

## NADPI - New Approaches in Drug Policy & Interventions

### WS1 - Innovative cocaine and poly drug abuse prevention programme

## Operating Guidelines

*“Beyond the disease model, new perspectives in HR: towards a self regulation and control model”*

by Jean Paul Grund, Susanna Ronconi, Grazia Zuffa

## **NADPI WS1 Innovative cocaine and poly drug abuse prevention programme**

### **Operating Guidelines “Beyond the disease model, new perspectives in HR: towards a self regulation and control model”**

#### **Introduction**

**New Approaches in Drug Policy & Interventions (NADPI)**<sup>1</sup> aims to strengthen the evidence base of European drug policy making by expanding the knowledge base and exchanging best practices on a number of key policy dilemmas related to demand reduction, prevention and harm reduction strategies. The expected results are

- to bring technical detail into the policy debate to ensure that choices are evidence-based and outcomes pragmatic and constructive
- to strengthen collaboration between authorities, public services and NGOs in the region and to facilitate civil society involvement in the implementation of the EU Drug Strategy and Action Plan.

The main thematic area of focus is the European stimulants market, specifically the development of dependence risk reduction strategies to prevent problematic cocaine use patterns and the development of policy responses to better manage changes in the stimulants market occurring due to the appearance of new psychoactive substances. The body of the proposed two-year work plan for 2013 and 2014 consists of the elaboration of guidelines for cocaine abuse prevention and a series of seven expert seminars and four informal drug policy dialogues. The activities will serve to cross-fertilize policy debates transnationally and to exchange experiences and lessons learned between the main target groups: government officials involved in drug policy making at local, national and international levels, and drug policy experts from academia and civil society as well as practitioners active in the field of prevention, treatment and harm reduction.

The project applies a unique format in which the often disconnected areas of practice, research and policy are brought closely together in a series of expert seminars and informal policy dialogues to address some of the most challenging drug policy dilemmas on the European agenda. The seminars will take a ‘dream team’ approach and bring to the table the best experts from academia, governmental agencies, international organizations and NGOs. The challenge is to make a collective effort to go beyond the current state of knowledge regarding the understanding of the topic at hand and in the design of adequate policy responses. The main challenge of the dialogues is to reach a ‘critical mass of like-mindedness’ in support of certain evidence-based policy changes.

#### **NADPI Workstream1 : Innovative cocaine and poly drug abuse prevention programme.**

The workstream **Innovative cocaine and poly drug abuse prevention programme**, co-ordinated by Forum Droghe (I)<sup>2</sup>, has the objective of developing new approaches to prevent or reduce the risks of harmful use and dependence among regular cocaine/poly-drug users.

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<sup>1</sup> Applicant: Trans National Institute (TNI)- The Netherlands, partners: Forum Droghe (Italy), De Diogenis Association (Greece), International Drug Policy Consortium (IDPC)- UK

<sup>2</sup> NADPI Workstream 1, associated partners: CVO-Addiction Research Centre (NL); HOPS (MK); RHRN - Romanian Harm Reduction network (RO); Scottish Drug Forum (UK); VEZA (SRB); CTCA – Coordinamento Comunità Accoglienza Toscana (IT); Coop. Lotta contro l'emarginazione – Milano (IT); State University of Florence (IT).

Quantitative and qualitative research on patterns of use in natural settings has shown that most of these users are not in contact with the system of treatment services, though they regularly use cocaine and other drugs. Moreover, most of them are unwilling to enter treatment: the main reason is that available treatments (mostly led by the “disease” model of addiction) are usually unsuitable for this type of drug users who do not meet the diagnostic criteria of dependence. Nevertheless, these users might benefit from a new type of brief interventions, aimed at supporting natural “controls” by “stepping down” from the most risky patterns of peak use or reducing the frequency of, so called, “binges.”

The workstream focuses on developing new, community-based brief interventions aimed at the reduction of harmful patterns of cocaine use thanks to the collective effort and work of academic experts, drug prevention and treatment providers, policy makers, civil society and other (local, national and EU) stakeholders. Specific objectives of the workstream are:

- collect findings on patterns of use and change in drug use based on research in natural settings;
- collect knowledge on approaches, best practices and tools in the field of prevention of cocaine abuse and reduction of dependence risk in Europe;
- compare and evaluate approaches, best practices and tools through peer-to-peer approach among professionals, experts and peer educators;
- develop, publish and disseminate guidelines on new operational models and prevention / risk reduction practices
- propose recommendations for the implementation of the new approaches.

### **Operating Guidelines “Beyond the disease model, new perspectives in HR: towards a self regulation and control model”**

The Operating Guidelines are the result of a three steps process:

- a) the preliminary work of the NADPI WS1 experts staff<sup>3</sup> aimed to implement and promote the Experts’ Seminar, through a *Working Paper* focusing on theoretical and methodological issues and researches findings dealing with cocaine and stimulants pattern of use and self regulating strategies;
- b) the *Repertoire of Scientific Literature* “From Diseased to In-Control? Towards an Ecological Model of Self-Regulation & Community-Based Control in the Use of Psychoactive Drugs”, collecting the most relevant researches’ findings on the subject at international levels<sup>4</sup>
- c) the *Experts’ seminar Report*, focused on the results of the NADPI Experts’ Seminar held in Florence, Italy, from 20th to 22nd June 2013, where 35 people, 15 from Europe (partners’ delegates and single experts) and 20 from Italy (experts and workers from the public and the private sectors, peer supporters and users, researchers) discussed and shared knowledge and practices aimed at finding a new approach and new and more effective interventions in the field of Harm Reduction and risks limitation of the use of cocaine and other stimulants<sup>5</sup>.

<sup>3</sup> With the collaboration of Forum Droghe (I), CVO (NL) and the University of Florence (I)

<sup>4</sup> From Diseased to In-Control? Towards an Ecological Model of Self-Regulation & Community-Based Control in the Use of Psychoactive Drugs, *Repertoire of Scientific Literature* Compiled by Jean Paul Grund, Patrizia Meringolo, Grazia Zuffa

<sup>5</sup> *Innovative cocaine and poly drug abuse prevention programme*- Experts’ seminar Report, Florence, Italy, 20th -22nd June 2013, by Grazia Zuffa (Forum Droghe)

This last step, especially, has been the precious source which has shown that nowadays we have not only the scientific evidence of a necessary innovation in Harm Reduction approach and interventions, thanks to the qualitative research, but that all over Europe good and innovative practices— both in informal settings and in formal services systems – are growing, giving important inputs on an operational ground. Promoting an “alliance” between local concrete experiences and researchers is the concrete basis to shift from local bottom up experimentations to new operational models.

In these Guidelines the focus is the relationships between PWUDs’ [People Who Use Drugs] natural self-regulation strategies and controlled patterns of use and Harm Reduction approach, mission and services systems. It is not really a new topic: from the very beginning, Harm Reduction approach underlined the core role of PWUD and their cultures, relationships and individual and group strategies in implementing Harm Reduction interventions and pursue its objectives. Empowering PWUD, promoting peer support and often including users’ activities and skills directly in the formal services systems are well known practices from the 80s<sup>6</sup>.

At the same time, the most significant innovation from research on “control” shows that using drugs doesn’t imply that users are on a unique and linear trajectory, a “destiny of dependence”, whose only remedy would have been abstinence: the medical model has been so many times disavowed thanks to the evidence given by different biographies, highlighted by qualitative research. These have illustrated different trajectories of use, describing different skills of controlling the use, analyzing individual copying and self regulating strategies, stressing the role of the social and local contexts in minimizing or on the contrary maximizing the drug related harm, evaluating the efficacy of self control skills. Research in natural settings suggests that the “escalation” career is relatively rare, while the most common trajectory of use is *variable*, with a trend towards moderation.

