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A Drug Free Approach to Treatment – Cultural/Social Aspects and Follow-Up Studies: the case of 'San Patrignano' Therapeutic Community

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Abstract

The dispute between those who seek to accommodate drug misuse (whose opponents dismiss them as 'fatalists') and those who seek to enable a return to drug-free lifestyles (whose opponents dismiss them as 'dreamers') has long existed in many countries. This paper, originally presented by its author, verbally in Italian at a conference in Rimini, Italy, targets this dispute, and expands on it by looking at the related social, cultural, and sociological factors. As the author explains, drug addiction can be seen as a 'disease of the soul' – and in this setting, detoxification is the least of the problems. After discussing and characterising this change of paradigm, the author supports it by presenting research results based on the experiences of present and former residents of the San Patrignano Community, the facility on which this paper is based.

Introduction and Background

The research described in this paper is substantially based on experience within the San Patrignano Therapeutic Community, located in Rimini, on the Adriatic coast of Italy. San Patrignano Community houses and interacts with almost 1,500 residents at any one time, and since it's founding in 1978 has served more than 18,000 people, at no charge. The resident group is diverse, and includes families with children. Some residents are HIV positive. The community provides medical care through a sizeable hospital within the site. Residents receive training to prepare them for possible employment in diverse trades and professions.

The community philosophy is perhaps best summed up in the words of the founder, the late Vincenzo Muccioli, who said: “Among the problems that affect the drug addict, drug use is the least relevant. The core of the problem is not drugs, nor the abstinence crisis: it is the human being with his fears and the black holes that threaten to suck him in. That is why I do not like to say nor hear that ours is a community for drug addicts. Ours is a community for living, where you can restart after years spent as a social outcast. Ours, if we really need a definition, is a community against social marginalisation.”

In favour of a cultural approach to drug addiction

In this paper, the author will focus on the issue of drug addiction in cultural terms rather than using the antiquated idea of a medical vs. social approach to drug addiction (in this context, this opposition between medical and social made sense 25 years ago when, for instance, it was important to legitimise and show the value of the work done by therapeutic communities).

Today, if one assumes that the pioneering stage of intervention can be considered as ‘behind us’, the clash is reduced between ‘medical approach’ and ‘social approach’. But the clash still exists: it is primarily a cultural clash between the tendency to consider drug addiction as a lifestyle choice, and the tendency to approach drug addiction as a disease that highlights the drug-free condition.

In this sense, the cultural dimension cuts across the medical and the social approaches. A drug-free culture may influence physicians and other relevant workers’ interventions; similarly, a culture that is bound to the idea of drug addiction as a lifestyle (often inspired by what is generally known as “harm reduction”) may be a source of inspiration for social intervention, possibly implemented by professionals who are typically present in the social field (e.g. sociologists and social workers).

Given this general distinction, and since a clear stance should be expressed by everyone addressing these issues, the preference of this author is to adhere to the drug-free approach: the approach of “sobriety” to quote a favourite term of Alcoholics Anonymous. Against this background, some of the main implications of this approach will be considered within the space limitations of this paper.

Choosing a drug-free approach means that one considers drug addiction to be a non-chronic disease, despite being a recurring one. This implies that the objective is to abstain from substance use and to be able to live without drugs throughout time (i.e. living permanently without drugs).

The **first implication** of this choice can be characterised as follows: it is possible to stop taking drugs and drug addicts are not chronic patients. Obviously, this does not mean that relapses do not occur and that the way out of drug addiction is linear. On the contrary, relapses and interruptions are the rule: since these 'incidents' are ever present, this supports the suggestion that drug addiction is not a chronic disease. Unfortunately, as is too often the case, drug addicts are considered unrecoverable (i.e. terminally ill patients).

Clearly, in this type of scenario, the objective is not to improve the quality of life of those who continue to be drug addicts; rather, the objective is to find a way out of drug addiction. In radical terms, the drug-free approach combines the idea of quality of life with the idea of living permanently without drugs (In contrast, the harm reduction approach focuses only on the improvement in the quality of life of the addict, regardless of the drug-free condition and regardless of the impact on the rest of the community at large.

The **second implication** concerns the distinction between different types of drugs. If one opts for a *drug-free* approach, the distinction between soft and hard drugs becomes less significant. This is not to say that there are no differences between substances but, this aspect is irrelevant for those who choose an approach aiming at sobriety and who consider sobriety to possess value.

