguish clearly between physiological dependence and addiction. Although the terms are often used interchangeably, they refer to fundamentally different phenomena and carry distinct implications for diagnosis, treatment and legal interpretation.

Physiological dependence represents a biological adaptation to repeated exposure to a substance. Tolerance and withdrawal are predictable consequences of neuroadaptation and may occur with numerous pharmacological agents, including medications used appropriately in medical practice. The presence of withdrawal symptoms does not in itself imply loss of behavioural control, nor does it necessarily indicate a pathological relationship with a substance [1].

Addiction, by contrast, concerns behaviour rather than pharmacology alone. It develops when interaction with a rewarding substance progressively alters motivational systems and behavioural regulation, leading to increasing difficulty in controlling use despite adverse consequences. In its early stages, substance use may remain organised and compatible with social functioning. Individuals may still plan their actions and maintain roles and responsibilities while pursuing the rewarding effects of the substance. Over time, however, behavioural organisation deteriorates, reflecting a progressive erosion of executive control rather than a deliberate choice to act against one's own interests [13, 19].

The failure to maintain this distinction produces two opposing errors. Individuals with physiological dependence may be incorrectly identified as addicted, while individuals with addiction may be judged primarily on the basis of quantity or frequency of use rather than on behavioural dysregulation and loss of control. The result is diagnostic ambiguity and the adoption of responses that are neither clinically appropriate nor conceptually coherent.

2. The developmental nature of addiction

Addiction is best understood not as a static condition but as a process unfolding over time. Substances initially enhance subjective experience, increasing sensitivity to pleasure or reducing psychological distress. This early phase contributes to reinforcement and may create the impression of improved functioning or emotional regulation. With continued exposure, however, neurobiological adaptation gradually reverses this effect. The capacity to derive pleasure from ordinary experiences diminishes, and the individual becomes increasingly reliant on the substance not to enhance well-being but to compensate for its absence [8, 12].

This progression has important clinical consequences. Behaviour associated with advanced addiction cannot be adequately interpreted through models based solely on voluntary action. Individuals may retain intellectual awareness of consequences while experiencing a reduced capacity to translate such awareness into effective behavioural inhibition. The disorder thus occupies a complex space between understanding and control, where intention and action progressively diverge [14].

Within this framework, relapse must be interpreted as an intrinsic feature of the illness rather than as an external failure. Recurrence of substance use represents a manifestation of the chronic and relapsing nature of the disorder..

3. Addiction as chronic illness

Recognising addiction as a chronic condition does not imply that it is identical to other chronic diseases. Nevertheless, it requires the application of similar conceptual principles. Chronic illnesses are characterised by long duration, fluctuating course and the possibility of recurrence despite treatment. Clinical management therefore focuses on stabilisation, reduction of risk and restoration of functional capacity rather than definitive cure in all cases [12].

From this perspective, treatment cannot be meaningfully constrained by arbitrary temporal limits. The duration and intensity of intervention must reflect the clinical course of the disorder rather than administrative expectations or judicial timelines. Different phases of illness may require different therapeutic approaches, ranging from pharmacological stabilisation to psychosocial interventions, yet continuity of care remains central [11]. The chronic and relapsing nature of addiction implies that therapeutic objectives should be defined primarily in terms of stability and functional recovery, rather than in terms of immediate or definitive resolution. Clinical experience across chronic conditions indicates that treatment strategies cannot be constructed around exceptional outcomes, but must instead respond to the needs of the majority of patients whose condition evolves over extended periods and requires long-term therapeutic engagement.

When addiction is approached as an acute condition requiring rapid resolution, therapeutic strategies tend to prioritise detoxification or abstinence as isolated objectives. Although detoxification may be necessary in specific circumstances, it does not address the behavioural and neurobiological mechanisms that sustain addiction. The assumption that removal of the substance alone constitutes treatment reflects an incomplete understanding of the disorder's complexity and contributes to recurrent cycles of instability..

4. The ambiguity of punitive frameworks

Legal systems often encounter difficulty in integrating the chronic nature of addiction within frameworks historically constructed around individual responsibility and deterrence. As a consequence, individuals may be recognised as ill in one context and treated as fully culpable in another, generating inconsistencies that undermine both care and justice [10]. This dual framing produces significant practical consequences, particularly in situations where behaviours emerging during the course of illness are interpreted primarily through a penal lens, despite their close relationship with impaired behavioural control and the clinical evolution of the disorder.