Nevertheless, over the time, in Europe – even if in different ways in different countries – the medical model has strongly influenced Harm Reduction, with two different and important consequences: on one side, on the services systems, where the disease / pharmacocentric model still dominant “forces” Harm Reduction in the corner of (only) a set of specific interventions (the so called “fourth pillar” in drug policies), preventing Harm Reduction from developing its proactive potential in a self regulating perspective; on the other side, on PWUDs, as the medical model itself, focused on chemical “addictive” properties of drugs rather than on skills, cultures and strategies of the users, thus underestimating and disempowering the “patients” abilities and expertise in self-management. As a matter of fact, in a medical approach oriented Harm Reduction, self- management and self regulation still appear as awkward concepts, and in this perspective PWUD risk to be at most good “partners” of interventions and professionals, not the protagonists of a real empowering process. Changing the mission of Harm Reduction services systems from (only) limiting the damage to (firstly) promote the control is a challenge and a task.

Thanks to the common work and the discussion among NADPI experts and on the basis of the most relevant qualitative researches findings, these Operational Guidelines suggest professionals and peers a decisive shift to innovative approaches, challenging the limits and contradictions of the current dominant model in Harm Reduction. It is a first and preliminary

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<sup>6</sup> At EU level an important experiences of producing and spreading good peer support practices is the Correlation Project, European Network Social Inclusion and Health, [www.correlation-net.org](http://www.correlation-net.org)

step, much more further steps are needed, both in theoretical and in operational work. However so many evidences, knowledge and experiences show that it is time to “force” the theoretical and operational boundaries that are currently limiting, impoverishing and degrading Harm Reduction potentialities.

The Operational contents:

- Summarize the most interesting findings from epidemiological and qualitative researches as a scientific basis of operational changes<sup>7</sup>
- Promote a new perspective for services’ mission stressing the proactive potential of Harm Reduction approach itself
- Suggest innovation and changes in informal setting interventions and in formal services, also including short inputs from current good practices in different national contexts
- Summarize some crux topics in a political perspective, in order to underline the importance of national, local and international contexts as variables conditioning innovation in Harm Reduction

## 1. A short epidemiology of stimulant use<sup>8</sup>

### ***After cannabis, stimulants are the most commonly used illicit drugs worldwide***

Stimulants are commonly used around the world. Amphetamines are the second most frequently-used illicit drug worldwide (after cannabis<sup>9</sup>), with a last year prevalence (LYP) of 0.3-1.3% (14-57 million) among adults aged 15-64 in 2009. LYP was 0.55% in Europe, 0.8% in East and Southeast Asia as well as in Africa, 1.0% in Middle East and Southwest Asia as well as in South America, 1.1% in North America, and 2.4% in Oceania. The corresponding LYP for cocaine use was 0.37% worldwide, 0.05% for Asia, 0.43% for Africa, 1.3% for South America as well as Europe, 1.5% in North America, and 1.6% in Oceania. The global annual prevalence of ecstasy use is estimated at between 0.2% and 0.6% of the population aged 15-64, or some 11 to 28 million past-year users (UNODC - [http://www.unodc.org/documents/ATS/ATS\\_Global\\_Assessment\\_2011.pdf](http://www.unodc.org/documents/ATS/ATS_Global_Assessment_2011.pdf)) Use of stimulants (and other drugs) is eminent in nightlife and at festivals, in particular at venues where DJs play dance music (Nabben et al., 2007; Grund et al., 2007). It has become an important feature of youth culture (ter Bogt et al., 2012; Van Havere, Vanderplasschen, Lammertyn, Broekaert, & Bellis, 2011).

### ***Stimulant use rates vary greatly in each global region.***

For example, the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA, 2009) estimates that at least 3.9% of the total adult population (15–64 years) in European Union (EU) Member States has used cocaine at least once in their lifetime (LTP), but substantial variations in prevalence and patterns are found between countries, demographic and social groups, and specific settings (EMCDDA, 2009). Higher levels of cocaine use are found in western and southern countries, notably Denmark, Spain, Italy, Ireland and the United Kingdom, with relatively low LTP in most other European countries, ranging from 0.1% to 8.3%.

<sup>7</sup> A more detailed report on qualitative research findings in From Diseased to In-Control? Towards an Ecological Model of Self-Regulation & Community-Based Control in the Use of Psychoactive Drugs, *Repertoire of Scientific Literature* Compiled by Jean Paul Grund, Patrizia Meringolo, Grazia Zuffa

<sup>8</sup> References p 26-27

<sup>9</sup>And leaving alcohol out of the equation. Alcohol is not an internationally scheduled ‘drug.’

### ***Illicit drug use is concentrated among young adults***

Cocaine use is concentrated among young adults (15-34 years) with an average LTP of 5.3% among young men in particular, with an LTP over 10% and last year prevalence (LYP) over 5% in countries like Denmark, Spain, and the UK (EMCDDA, 2007). LYP for all EU adults is 1.2%, ranging from 0% to 3.1% by country. LYP among young adults is 2.2%, ranging from 0.1% to 5.5%. Last month prevalence (LMP) for all adults range from 0% to 1.1%, two-thirds of whom are young adults (EMCDDA, 2007). Cocaine use appears to have increased among young adults since the 1990s and, while prevalence is levelling off or decreasing in many countries (EMCDDA, 2007), Denmark and Italy report considerable increases as recently as 2005 and Spain, France, Denmark, and the UK recently reported rapid growth among adults aged 15-24 (EMCDDA, 2007). Those countries with data on problem cocaine use include Spain, with 4.5 to 6 problem cocaine users per 1000 adults in 2002, Italy with 2.9 to 4.1 per 1000 adults in 2005, and England with 5.7 to 6.4 problem crack users per 1000 adults in 2004/05 (EMCDDA, 2007)

LTP of amphetamines among EU adults is 3.3%, ranging from 0.1% to 11.9%, with 0.6% LYP. As with cocaine, young adults use more amphetamines, with 5% LTP and 1.3% LYP (EMCDDA, 2008). In contrast to cocaine, amphetamine use is higher in northern, central and eastern parts of the EU, particularly the Czech Republic, Sweden and Finland, with rising rates among young adults in Estonia, Austria, Germany, Denmark, Slovakia, Hungary and southern Italy (EMCDDA, 2008; Degenhardt et al., 2009; Griffiths, 2008). Amphetamine is furthermore increasingly popular among young people in countries across the eastern borders of the EU, such as Ukraine, Belarus, Russia and Georgia (Degenhardt et al., 2009; Griffiths et al., 2008; Grund et al., 2009; Grund and Merkinaitė, 2009). LTP of Ecstasy use among EU adults is about 3%, ranging from 0.3 to 7.3%, with 0.8% LYP. Among young adults, LTP is 5.6% and LYP is 1.8% (EMCDDA, 2008).

Drug use and problem drug use are contingent on a myriad of social and cultural factors

The geographic diffusion of ecstasy is less evident, but the increase in ecstasy use is clearly associated with diffusion of the electronic dance music culture (House or Techno parties, Raves, Dance festivals, etc.). Ecstasy has been equated with House music since 1988. Like ecstasy, cocaine and amphetamines are more commonly used in nightlife and at festivals (Cohen et al., 1993; Cohen et al., 1994; Decorte, 2001; EMCDDA, 2007; Nabben et al., 2007; Grund et al., 2007; Haasen et al., 2004 (ter Bogt et al., 2012; Van Havere et al., 2011)), but also in less fortunate social circles, such as sex workers, homeless people, treatment participants and marginalized young adults (EMCDDA 2007; Haasen et al., 2004).