In this sense, the distinction between different types of drugs is only significant with a view to better targeting interventions, whose main objective should be to achieve a drug- free condition (for instance, in case of drug addicts who do not perceive themselves as such, it would be necessary to implement outreach strategies to act upon this very frequent situation today).

The **third implication relates to** the duration of treatment and its minimum prerequisites. Considering minimum prerequisites first, without going into detail about different modes of intervention, once the drug-free approach is adopted, the aim of the course of treatment should also include abstinence from

drug use and monitoring that abstinence should be maintained throughout treatment. From this perspective, even when alternative medications are employed (e.g. methadone), it is necessary to ensure that no drug be used together with methadone (in fact, this is something more than likely to occur, regardless of the norms in place, as can be testified by people working in this sector). In sum, treatment cannot be compatible with the use of illegal substances.

From this perspective, the course of treatment is of paramount importance, not only because it aims at living permanently without drugs once it has been completed, but also because the subject is in a drug-free condition for the entire duration of the treatment itself (in many therapeutic communities this means that even methadone-based treatment is excluded, with only few exceptions and for a short period of time).

On the issue of treatment duration, in this author's view, drug addiction is a disease (suffering) of the soul (in practical terms, this means that physical detoxification is the least of the problems, and to achieve behavioural change, it is not enough to stay drug-free throughout time, unless it is associated with a certain "internal" dynamic). If drug addiction is considered a disease of the soul, the timing of treatments would be the same as what would be required for psychoanalysis. However, the author is not suggesting that people on drugs need to undergo psychoanalysis (indeed, a competent analyst would never accept to treat anyone on drugs); but it should be recognized that it takes years to quit drug addiction, insomuch as a short-term, analytically-oriented psychotherapy (i.e. not psychoanalysis proper) would normally last no less than three years. Thus, to better clarify the position, it is conceded that "it is true that there is a way out of drug addiction, but it is equally true that it is a long and hard way to go" and that in order to be fruitful, possibly it should be drug-free.

Finally, the **fourth implication** of a drug free approach necessarily regards follow-up. Indeed, choosing this type of approach means that the first aspect to be assessed is abstinence from substance use throughout time – only after this will reintegration and social behaviour be evaluated.

On the issue of assessment in general, and follow-up or outcome evaluation in particular, a key point worthy of further consideration is that results need to be evaluated starting with an assessment of the

drug-free condition, possibly by means of scientific trials, such as hair strand analysis, which makes it possible to trace back up to several months.

In the particular case of outcome evaluation, some fundamental integrations are essential, including programmes' retention factor or, even prior to that, enrolment selection criteria in individual therapeutic programmes.

These are a few of the implications involved in a drug-free approach. Building on extensive field experience (spanning nearly 30 years), the aim of this paper is to provoke more widespread appreciation of this paradigm , and to establish parameters, as a first step towards systematizing and evaluating the evidence (possibly scientific evidence) around the paradigm.

On a cautionary note, this shared knowledge should not be entangled in political or ideological confrontations and reductionism, which too often, especially in the Italian context, have characterised the debate over drug addictions.

The "Beyond the community" research project[1]: methodological aspects and findings

Phases of the study

The aim of this research project was to examine subjects who were residents in the 'San Patrignano' therapeutic community in Italy. Evaluations were carried out during their therapeutic program and in the following two to four years after the completion of the aforementioned program (*follow-up*). Three Universities were involved in the Project, namely Bologna, Pavia and Urbino.

The first phase of the study, conducted by the Department of Forensic Medicine and Public Health of the University of Pavia, included an evaluation of retention in treatment: specifically, the percentage of subjects who remained in treatment for a predetermined amount of time. Indeed, one of the main parameters that should be considered when carrying out a comparative evaluation of drug abuse treatment facilities is the capacity to keep patients in treatment for a reasonable length of time. To this end, the therapeutic community's archives, with data about residents from 1999, 2000, 2001, and part

of 2002, were examined to calculate the percentage of subjects who were still present in treatment after one, two, and three years. The percentage of those still in treatment after one year, which is the typical standard used in this type of study, was between 61% (1999) and 71% (2001). After two to three years, the percentage of subjects still in treatment was between 52-55%, and 45%, respectively.

The second phase of the research was a *follow-up* study of former community residents. The data set of cases under consideration included only subjects who had been treated at San Patrignano for drug addiction-related problems (the majority had problems related to heroin), were permanent residents of the community for at least 3 years, and who left the community in 2000, 2001, or 2002. Of these, 408 subjects were discharged from the community, whereas 103 subjects left the community without consent. The objective was to evaluate abstinence from drugs after two, three, and four years from the completion of the therapeutic program. Data collection took place between May and November 2004.