This ambiguity becomes particularly evident when access to treatment is mediated through judicial processes or when therapeutic progress is evaluated according to legal criteria. When relapse leads to the withdrawal of benefits or the reintroduction of punitive measures, symptoms of illness are effectively transformed into grounds for sanction, a mechanism not observed in ordinary medical practice [3]. The distinction between the capacity to understand and the capacity to act becomes central in this context, as substance-related behaviours may occur in the presence of preserved cognitive awareness but reduced volitional control, raising complex questions regarding responsibility and therapeutic obligation.

Similarly, the substitution of custodial or quasi-custodial environments for treatment risks confusing containment with therapy. Uniform responses to heterogeneous clinical conditions fail to acknowledge the variability inherent in addiction, where severity, comorbidity and treatment needs differ substantially among individuals [6]. Where treatment settings function primarily as instruments of control, dependence risks being reframed as a justification for supervision rather than as a condition requiring clinical intervention, thereby reinforcing the ambiguity between care and punishment that characterises many contemporary responses to substance use disorders.

5. Treatment, stabilisation and the role of harm reduction

Harm reduction has emerged as an important component of public health strategies in the field of substance use. Measures aimed at reducing infectious disease transmission, overdose risk or social harm have demonstrated clear benefits, particularly among individuals not yet engaged in treatment [9].

However, harm reduction and treatment serve distinct purposes. Harm reduction mitigates consequences; treatment seeks to modify the course of illness. When these functions are conflated, there is a risk that reduction of harm becomes an endpoint rather than a transitional strategy facilitating access to effective care. Within a clinical framework centred on chronic illness, stabilisation represents a primary therapeutic objective, and the availability of effective treatments requires that harm reduction strategies remain integrated within broader treatment pathways rather than replacing them.

Effective treatment requires adherence to scientific evidence and individualisation of care. Inadequate dosing, insufficient duration of intervention or reliance on standardised approaches may contribute to poor outcomes that are mistakenly attributed to patient resistance rather than therapeutic insufficiency [16, 18]. Such misunderstandings reinforce stigma while obscuring systemic limitations. Where appropriate care is unavailable or insufficiently implemented, harm reduction may become a substitute for treatment rather than a complementary strategy, thereby reflecting organisational shortcomings rather than intrinsic limits of therapeutic effectiveness.

In this perspective, the failure to provide accessible and appropriate care may itself constitute a form of therapeutic omission, exposing individuals and society to preventable harm. Harm reduction approaches may therefore be understood not only as public health interventions but also as attempts to reconcile individual rights with health protection, particularly

in contexts where continuity of treatment remains difficult to achieve.

6. Knowledge transmission and cultural resistance

Progress in addiction treatment is further limited by insufficient transmission of knowledge within formal medical education. The existence of specialised services without corresponding academic structures contributes to fragmentation of expertise and variability in clinical practice [17, 20]. In the absence of systematic education, treatment approaches may depend on local traditions or personal convictions rather than evidence-based principles.

Cultural resistance continues to reinforce this problem. Addiction remains associated with moral judgement and stigma, leading to reluctance in recognising behavioural disorders as legitimate medical conditions. This cultural framing influences policy decisions and sustains models centred on correction or exclusion rather than stabilisation and care [7, 15]. As a consequence, treatment systems may oscillate between therapeutic intent and social control, reflecting broader societal ambiguities in the interpretation of substance use disorders.

The consequences extend beyond clinical settings. When addiction is perceived primarily as self-inflicted misconduct, institutional responses tend to prioritise control over treatment, thereby reinforcing marginalisation and delaying access to care. This dynamic contributes to the persistence of hybrid systems in which medical, social and judicial responses overlap without clear conceptual boundaries, creating conditions in which therapeutic objectives risk being subordinated to administrative or corrective functions.

7. Towards coherence between medicine and law and human rights

A coherent response to substance use disorders requires alignment between scientific knowledge, clinical practice and legal frameworks. Recognition of addiction as a chronic behavioural illness does not eliminate responsibility; rather, it situates responsibility within the limits imposed by the disorder itself. Legal systems routinely accommodate medical realities in other domains, and addiction should not constitute an exception [5]. The ambiguity between care and punishment becomes particularly evident where legal systems continue to oscillate between recognising dependence as a medical condition and treating behaviours arising during the course of illness as expressions of criminal liability.