Ecstasy is almost exclusively taken orally and most users are well-integrated and few seek treatment for drug or alcohol problems (EMCDDA, 2008). Socially integrated users mostly sniff cocaine and do so occasionally within rather well-defined leisure settings and periods (Prinzleve et al., 2004; Bellis et al., 2003, Cohen and Sas, 1994; Decorte, 2001), with some experiencing periods of uncontrolled use (Cohen and Sas, 1994; Decorte, 2001), a finding consistent with laboratory studies in which experienced cocaine users regulate their use (Sughondhabirom et al., 2005). Marginalized users, on the other hand, very often smoke cocaine-base (crack) or inject cocaine, use more frequently and chaotically, and more often use heroin, benzodiazepines or alcohol, while also experiencing a wide array of social-economic and medical problems (Prinzleve et al., 2004, Beek, van, 2001; Hando et al., 1997). Users in former Soviet states often produce amphetamine-type stimulants at home (Borodkina et al., 2005; Grund, 2001; Heimer et al., 2007), creating an environment where injecting is common among recreational users, in contrast to western EU

countries where a stronger division between integrated (party) and marginalized users of amphetamine seems to exist, similar to that between cocaine snorters and smokers or injectors (Grund, 2001; Grund et al., 2009; Degenhard et al., 2009).

**From Epidemiology with Love: three lessons for policy and practice**

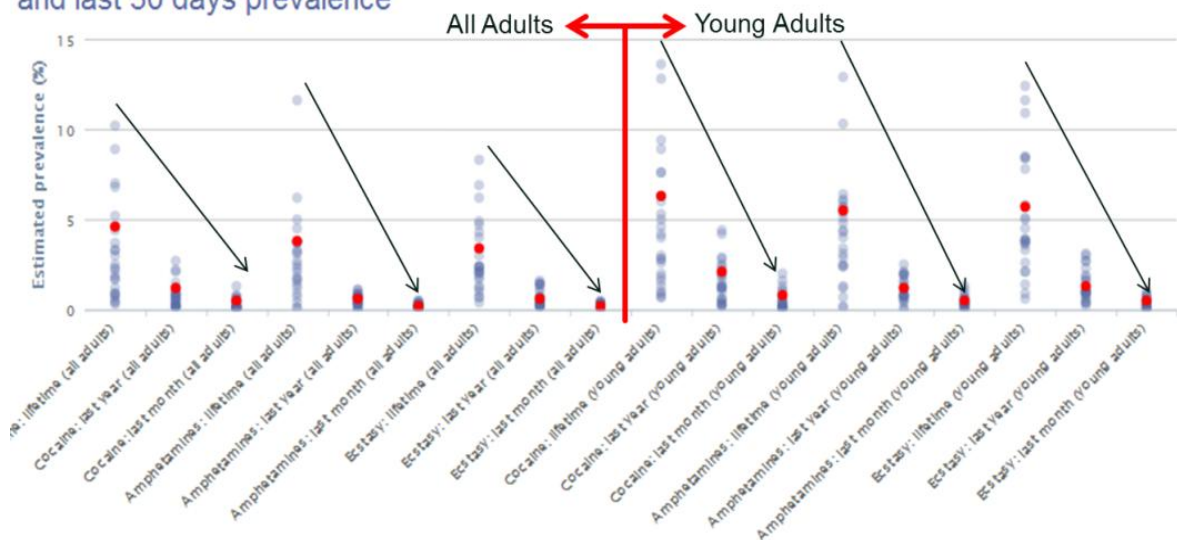
A number of interesting lessons can be learned when carefully scrutinizing the epidemiology of drug use in the general population.

First of all, what particularly stands out is the large gap between life time and current use. The figure below, from the UNODC World Drug Report 2012, provides an overview of the lifetime, last year and last month prevalence for cocaine, amphetamines and ecstasy – the most commonly used stimulants – in Europe.

This figure clearly shows that – in contrast to the frightful public image of the addictive properties of these substances – most people who have tried these drugs or even used these with some regularity at some point in their lives, do not continue to do so. Indeed, the second lesson is that most use of illicit drugs is limited to specific age segments – adolescence and early adulthood. A smaller group of adults continues to take illicit substances throughout their life-span, but the large majority seems to do so in a rather controlled fashion, without much evidence of health or social problems. Finally, the use of stimulants and other drugs is elevated in specific social and cultural environments. In the European Union, most stimulants are taken for pleasure and in the context of leisure, nightlife in particular. In the next section, we look beyond epidemiological research, into the natural settings of stimulant use, at qualitative studies that have looked at determinants of controlled drug use in non treatment populations.

Figure GPS-18. Overview of drug prevalence estimates in Europe for all adults (aged 15 - 64) and young adults (aged 15 - 34)

Part(ii) Cocaine, amphetamines and ecstasy use – lifetime experience, last 12 months and last 30 days prevalence



## **2. Beyond epidemiological research. 3 key issues from qualitative research<sup>10</sup>**

In this chapter 3 highlights from the qualitative research on drug use are stressed to show why and how observing and knowing individual and group strategies, behaviours, skills, cultures, rules and contexts of use may be the basis for developing an approach supporting PWUD self regulation and self control in drug use. Acquiring (and/or producing) this kind of knowledge and the adoption of a qualitative, ethnographic research approach is a fundamental and irrevocable task in the development of a Harm Reduction strategy that is realistic and at the same time innovative, and moves outside of the “tunnel” of the medical viewpoint.

### **2.1 Worst case scenarios are rare: beyond the “drug rhetoric”**

The illegal status of substances has important and significant consequences on research. Most research originates from “captive samples”, i.e. from problematic users enrolled in drug addiction treatment and/or from users referred to drug services in place of punishment. Research taught us very much about the potential harm from drugs, but very few studies have highlighted the pleasure from drugs – experienced by most users. The experts “tunnel view” on a minority (and on a limited type) of drug users leads to a limited conceptualization of drug use: the focus of most research is on chemical properties of drugs, deterministically identified as explanatory of the drug addiction phenomenon. Both this pharmacocentric lens and the typologies of drug users usually involved in researches prevent from observing and analyzing the learning processes in drug use controlling and safer using, the individual strategies of self regulation, the social norms and rituals that let the overwhelming majority of PWUD control their use. To counterbalance this minor and rhetorical knowledge and adopt users’ perspective, more qualitative studies are needed, not limited to problematic users only.

### **Cocaine’s “pleasures and pains” and users’ self regulatory mechanisms**

#### **A twelve year follow up study**

In 1996-7, a baseline ethnographic study in Antwerp was conducted among 111 cocaine users, aimed at investigating levels and patterns of use over time, temporary abstinence and decreased use, advantages and disadvantages of cocaine use, dependency etc (Decorte, 2000; 2001). In 2008/09, twelve years after the original study, Tom Decorte and Marjolein Muys retraced and re-interviewed 56 users (50.5% of the original sample). Most of follow up participants had continued to use cocaine with some regularity for several years for pleasure seeking. There was however variation in the quantity and frequency of use, cocaine use periods and effects perceived. For a majority, regular ingestion of cocaine over a 12 year period did not result in “loss of control” or in any disruption of daily life engagements.

Anyway, participants showed a high degree of awareness about the possible negative effects of cocaine use and many of them experienced adverse physical and psychological effects on themselves. During the years, while the perceived “pleasures” (such as euphoria and the increase in sociability) changed little, the (perceived) “pains” were more emphasized (such as hang over, the financial costs and the concern with addiction). Users’ awareness about the negative effects helped them to “control” their use.

Also, the study confirms one of the most important phenomena keeping users from becoming dependent is involvement in a social network and in significant activities and relationships. These

<sup>10</sup> References p. 27-30



findings call for the implementation of broad social policies, aiming at helping people hook into opportunities for conventional lives.