Results of hair strand analysis

The evaluation was carried out by means of hair strand analysis, which makes it possible to detect exposure to drugs back to one month per centimetre of hair analyzed.

A considerable difference was found between subjects who left the community with consent and those who left the community without consent, both in terms of participation and results. Of all the subjects who left San Patrignano with the community's consent, on average 61% took part in the study, with a peak of 70% among former residents who left in 2002 (2 year follow-up) and a minimum of 53% among those who left in 2001 (3 year follow-up).

The percentage of subjects involved in the study and who resulted negative for drug use at the time of the research was 78% two years after leaving the community, 62.3% after three years, and 70% after four years.

The percentage of subjects who took part in the study and who resulted negative, but who left the community without consent was considerably smaller (39%) than those who completed the program and left the community with consent.

In a group of 247 participants, hair strand analysis found a total of 50 positive samples for one or more illicit substances. Cocaine was the most frequently used substance (12% of analyzed samples), followed by cannabinoids (8.5%), methadone and opioids (7% and 6%, respectively) and ecstasy derivatives (1%).

Samples testing positive for more than one substance (i.e. opioids, methadone and cocaine, cocaine and cannabinoids) accounted for half of the positive samples (25 cases). The other half resulted positive for just one class of substances (44% were cannabinoids).

Sociological analysis: main results

Features of interviewees

The sociological part of the research involved 252 subjects, who were asked to fill out an interview-questionnaire. The interview-questionnaire consisted of fifty-seven questions, including three open questions. The questionnaires were administered in face-to-face interviews by interviewers experienced in the field of drug addiction, in locations that guaranteed full privacy and a neutral environment.

The interviewees included 200 men (79.4%) and 52 women (20.6%), averaging thirty-six years of age at the time of the interview, and twenty-nine when they entered the community for treatment. The age of the subjects ranged from a minimum of twenty to a maximum of fifty-five years at the time of the interview, and from a minimum of fourteen to a maximum of forty years at the time of entrance into the community.

As highlighted earlier, the prerequisite for taking part in this study was a minimum stay in the community of three consecutive years. In this respect, the group of relevant subjects was divided as follows: 101 subjects (40.1%) had spent between three and four years in the community; 107 subjects (42.5%) had spent four to five consecutive years, and 44 subjects (17.5%) had spent more than five years.

Even those who had spent at least three years in treatment did not necessarily leave "with consent" by the community's staff. In fact, 222 subjects (88.1%) left with consent, whereas 30 subjects (11.9%) left on their own, i.e. against the community staff's recommendations.

With respect to the addiction period of each subject, about 39% had been using illicit substances for more than ten years (97 cases). Of these, fifty one subjects (20%) had been drug addicts for more than sixteen years. About 23% declared that they had been drug addicts for a period of "up to five years".

As to the types of substances used, the majority of interviewees (95%) had used heroin, whereas 53% had used cocaine. It is worth pointing out that more than 12% of the subjects ticked the box "all" as an answer to what substances had been used. 36% had previously been in therapeutic programs in other communities. 17% went to San Patrignano under house arrest or under court order (of these, 59% had a sentence of more than two years).

After leaving the community

Upon leaving the community, 37% of subjects "found a job and were working in one workplace", 19% of subjects "were doing the same job in more than one workplace", 20% of subjects "changed their job once", and 24.5% of subjects "changed their job more than once". Within the reference group, the types of occupations were extremely diverse: 135 different answers were given to the question "what is your current occupation?" "Worker" was the most frequent answer – the only one selected more than ten times.

To the question of "place of origin", 63% of subjects answered that they were living in the same city where they used to live before entering the community, whereas 37% were living in a different city. Furthermore, 33% of subjects (84 cases) were living with their parents (this figure was almost 60% in the period immediately after leaving the community), 46% (115 cases) had a family of their own, and about 20% were living on their own. Among those who "have their own family" (i.e. a different family from their family of origin), 67% of these subjects formed their family after leaving the community, 25% already had their family when they entered the community, and the remaining 8% formed their

family while living in the San Patrignano Community. Of those who built their own family, 63% had at least one child (in 25 cases they had two and 9 couples had three children).

Considering the data presented above, a number of conclusions can be drawn.