The central objective of intervention must be the restoration of behavioural control and functional stability. This objective cannot be achieved through punitive mechanisms alone, nor through approaches that disregard the medical nature of the condition. The integration of medical and legal perspectives does not imply the medicalisation of all substance-related behaviour; rather, it acknowledges that when addiction is present, effective responses must prioritise care over sanction [21].

Within the Italian legal system, substance dependence occupies an inherently ambiguous position, oscillating between its recognition as a medical condition and its treatment as a source of criminal responsibility. This dual framing produces significant practical consequences. On the one hand, addiction is increasingly understood within medicine as a chronic, relapsing disorder characterised by progressive stages, ranging from intoxication and withdrawal to behavioural dysregulation and long-term psychosocial complications. On the other hand, behaviours arising during the course of illness may still be interpreted primarily through a penal lens. This ambiguity affects clinical responsibility, access to care, and the assessment of criminal responsibility, particularly in cases where cognitive awareness remains intact while volitional control is impaired. The distinction between the capacity to understand and the capacity to act therefore becomes central, as substance-related offences may reflect illness-driven behaviour rather than autonomous criminal intent.

The 2006 United Nations Convention on the Rights of Persons with Disabilities (CRPD), ratified by Italy in 2009, is therefore binding within the domestic legal order and operates as an interposed parameter for constitutional review; it introduces a rights based perspective that calls coercive approaches to treatment into question. Articles 3, 12, 17, 19 and 25, taken together, affirm equality before the law, respect for physical and mental integrity, independent living, participation in society, and the right to health based on free and informed consent. Within this framework, therapeutic pathways provided under Presidential Decree 309/1990 as alternatives to imprisonment raise a fundamental tension: when treatment is accepted under the threat of penal consequences, the voluntariness of consent becomes questionable. The legal form of consent may persist, but its substantive freedom is potentially compromised.

Therapeutic communities, frequently presented as humane alternatives to incarceration, must therefore be evaluated in light of both the CRPD and the European Convention on Human Rights (ECHR). Article 15 CRPD prohibits inhuman or degrading treatment, and risks emerge when therapeutic settings operate as environments of control rather than care. Where treatment becomes indistinguishable from custodial supervision, dependence risks being transformed into a justification for prolonged monitoring rather than a condition requiring clinical intervention.

The legitimacy of such measures depends on proportionality, individualisation, and the presence of genuine therapeutic objectives.

Articles 122–124 of DPR 309/1990 may be interpreted as forms of reasonable accommodation, as defined by Articles 2 and 5 CRPD, insofar as they allow alternatives to imprisonment that recognise health-related needs. However, Articles 94–95 risk relocating punishment within treatment itself when therapeutic participation becomes functionally equivalent to penal execution. Corrective measures would require clearer differentiation between offences directly related to the clinical condition and those independent of it, alongside the development of evidence-based treatment pathways that may begin even within custodial settings but remain clinically, rather than penal, oriented.

The Italian psychiatric reform initiated by Law 180/1978 (the so-called Basaglia Law) introduced strict limitations on compulsory psychiatric treatment, grounding intervention in necessity, proportionality, and temporariness. Applying these principles to addiction care highlights the need for person-centred models that respect legal capacity and therapeutic choice while avoiding both abandonment and punitive responses to vulnerability. The challenge lies in balancing autonomy with protection in situations where decision-making capacity may be transiently impaired. In this context, a further critical issue concerns individuals affected by severe substance use disorders who, during acute phases of illness, may temporarily lose the capacity to understand or to make informed decisions regarding their own health. While compulsory treatment has been progressively restricted in psychiatry in order to safeguard individual rights, the absence of comparable clinical instruments in addiction care risks producing an unintended consequence: the abandonment of individuals who are no longer capable of exercising autonomous choice precisely because of the illness itself. Extending to addiction care the same principles that govern compulsory psychiatric intervention – namely, strict clinical indication, proportionality, temporariness, and appropriate administrative, technical, and judicial safeguards – would not represent a return to coercive models, but rather an attempt to prevent therapeutic omission and to ensure protection in situations where the disease temporarily compromises decisional capacity. Within this framework, compulsory intervention should be understood not as a punitive or corrective measure, but as an exceptional clinical tool aimed at restoring the conditions necessary for the recovery of autonomy. Article 17 CRPD, concerning the protection of personal integrity, is particularly relevant in the field of addiction treatment. Violations may occur not only through excessive or incongruent interventions but also through therapeutic omission. The failure to provide accessible and appropriate care may result in abandonment, exposing individuals and society to preventable harm. Harm reduction approaches, in this context, represent an attempt to reconcile individual rights with public health protection, acknowledging that social participation and substance use are not mutually exclusive realities.