T.Decorte, M.Muys (2010), Tipping the balance. A longitudinal study of perceived “pleasures” and “pains” of cocaine use (1997-2009), in T.Decorte, J.Fountain (eds), *Pleasure, Pain and Profit. European perspectives on drugs*, Pabst Publishers

## 2.2 In search of hidden knowledge. Findings on controlled / uncontrolled use from cocaine research

From a proactive approach and a self regulation supporting perspective, qualitative researches and ethnographic studies carried out of the “drug rhetoric” show some findings which are crucial basis to developing innovative interventions. Summarizing:

- PWUD control on cocaine and other stimulants use develops from an ongoing process of learning from experience, similar to learning processes for any other human activity. It is a “trial and error” process and during the different steps and phases users learn from their own experiences and become able to produce changes in their behaviours
- Users adopt a wide range of informal drug control mechanisms in multiple areas such as: the setting and situations of use, the persons (not) to use with, the maximum number of times one should use cocaine in a given time period, frequency of use, appropriate feelings when using, suitable and unsuitable combinations of cocaine with other drugs, route of ingestion, appropriate dose, how to manage financial consequences of cocaine use, how to avoid police attention etc. Each one of these items – and / or a combination of different items - may become variables of a self control process and “fields” of a personal strategy of safer and regulated use
- Users adopt rituals, behaviour patterns surrounding substance use, including the methods of acquisition and administration, the selection of the physical and social environment for use, activities after the drug is administered, and methods to prevent unwanted effects of the drug or its status. “Rituals” are influenced by cultural, social and environmental variables, the user is not isolated and the socio-cultural environment is a crucial factor in a social learning process
- Cocaine use shifts from one level to another through time, both upward and downward, but medium and high levels of use do not last. In opposition to the disease model, prevalent trajectories run downward, in the long term. “Stepping down” and “temporary abstinence” appear as “natural” strategies, to achieve control again after periods of diminished control
- In opposition to the “linear and rising trajectory” drawn by the medical model – from use to dependence – qualitative researches show that drug use careers are dynamic and patterns of use vary with transitions and with changes in life circumstances and life engagements.
- In opposition to the medical model “all or nothing” (abstinence or addiction ) perspective, the studies on controls over drug use show that drug use patterns fluctuate along a continuum, from diminished control to increased control and vice versa. That means that PWUD are not divided into two different “typologies” – controlled or uncontrolled users – but each user may experiment both the situations, change her/his pattern of use, pass from an intensive use to a more moderate one.

- Qualitative researches adopting users' perspective on controlled / uncontrolled use show discrepancies between users' and professionals perception: i.e. considering the controlled use only a temporary step towards abstinence rather than a goal itself, or neglecting different life problems and assuming drug problems as "the" problem. Both these discrepancies are reasons why most PWUD don't think useful for them to contact a drug services even when it could be helpful for them receive more information or counselling to maintain / regain a controlled pattern of use

### Cocaine users in natural settings: perception of controlled/uncontrolled use and self regulation mechanisms

Two Italian qualitative researches analyze cocaine users perception of controlled/uncontrolled use and their self regulation strategies:

- **Cocaine use among young people in natural settings.** Qualitative study among 115 "experienced" cocaine users from Tuscany, Italy: 115 semi-structured interviews using the snow ball sampling, 10 in depth interviews, 2 focus groups. The aim has been to find out patterns and trajectories of cocaine use; users' perceptions of "controlled" and "uncontrolled use"; social controls and self regulation mechanisms. Co-ordinated by CNCA (National Italian Network of Therapeutic Communities), Forum Droghe, Cooperativa CAT and University of Florence, Department of Psychology, promoted by Tuscany Region, 2009-2011
- **Cocaine users' perception of controlled/uncontrolled use.** Qualitative study based on 21 narrative autobiographical interviews to cocaine users in Torino, Piemonte Region. Focused on personal strategies for self regulation, evaluation of advantages / disadvantages, information, knowledge and learning. By Forum Droghe, CNND (National Network "New" Drugs) and European Institute on Addiction, 2009

While similar studies on cocaine use and controls have been inaugurated in Europe (Cohen, 1993; Decorte, 2001), these are the first studies on controlled drug use ever carried in Italy.

Both the studies relies on the theoretical model by Norman Zinberg (1979, 1984), focusing on the psychological and social components of the paradigm (set and setting) as the key elements to explain "controlled use".

**Findings:** Against the common (pharmacocentral) view, *escalation* is far the minor trajectory of use, while the general trend is towards *moderating* drug use: over the time, the large majority of cocaine users *learn* from their own experience and that of others how cocaine can be "tamed". Cocaine use is perceived as "under control" when it does not appear to affect drug users' structures of life. The perception of being able to lead a meaningful and not drug- focused life is a natural boundary to the users: when they feel they are overstepping it, usually they shift to more moderate patterns of use or to temporary abstinence. The studies show a trend towards moderation (often down to abstinence) in cocaine users as a result of self regulation processes of change. These mechanisms are largely unknown to drug addiction professionals, and these studies may innovate the practice in drug services. The relevance of social informal controls in illicit drug use (not dissimilar to controls in licit drug use) may change the social representation of illicit drug

users and may help to fight stigma. Also, it can innovate and rebalance drug policies, shifting the focus from legal controls to social controls.

Abstracts and articles in [www.fuoriluogo.it](http://www.fuoriluogo.it) and in *Cocaina, il consumo controllato*, a cura di G.Zuffa, Edizioni GruppoAbele, 2010

### 2.3 Drug, Set & Setting. Focus on environmental factors

The effects of psychoactive substances in humans are the result of a complex interaction between Drug, Set and Setting, where *Drug* refers to the specific psychopharmacological properties of the substance, *Set* refers to individual personality factors and *Setting* refers to the environment of use. In the current dominant medical model, setting is the forgotten factor, while on the contrary qualitative and ethnographic researches stress the specific role it has in influencing controlled / uncontrolled pattern of use. I.e., setting includes: the wide range of the social controls adopted by the overwhelming majority of controlled drug users; social controls in their interaction with drug availability and “life structure” are the main variables influencing individual self-regulation; it includes, on the other side, the political and legal context of prohibition which prevents / degrades PWUD’ empowerment and the spreading of safer / controlled use cultures and strategies. From an environmental perspective, the drug related risks are seen in the framework of contexts, where *the focus shifts from individuals to social situations*: the involvement of the setting in re-inventing operational models towards controlled use and self regulation is a crucial point.

#### Drug Use as a Social Ritual

##### Drug use management among regular cocaine and heroin users

In contrast with conventional wisdom, even people considered ‘problem drug users’ maintain social rules and engage in individual behaviours aimed at controlling their drug use. A 1988 – 1993 ethnographic study in Rotterdam observed daily and regular consumers of cocaine and heroin at “House Addresses,” apartments where both drugs were sold and consumed at the time of the study. The study found that self-regulation is more than limiting the intake of drugs, but includes prevention and management of drug related problems. Drug Use *Rituals* have both instrumental and social functions. In solitary rituals in particular drug use management is stressed, and aims at:

1. Maximizing the desired drug effect.
2. Controlling drug use levels and balancing the positive and negative effects of the used drugs.
3. Preventing secondary problems.

A functional relationship between heroin and cocaine has evolved, presented by the combined use of both drugs, the aim of which is to maximise the desired and minimise the undesired drug effects of frequent and heavy cocaine use in particular.

Sharing drugs was a strong *rule* (present in 50% of the observations), serving both instrumental (e.g. preventing withdrawal) and social functions (e.g. reinforcing relationships, smothering conflict or as social capital). At house addresses, cocaine and heroin were mostly consumed in a pub-like atmosphere which obeyed both by explicit and implicit rules, aimed at limiting nuisance for the neighbours – reducing the chances of police detection – and at facilitating an undisturbed

and pleasurable drug experience. At some house addresses, the 'house rules' were posted on the wall (e.g. sharing is permitted but begging not; keep things quiet, especially when cocaine is smoked).

The ability to exercise control over individual drug use is not evenly spread over all users. Some cocaine users, such as dealers, use large amounts of cocaine seemingly with little or no cocaine-related problems. Other users --typically the "down and out" street users-- actually use much less cocaine, but seem most susceptible to cocaine-related problems. The effectiveness of rituals and rules in regulating drug use is moderated by important additional factors which impact on the individual's ability to comply with these rituals and rules. These are the *availability* of drugs – e.g. the trouble one needs to engage in to acquire drugs – and what's termed *life structure* - the regular activities (both conventional and drug use related) that structure daily life. Ritual and rules, life structure and the availability of drugs are subject to many outside influences. For example, under restrictive drug policies, rituals and rules aimed at controlled use are less likely to flourish when all energy goes into the purchase of drugs and avoiding law enforcement.