- The range of professions (135), within the subject group, was very diverse. It is worth emphasising this result, in that it can be considered as evidence of the correlation between the professional training received within the community and the increasingly diverse skills that are necessary in the current job market. Indeed, it seems likely that the professional development gained within the community provided subjects with more flexibility, i.e. the ability to better adjust to the opportunities encountered in the job market and its specialised sectors.

- Among the 252 subjects who took part in the study, 97 stated that they had been drug addicts for over eleven years. Of these, 51 stated that they had been addicts for more than sixteen years. These 97 subjects would have been classified as chronic and incurable by most standards in Italy and abroad, using traditional approaches to drug addiction. Indeed, harm reduction and similar strategies are often considered the only option for those who have been addicts for ten years or more. This is why it is exceptional that about 60% of these ninety-seven people (with more than eleven years of experience as drug addicts, and some with as much as 20 years) are not only alive and well, but have also stopped taking drugs as a form of emotional anaesthesia, and as a means to relate with the outside world.

- Generally, these subjects would not have been considered viable candidates for starting a “drug-free” program, but could only hope for (at best) a “maintenance” program involving a substitutive therapy. Instead, the introduction of long-term drug addicts into a protected environment, where they were trusted and counted upon in their daily life and in the workplace, proved to be a system that offered tangible, undisputable and scientifically solid results.

- When examining the relationships between the subjects and the San Patrignano community, or its associations (which are bound to the community and deal with drug addiction), we see some interesting correlations. A stay of at least thirty-six months contributed to building up of a close "bond" with the community. In the past, this "bond" would have been considered equivalent to a "dependence" on the community, thus ascribing a negative connotation to this feeling. However, in this situation, such a "dependence" on the community derived from a sense of belonging and gratitude towards a place (and people, obviously) by its ex-residents, not from an incapacity to develop autonomy. Sixty subjects did some sort of volunteer work in the fight against drug addiction after completing their program, and thirty-five subjects (about 14%) were continuing to do so at the time of the interview.

The 'relapses'

- In conducting a study based on toxicological analysis of biological samples (hair strands), 'relapses' can be defined as those cases where analysis returned a positive result (in our case there were fifty subjects). In this sense, it is of critical importance to focus on this group of subjects, who represent about 20% of the original sample.
- Among the fifty subjects who "relapsed", thirty-nine (or 17% of the total group numbering 222) had left the community "with consent" and eleven had left the community "without consent" (37% of the "relapsed" group). Among the 39 subjects "with consent", 10 cases resulted positive exclusively to "cannabinoids" (among those who had left the community without consent, only one subject was found positive exclusively to cannabinoids: in this group, relapses involved mostly other substances, such as cocaine, heroin and methadone).
- When dealing with figures and percentages, caution is advised. However, a sociological character profile can be constructed, even though a limited number of subjects were involved in this study.
- The group of relapsed individuals included forty-four men and six women. This might be indicative of a trend: women tended to "relapse" less (11.5% compared to 22% among male subjects). As could be expected, the length of time spent in the community had a substantial

effect on the subjects' probability to relapse. Indeed, the incidence of relapse was almost 28% among those who lived in the community from four to five years, whereas, it dropped to 11% for those who had lived there for more than five consecutive years.

- The sociological profile of this specific group can be further defined by using the information gathered with the interview-questionnaire about the life of subjects "after the community".
- Among those in this group, thirteen people sought help in other communities or at state-run facilities (called Ser.T) after leaving San Patrignano (eleven subjects approached Ser.T services and two subjects went to therapeutic communities. In particular, this group showed a greater level of instability in their jobs (the results showed an increase by 15% in the number of people who gave a positive response to the questionnaire item "changed job more than once").
- Two aspects deserving special attention regard what has been defined as "change of environment". The relapse rate was decidedly higher, more than 11% higher, among those who decided to return to live in the same city where they used to live before entering the community. The relapse rate was also higher among those who returned to live with their family of origin after leaving the community (eight percent higher than those who went to "live on their own", and twelve percent higher than those who "went to live with their own family"). Furthermore, as stated above, the relapse rate was greater among those who went to live with their parents than those who opted for living alone or with the family they created.

To summarize, the data shows that the relapse rate was greater for those who returned to their city of origin and those who returned to live with their parents. A "break" with the place of origin, therefore, appears to be a vital factor in the stabilization of the results that have been achieved during the subjects' therapeutic program. This evidence should be investigated further, steering clear, as always, of simplistic or unidimensional conclusions.

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Conflict of Interest Statement:

I have no financial interest or conflict in writing this paper. I have not been paid to write this paper.

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Marco Castrignanò was also member of the research teams that conducted the following studies.

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