Finally, the tendency within the Italian system to equate addiction with social dangerousness raises serious concerns under CRPD principles of non-discrimination and equal recognition before the law. The high prevalence of substance use disorders among incarcerated individuals and those detained in REMS facilities suggests that penal responses are often selectively applied to a medically defined condition. The conflation of illness with dangerousness risks producing structural discrimination, whereby individuals affected by addiction are disproportionately subjected to deprivation of liberty. A rights-compliant approach requires distinguishing between criminal behaviour arising independently of illness and conduct intrinsically linked to pathological processes, ensuring that treatment remains a health intervention rather than an extension of social control.

In this context, particular attention must be paid to the role of Residences for the Execution of Security Measures (REMS), which were introduced in Italy as healthcare-oriented alternatives to forensic psychiatric hospitals. Although conceived as therapeutic environments, practical implementation has at times revealed a structural tension between custodial and clinical functions. In situations where security requirements prevail, organisational priorities may shift towards supervision and risk containment, while therapeutic planning and continuity of care assume a secondary role. When medical intervention is not prioritised and clinical objectives become subordinate to surveillance needs, the risk emerges that individuals affected by mental disorders or substance use disorders are managed primarily through control rather than treatment. Such configurations may inadvertently reproduce custodial dynamics within healthcare settings, blurring the distinction between clinical responsibility and security management and reinforcing the ambiguity between protection, punishment and care that characterises many contemporary institutional responses to addiction.

8. Clinical and ethical implications

The challenges posed by addiction arise not only from its clinical complexity but also from the persistent difficulty of reconciling scientific understanding with legal and cultural frameworks historically shaped by moral judgement and concepts of individual fault. The failure to distinguish clearly between voluntary substance use and the progressive loss of behavioural

control that characterises addiction continues to generate responses that oscillate between care and punishment, often producing outcomes that are inconsistent with contemporary medical knowledge.

Addiction must be understood and treated as a chronic behavioural illness. This recognition does not deny the voluntary nature of initial substance use, nor does it eliminate personal responsibility in a general sense. Rather, it acknowledges that, as the disorder progresses, behavioural regulation may become increasingly compromised. Actions that initially arise from voluntary decisions may gradually lose this character as neurobiological and psychological mechanisms alter motivation, reward processing and inhibitory control. The transition from voluntary use to impaired control represents a central clinical feature of addiction and constitutes the basis for its medical interpretation.

Within this framework, the appropriate objective of intervention is not punishment but treatment, stabilisation and the restoration of functional autonomy. The management of addiction should therefore follow the same principles applied to other chronic conditions: continuity of care, proportionality of intervention, individualisation of treatment and protection from discrimination. Recognising addiction as illness implies that individuals affected by substance use disorders should benefit from the same safeguards and rights recognised in international human rights instruments, including equality before the law, respect for personal integrity and access to appropriate healthcare without coercion or stigma.

The persistence of hybrid models, in which therapeutic pathways remain intertwined with penal responses, reflects the incomplete recognition of addiction as a medical condition. As long as addiction continues to be interpreted primarily through the lens of deviance or dangerousness, treatment risks being subordinated to social control, and individuals affected by the disorder may be exposed either to punitive measures or to therapeutic omission. A rights-based approach requires moving beyond this ambiguity and affirming that health protection and respect for autonomy are not opposing principles but complementary objectives within clinical practice.

A coherent future framework depends on the full recognition of addiction as a behavioural disorder in which responsibility and vulnerability coexist. Only by acknowledging the progressive reduction of voluntary control inherent in the illness can treatment systems, legal institutions and social policies converge towards responses that prioritise care over sanction. In this perspective, aligning addiction treatment with the principles articulated in international human rights law does not represent an expansion of medical authority, but rather the restoration of a fundamental medical principle: that illness, wherever it occurs, must be addressed through care, dignity and the protection of human rights. For clinicians, this implies a clear responsibility to recognise addiction as a medical condition requiring continuity of care, to resist the substitution of therapeutic judgement with punitive logic, and to ensure that clinical decisions remain grounded in the primary obligation of medicine – the protection and restoration of the patient's health and autonomy.

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