Grund J-PC: Drug Use as a Social Ritual: Functionality, Symbolism and Determinants of Self-Regulation. Rotterdam: Addiction Research Institute (IVO), 1993.

(<http://repub.eur.nl/res/pub/39132/>; <http://www.drugtext.org/Table/Drug-Use-as-a-Social-Ritual/>)

### 3. Beyond the disease model: changing the mission of services.<sup>11</sup>

When self regulation and controlled use are adopted as a mainstream in Harm Reduction approach, professionals, peers and services' mission can be re-written in a real proactive perspective. In this perspective, the focus is on user's abilities and competencies to be promoted, and the user is seen as an "expert", having a fundamental expertise on his/her life. The self-management concept itself is embedded in this theoretical background. Shifting the mission of Harm reduction from "secondary prevention" based on avoiding risks to a proactive perspective based on activating self regulating competencies and skills, entails reshaping interventions both in natural and informal settings and in formal settings and services.

#### 3.1 Supporting self regulation in informal settings

What do we mean by "informal settings"?

- Natural *settings of use*, where users "naturally" develop their own control strategies
- Informal *settings of HR interventions* in natural settings of use, such as the night entertainment scenes, rave parties etc.

As users' self regulation strategies in "natural" setting of use have been illustrated through research findings in the previous paragraphs, in this paragraph we will focus on HR interventions in natural settings of use.

*Interventions in informal settings: from Harm Reduction to support of users' controls*

- *Target*: cocaine and stimulants users with different patterns of use, from moderate to intensive. Most of these users are not in contact with drug services and are unwilling to be

<sup>11</sup> References p. 27-32

enrolled in treatment. In principle, most users targeted by HR interventions are suitable to receive support for their self regulation strategies. In particular, users with discontinuous “up/down” trajectories might benefit from this kind of intervention

- *Goals:* in HR interventions the aim is to reduce drug use risks, related to the drug, set, setting dimensions, with a wide range of goals. Both in the “harm reduction” and in the “control” perspectives, the choice of different goals stems from the assumed “continuum” in drug use (users are supposed to move from diminished to increased control and vice versa). As for the “drug” dimension, stepping down and “temporary abstinence” should be considered as the most common goals of choice (as they are the most frequent users self regulation strategies).
- *Relationship:* support may be offered by peers as well as by HR professionals. Peer to peer and (horizontal) client/professional relationships are already a tenet in HR practices and HR professionals have a training in “horizontal” relationships. Furthermore, supporting self regulation may require a more continuous relationship in more structured settings of intervention, beyond episodic contacts in the nightlife / club scenes.
- *Main actions:* HR interventions already support self regulation, by promoting less risky practices through peers and/or professionals advice (within the “drug, set, setting” dimensions - for example, less risky substances or mix of substances, less risky physical and psychological subjective conditions, less risky settings of use). Developing support to self regulation should provide new actions, such as training to support users’ self management programs and to brief counselling programs (see below: how to plan change in drug use and how to monitor it).

### Substance Use Management- SUM

*Substance Use Management* is a guide to manage alcohol or drug use. Drug users can use the guide by themselves or with the help of friends, family members, professionals.

Among SUM’s specific managing techniques:

- changing the amount of alcohol and drug used
- changing the numbers/types of drugs used together
- changing the frequency of use
- changing the route of administration
- changing the situation (using alone versus with others etc.)

Every item is explored within the drug, set, setting dimensions.

For example, see the item “Changing the amount”, in the “drug” dimension: the authors suggest to start by writing the details of current use in a journal or notebook (how much, how often etc.) and to keep track for a week or so. Having a clear picture of typical levels of use, users can make a stepping down plan and keep track of their progresses.

For drugs with a rapid onset and short acting, like cocaine, it can be difficult to reduce the amount: the authors rather suggest to change the frequency of use.

An example of stepping down plan: changing the frequency of ecstasy use

- Go to fewer parties (setting)
- Go to “sober” dances (setting)
- Switch to alcohol (drug)

Denning P., Little J.& Glickman A. (2004), *Over the influence. The Harm Reduction Guide for managing drugs and alcohol*, The Guilford Press, New York

**Association / Institution:** Mainline Foundation

**Name of the intervention /service:** Self control & harm reduction – outreach work in the Netherlands

**Nation /Region / City:** The Netherlands

**Clients:** Problematic basecokes users

**Operational model:** Outreach workers of Mainline use the so-called ‘presence-approach’ to get near to substance users anywhere in the country. Their primary aims are to provide substance users with health information related to drug use, and to empower users to make informed and conscious decisions related to their substance use. Reserving moral judgments, this closeness enables outreach workers to delve deep into the daily lived experience of users. Taking the users’ perception - and not that of professionals - as a starting point, interventions developed by Mainline convey the importance of self control by focusing on the advantages this has from the users’ perspective/to the user. Using over 20 years of experience, Mainline has developed a variety of interventions focused on improving self control and reducing harm.

Some examples: ● A quarterly ‘Mainline’ magazine, which features interviews with users that highlight the subjective and experiential dimensions of drug use, autonomy and self control, supplemented with tips and tricks from healthcare professionals. This narrative approach to health communication is a strong prevention tool. ● ‘All Cards on Safe Coke Use’; a deck of cards with different tips to improve self control (or other methods for safer drug use) on each card, such as: ‘smoke your last rock from foil to ensure a smoother landing’ or ‘eat first before smoking, you’ll enjoy it more’. ● ‘Baselab’ is an intervention in which outreach workers visit consumption rooms, to discuss basecokes use with users; e.g. the disadvantages of using ash, the length of the pipe and methods to limit the negative effects of cocaine use. Outreach workers distribute specially designed placemats (*‘basemat’*) that visually detail all possible aspects of cocaine smoking where harm can be further reduced.

<http://www.mainline.nl> [info@mainline.nl](mailto:info@mainline.nl)

#### Focus on innovation

- *Beyond the “risk/harm perspective”*: in spite of the common theoretical background (the assumed continuum in drug use under the influence of drug, set, setting factors), the concepts of “risk” and “control” are at odds, the former focusing on the *negative* side (the negative properties of drugs), the latter emphasizing the *positive* (users’ ability to be “over the influence” of drugs). As a consequence, the crucial question “what is a less harmful relationship with drugs” should turn into “what is my healthy relationship with drugs”?, the latter focusing on the subjective process of self regulation, in search for “personal boundaries”.

- Being aware of informal controls is an important achievement for users. For professionals, it should be the first step in supporting to self regulation. Informal controls are topics that are worth to be discussed between professionals and users. Often users are not conscious of the rules they apply, because of the illegal status of drugs: social prescriptions for illegal drugs have no circulation in the mainstream culture.
- In HR interventions, the focus on negative side of drugs may prevent to investigate the positive effects of drugs (i.e. the effects that make them attractive to users). On the contrary, *it is essential to identify the advantages* as well as the disadvantages of drug use and professionals are required to help users to explore both sides of the drug experience, so as to realize the function of drug use<sup>12</sup>. Being aware of the reasons of drug use is the necessary, preliminary step to change.
- Identifying advantages (and not only disadvantages) is even more crucial in assessing *multidrug use*. Following the exclusive focus on “harm”, multidrug users are simply labelled as “poly drug users”, the term itself resulting in a “multiple” stigmatization of users. The negative focus prevents understanding of the rationale of multi drug use: for example, different substances are often used to balance/mitigate the effects of some drugs. Such is the case for the cannabis/cocaine mix, where cannabis helps to moderate the stimulating effects of cocaine; also heroin is often used to the same purpose, after a binge of cocaine.
- An unbiased perspective on multidrug use can help to identify more stepping down strategies, such as shifting to less risky drugs: from cocaine to cannabis, for example.

### 3.1.1 Individual self management 2.0

The web represents an effective opportunity to support drug use self management individual strategies, thanks to its easy accessibility, anonymity, confidentiality, friendly communicating and exchanging experiences. Electronic self evaluation and self management forms make users able to check their pattern of use, focusing on advantages and disadvantages, promoting a reflective and self conscious attitude and, in case of 2.0 communication, interact with other users and/or experts and have a feedback.

**Association / Institution:** Global Drug Survey

**Name of the intervention /service:** Drug Meter [www.drugsmeter.com](http://www.drugsmeter.com)

**Nation /Region / City:** London (UK)

**Clients:** all drug users

**Goals:** supporting PWUDs’ self management and self regulation of use through a web tool aimed to checking personal drug use and giving a professional feedback and advice.

<sup>12</sup> Control is in relationship with the function of drugs. Quoting P. Cohen (1999): “Applying user based rules of control is the only way to maintain the *reasons* and pleasures of drug use”. When drugs become dysfunctional, patterns of use are changed, mitigated or quit.

**Description of the operational model:** Drugs Meter is a secure and anonymous web and smartphone app, it is independent and not funded by any government and committed to giving honest, accurate information on 9 drugs (alcohol, tobacco, cannabis, cocaine, MDMA, amphetamine, GHB, ketamine and mephedrone). All data are anonymous, secure and cannot be traced back to any individual. By filling in a set of questions about personal drug use, Drugs Meter provides immediate personalized feedback: a) compares one's answers to other people who have also completed Drugs Meter and used the same drugs, as well as giving stats about the general population b) give feedback about risks related to one's personal use c) The "Personal risk adjuster tool" allows to modify one's own drug / alcohol use based on personal make up. Drugs Meter increases the amount one's report using for each risk factor d) through one's personal ID it is possible to track changes in one's drug use over time e) a blog allow exchanging information and experiences f) it is possible to contact a professional by mail.

**Web site & contacts:** Global Drug Survey [info@globaldrugsurvey.com](mailto:info@globaldrugsurvey.com)  
Fergusson House 124/128 City Road - London EC1V 2NJ +44 (0)20 7324 3536

**Association / Institution:** Mainline Foundation

**Name of the intervention /service:** Apexx, online magazine on drugs, sex and partying

**Nation /Region / City:** the Netherlands, Amsterdam

**Clients:** during its outreach work Mainline initiates talks with people who use drugs about e.g. controlled drug use. Apexx is a web medium that targets young people with the same messages.

**Goals:** The aim of the web magazine is to help diminish physical, psychological and social health risks caused by substance use, sexual behaviour and party lifestyle in youth scenes.

**Operational model:** Apexx enhances knowledge on substances, sex and lifestyle issues and how to diminish their potential risks (harm reduction). It sparks the discussion about the (often secretive) topic of substance use. It stimulates personal reflection (for example on the question of when substance use turns into abuse) and it functions as a bridge between young users and other organizations (mainly in the field of drug prevention and treatment). As a side effect, Apexx offers professionals a revealing insight into the lifestyle and culture of the target group. Apexx was officially launched in June 2012 and since then three more issues have appeared:

- Apexx #3 had 2000 readers in April of 2013
- Apexx's complementary Facebook page offers an interactive element to the more 'old school' setup of the magazine
- Apexx fills a gap in existing secondary drug prevention methods. It combines the professional and the scientific standards of 'objective' information websites on substances with the subjective, experiential dimensions of online drugs forums and peer-driven interventions.

**Web site & Contact person:** [www.apexx.nl](http://www.apexx.nl) Sanne van Gaalen: [s.vangaalen@mainline.nl](mailto:s.vangaalen@mainline.nl)



### 3.1.2 *Promoting Safer settings of use*

According to the Drug Set Setting approach, the setting of use is a crucial variable influencing controlled use, self regulation skills and opportunities and risks limitation. As the qualitative research shows, choosing a safe setting of use – places ad locations, privacy, people to use with etc - is one of the most frequent users' self regulation strategies that users employ. When the setting of use is a social, collective one, promoting the safety of the context of use may support and facilitate users' self regulation skills and practices.

*-Main actions:* co-operating with events' organizers for a safe context management; training the organizers in first aid; organize and manage chill out zones ; organize, manage and / or supervise a first aid services; supply fresh water and other necessities; provide information; provide drug-checking and pill testing.

**Association / Institution:** Lab57 – Alchemica (ngo)

**Name of the intervention /service.** Laboratorio Antiproibizionista Bologna (Anti-prohibitionist Laboratory Bologna) (Indipendent information and interventions on legal and illegal drugs to limit risks and abuse)

**Nation /Region / City:** Italy, Bologna

**Clients:** Drug users, peers, indipendent free parties, teknivals, street parades organizers and legal events (festivals, clubs, demonstrations) promoters, criminalized users, users' parents and adult people in contact with young users, social and health professionals and workers (nurses, doctors, educators)

**Goals:** Lab57-Alchemica doesn't condemn nor promote in any way the use of drugs, but it is active in researching independent, reliable and non-judgmental information, as only a real aware and well informed use can limit risks and abuse through improving a critical attitude. The objective of the intervention is to promote cultures and life styles which are not oriented to a consumerist attitude, both in drug users and in cultural, music and artistic events' organizers

**Operational model.** Lab57-Alchemica's approach is based on the access to independent information, spreading messages promoting health, balanced relationship mind-body, sharing knowledge, social communication and social spaces, social inclusion and solidarity, respect of enviroment. All the participants are volunteers, both users and peers, and professionals (doctors, nurses, lawyers, educators, psychologists, chemists); they coordinated through peer assemblies and focus groups. *Settings & Tools:*

- pragmatic and specific flyers on legal and illegal drugs effects, health and legal risks
- Chill-out Zones in the recreational settings for young people, with supply of water, non alcoholic drinks, energy food, condoms, safer use kits etc
- Drug-checking with different colorimetric reagents, safeguarding users' privacy
- first aid for overdoses, dangerous drug mixes and abuse in different natural settings as festivals, street parades or raves
- info point and free of charge informal and legal counselling
- harm reduction interventions and events in schools and youth centers
- Training sessions for professionals and artistic events' organizers
- promotion of local and national networking between artistic events' organizers to protect participants' health, to respect the environment and the neighborhood during the events and limit the legal risks

|                                |              |  |   |  |
|--------------------------------|--------------|--|---|--|
| <b>Website</b>                 | <b>&amp;</b> | <b>e-mail:</b>   | <a href="http://lab57.indivia.net">http://lab57.indivia.net</a> , | <a href="mailto:lab57@indivia.net">lab57@indivia.net</a> |
| Coordinator: Massimo Lorenzani |              | <a href="mailto:pumax72@gmail.com">pumax72@gmail.com</a> |   |  |

**Association / Institution:** Technoplus

**Name of the intervention /service:** Harm reduction intervention within recreational settings

**Nation /Region / City:** France, Paris

**Clients:** partygoers, event organizers, peers

**Goals:** • Promote well-being within recreational settings by implementing health promotion actions at parties • Promote individual harm reduction strategies among partygoers • Improve accessibility to harm reduction information and material

**Operational model :** the intervention is based on a multidisciplinary approach: supporting individual harm reduction strategies and improving safer settings by involving event organizers. The intervention team is made up with peers trained to harm reduction and crisis situation management. They are providing free harm reduction information, material and services to partygoers with a non-judgmental approach. This action aims at supporting self regulation among drug users by encouraging responsibility and autonomy. • Harm reduction information: leaflets about the different products and practices, drug mix, user/dealer... Techno+ has developed specific supports (leaflet and poster) named "*Consumption mark*" about self-regulation. The support proposes simple sentences such as "*I cannot go to a party without using: it would be too boring*" or "*I systematically take several substances during the night: whatever substance I lay my hands on, actually*". These drive users to examine their practice, reflect on their drug use and position themselves. • Harm reduction material: safer snorting kit, injection material, free base kit, alcohol tester... • Harm reduction services: drug checking, safer consumption space (sniff, injection), relax zone, chill out...

**Website & e-mail:** Techno+ +33 6 6 03 82 97 19 [tplus@technoplus.org](mailto:tplus@technoplus.org)  
<http://www.technoplus.org>

### 3.2 Supporting self regulation in formal settings

What do we mean by "formal settings"?

Usually, a setting (of intervention) is called "formal" when a set of rules (concerning professional/client relationship, place and time of intervention, etc.) has been established. Though "formal settings" may be found in different kinds of intervention, in this paragraph we will refer to formal settings of *therapeutic* interventions in drug addiction services.

As previously stated, the disease model is dominant in drug addiction services and the very concept of “self regulation” is at odds with such theoretical approach. To better highlight the difficulties in adopting the “control” approach in drug addiction services, the cornerstones of the disease model will be briefly introduced.

*The disease approach in the practice of drug addiction services, main features*

- *Offer of programs: long term intensive treatments are prevalent.* Most clients are heroin users<sup>13</sup>. Though the number of cocaine and stimulants’ users enrolled in drug services has increased, they are still a minority among drug addiction services’ clients. As a result of the focus on addiction (as a serious, chronic, relapsing disease), seeking outside help is considered a necessary step to recovery, in view of entering *long term intensive* treatment. This kind of offer is particularly unfit to cocaine users, especially users with discontinuous patterns of use and short term, non intensive programs would be more acceptable. Nevertheless, less intensive programs are a challenge to drug services operational models because of the theoretical “disease” background.
- *Target:* users diagnosed as drug dependent represent the most consistent group.
- *Goals:* abstinence is the goal of choice, as a consequence of the focus on the risks of drugs. Stepping down is (at best) a second choice goal, only for “chronic” users who will be *unable* to maintain abstinence.
- *Relationship.* The very concept of “addiction” as powerlessness and “lack of will” calls for an “unbalanced” client/therapist relationship, where knowledge and power are only on the therapist’s side. This is emphasized by the influence of the “moral” model: identifying abstinence as the only form of recovery is congruent with the “salvation” of client from the moral threat of drugs. As a consequence, the therapist is also the “saver” and “good” patients will “accept” and submit to any and all therapeutic instructions.
- *Actions.* The disease model emphasizes the diagnosis, followed by rigid and standardized treatment protocols and procedures.  
*“Rules” and tenets of the disease model:*
  - *“Seeking professional help is the necessary step to recovery”* (see also above). Nevertheless, there is a large body of research on natural recovery, showing that many who not define themselves as addicts stop using in problematic ways or quit completely.
  - *“Admit that you are an addict and accept that you are powerless over drugs”.* Addicts are supposed to be “powerless” over drugs, and addiction results in a *permanent loss of control*. This assumption is at odds with the concept of “self regulation”. Furthermore, psychological research shows that better effects are achieved by helping people to increase self-esteem and their sense of their own effectiveness, rather than increasing their sense of powerlessness (see also below).
  - *“Once an addict, always an addict”.* An addict is supposed to be in *permanent* loss of control and *permanently* unable to step down to more controlled/moderate patterns of use. The assumption is a consequence of the focus on individual bio psychological deficits:

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<sup>13</sup> The total number of opiod users receiving substitution treatment is estimated at 730.000 in 2011 (European Drug Report 2013, Trends and developments, p.52)

control is rather seen as a property of a specific group of users than as a dynamic process concerning all users (though at different levels) under the influence of multiple interacting factors (drug, set, setting). This leads to a dichotomous categorization of users: either controlled (i.e. individuals who are assumed to be permanently *able* to control drugs), or uncontrolled users (who are assumed to be affected by permanent loss of control). The analogy with the second disease concept for alcohol is evident: either moderate drinkers or alcoholics (supposed to be permanently *unable* to drink moderately).

### Proactive Approach and Self Management

The assumption of client's expertise and client's ability in self management is widely accepted, both in psychology and in medicine, even for seriously ill patients. In particular, the Health Promotion Model, elaborated in Developmental Psychology, aims at promoting "positive identities", focusing on "positive sides of human experience". As a result of focus on abilities, patients are seen as "experts", having a fundamental expertise on themselves. Self management programs are embedded in this theoretical background. The psychological "proactive" perspective has been adopted even in medicine. For example, at the Stanford Patient Education Research Center (belonging to the Department of Medicine at the Stanford University School of Medicine - Palo Alto, California), self management programs for patients with chronic health problems have been developed, tested and evaluated for over three decades.

The theoretical precept of the proactive Self Management model is: *"Patients can better understand their illnesses than professionals. Professional care has a limited role"*.

Though clients' expertise and abilities in self -management are widely accepted both in psychology and in medicine, even for seriously ill patients, this approach is hardly adopted in the field of drug use, or it is endorsed with "moral" limitations: for example, self- management is only accepted for patients enrolled in programs finalized to abstinence. From a proactive perspective, these are the principles (valid both in self management and in HR psychotherapy):

- Not all drug use is abuse
- People use drugs for reasons
- Problems do not just come from drugs themselves but from a combination of factors and circumstances
- You are your own expert
- Change is slow
- You can make positive changes while still using
- Just say Know: Substance Use Management (the practice of using alcohol and other drugs sensibly)

Denning P., Little J.& Glickman A. (2004), *Over the influence. The Harm Reduction Guide for managing drugs and alcohol*, The Guilford Press, New York

### Shifting to the "control" approach

- *Offer of programs*: short term, non intensive interventions are consistent with the "control" perspective, according to the shift from "helping" (powerless users *under* the influence of drugs) to "supporting" (users' abilities to be *over* the influence of drugs).
- *Target*: clients with different patterns of use and different levels of "control". This is congruent with the assumed "continuum" in control. As illustrated in the previous paragraphs, research shows a continuum in control (in opposition to the disease model's dichotomous categorization between "controlled" and "uncontrolled" users): as a result, there is a potential widening of the target, ranging from less problem/clients who may seek

for support during periods of less controlled use; to problem users already enrolled in treatment, who may benefit from a different approach, beyond the fatalistic view of addiction as “permanent loss of control”.

- *Goals:* any positive change in the field of drug use, but also in the user’s full life experience. As for the drug factor, there will be a continuum in goals (ranging from step down, to planned periods of abstinence, to quitting drugs). Considering users’ experience in regaining control after intensive “peak” periods, “stepping down” and “temporary abstinence” appear as the most common self regulation strategies: therefore they should have a prominent role as goals of choice in interventions<sup>14</sup>.
- *Relationship:* a more balanced client/professional relationship is congruent with the very concept of “support” to users’ capacities of self regulation. It can be defined as a *partnership* between users and professionals. A balanced approach is possible if users’ experience (on drug use as well as their whole life experience) is taken into consideration and accepted as a form of knowledge, so as to build a partnership between users’ and professionals’ expertise. “Clients and professionals should build together their own approach: a common framework to comprehend the individual user’s experience”.
- *Actions.* Assessing, setting goals, planning change, monitoring. Assessing client’s drug use in the interaction with set (his/her characteristics on the drug experience) and setting (context of use and larger environmental influences) is the first and crucial step in interventions (in place of diagnosis as the preliminary step to treatment, in the disease model). Supporting self regulation implies being proactive, in contrast to the reactive nature of treatment. The proactive perspective is suitable to clients at different stages of control over drugs.

**Association / Institution:** CAT - Cooperativa Sociale

**Name of the intervention /service:** Centro Java

**Nation /Region / City:** Italy, Florence

**Clients :** The centre is addressed to young drug users, most of them (34%) attending the Night Scene. Users show a wide variety of patterns of substances use.

**Goals:** Java Centre is able to address different specific needs from various types of users. The Centre is a low-threshold service where every user can have easy access and take part in all the initiatives and activities. Users may find an answer to any question concerning safer drug use

<sup>14</sup> From recent epidemiological research on alcohol, stepping down is confirmed as a natural “self regulation” and “self recovery” strategy, which appears to be more effective than the disease theory’s prescription of abstinence. As a consequence, the traditional hierarchy of goals in interventions should be revised, also for more intensive users (Peele, 2007).

and may be referred to other community services, under request. The relationship between professionals and users is quite informal.

**Operational model** : At Java Centre, young drug users can receive psychological counselling. It is a low threshold counselling with a flexible and non-judgmental approach: abstinence is not required nor it is the goal of the intervention, unless established by the user. Usually, users are in search of information on the short and long term effects of drugs (especially ketamine, opium, cannabis). They look for support in managing their drug use during periods of diminished control. Users who choose the counselling setting as a “light” alternative to long term intensive treatments provided in the Drug Addiction Public Services (Ser.T.). Sometimes users’ parents refer to Java to ask for advice about their son/daughter use. Also, young people who have received counselling play an important role in driving peers to Java, where they can ask for advice for a variety of problems ranging from difficulties at school, in the family, anxiety and other psychological troubles.

**Web site & contact:** [www.infojava.org](http://www.infojava.org) , Federica Gamberale +393478941687

#### Focus on innovation

- *Choosing the goals of interventions 1.* The choice of goals is up to the client, as users are assumed to be able to take decisions. Being able to make choices is the basis for being responsible for them. Professionals will support users in building a clear picture of themselves, their problems, their hierarchy of needs and, finally, in establishing what they want.
- *Choosing the goals of interventions 2.* It is important to keep broader goals in mind, concerning *set* and *setting*, beyond the *drug* field. Due attention is to be paid to “life structure”, as a crucial factor of control.
- *The stepping down controversy:* as illustrated above, in the disease model stepping down is not considered as a valid choice in interventions. Often, users who choose to step down are labelled as “denying” the severity of the problem, though stepping down and temporary abstinence seem to be the “natural” pathway to long term (or even lifelong) abstinence.
- *Self- efficacy versus powerlessness.* Both less problem clients and more intensive users (the so called addicts) might benefit from treatments that convey them greater power and self control. The self regulation perspective is corroborated by psychological constructs and research findings about the relevance of clients’ beliefs and expectancies about their own effectiveness: people who are not labelled as addicts are more likely to be “over the drugs”. On the other hand, the worse people think they are, the worse they are: it appears to be a self fulfilling prophecy.
- *Be aware of success, stress the positive.* The precept is a consequence of focus on self efficacy and self esteem. Also, it is consistent with the concept of change (not seen as “all or nothing”, but as a step by step process)
- *About the concept of change.* The “control” perspective fits with the behavioural model of change (TTM): focusing on the process of change and the entire person instead of simply the diagnostic label, can broaden perspectives in drug programs: interventions may occur

in many steps and life circumstances of users' careers, with a wide range of different goals, in accordance with the concept of change as a long term (and "step by step" process).

**Association / Institution:** ASL Napoli 1 Centro – Dipartimento delle Dipendenze Patologiche /Gesco Gruppo di imprese sociali

**Name of the intervention /service:** MamaCoca Project

**Nation /Region / City :** Italy, Naples

**Clients:** cocaine /crack users who don't attend traditional formal services; their relatives; friends and other people in contact with socially integrated cocaine /crack users

**Goals:** empowering users in self regulation strategies and skills; developing peer support practices, drug related risks limitation and harm reduction; facilitating users in attending public services for health promotion

**Operational model. Approach:** in the harm reduction framework, empowering users' skills and competencies. Abstinence is considered as a control tool rather than a goal itself. Professional competencies are oriented to supporting users' self regulation practices. **Methodology:** client/professional negotiation towards shared goals; short supporting counselling on learning process dealing with control on drug use and self efficacy; counselling on the patterns of use dealing with the interaction between drug, set, setting and personal life structure; peer support to share self regulation competencies and harm and risks reduction; medical advices for risks limitation and health promotion; networking with other services and intervention. **Setting:** outpatient public service in a private, unidentified apartment, flexible opening time, email and phone counselling, web and facebook information and communication **Tools:** psychological counselling, self help groups, medical counselling and tests, information on drug effects and risks, social support (on job, training etc), family and couple psychotherapy

**Web site and contact:** [www.mamacoca.it](http://www.mamacoca.it) Chiara Cicala [chiara.cicala@fastwebnet.it](mailto:chiara.cicala@fastwebnet.it)

#### 4. Twelve highlights towards an innovative operational model

Summarizing the different inputs and suggestions coming both from the qualitative research and from the exchange among experts, peers and professionals involved in the NADPI Experts' seminar, the following are the most relevant highlights towards an innovative operational model:

*4.1 Support rather than help.* Interventions should be intended as a *support to self- regulation strategies.*

*4.2 Assessment and self definition versus diagnosis.* Assessing user's career is a crucial phase of intervention and it is different from diagnosis. Assessment calls for an "exploratory" attitude, to help user to look into his/her drug experience and into his/her career and reconsider it in the wider context of the whole life experience.

4.3 *Identifying advantages of drug use as well as disadvantages.* Both of them are essential to understand the function of drug use. Moreover, change is a result of the “decisional balance” between costs and benefits of the present behaviour and clients should be aware of both sides of the balance to make a choice.

4.4 *Be aware of success, stress the positive and client’s resources.* This is a main point of difference from the traditional model. It is a crucial question of preserving self –efficacy. In order to understand how and why the user has reduced his/her control over drugs, it is preliminary to understand how and why he/she had previously achieved control and maintained it for some time.

4.5 *Any positive change* is the goal of intervention. Change is a *step by step process*, and change takes time. It is important to be fully aware of the (small) steps of change (and professionals’ support may help to identify the process)

4.6 *Setting the goals.* It is important to keep *broader goals* in mind beyond the *drug* area. Change may be pursued in any field of life experience. The *drug, set, setting model* is a useful blueprint both for assessing client’s situation in every area of his/her experience

4.7 *A balanced client/professional relationship.* Setting goals of intervention is *up* to the client, who is supposed to be able to take decisions. This ability is the necessary basis for client’s responsibility for these decisions. Professionals’ role is essential in clarifying the background for the decision and in helping to identify the steps to reach the chosen goals.

4.8 *Stressing the role of setting and life structure.* Due attention is to be given to “life structure”, as an essential factor of control.

4.9 *Information and Advocacy work for the rights of clients.* It should be a core action, to be aware of their rights and to claim them is a form of users’ control over their life.

4.10 *Innovating the whole offer of interventions.* Following the proactive approach, the new model is meant to extend across targets as well as traversing the prevention/treatment pillars. How to apply the new model in different settings (low threshold services, counselling, brief interventions, therapeutic settings) is the future challenge for the work on the self- regulation model.

4.11 *Changing the mission of services.* The new self-regulating model should not be seen as the “last resort”, to be implemented after the “mission” of services (abstinence) has failed. The control perspective as well as the whole Harm reduction approach should be taken “out of the backstage”.

4.12 *Welfare policies and the network of drug services.* Social policies may be more important for users’ “life structure” than drug treatment. Linking drug policies to welfare policies should be a core issue in innovating drug policies.

## 5. Self regulation, Harm Reduction and drug policies: notes for policymakers<sup>15</sup>.

Drug policies and drug policy reform are not the topics of these Operational Guidelines<sup>16</sup>. Nevertheless, shifting towards a Harm Reduction approach based on supporting self regulation

<sup>15</sup> References p. 32

<sup>16</sup> A “Policy Briefing”, addressed to European and national policy makers, will be published, in the framework of the NADPI WS1 “Innovative cocaine and poly drug abuse prevention programme”





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