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# Cocaine: towards a self-regulation model

## New developments in Harm Reduction

By Grazia Zuffa[1]

A significant body of research on cocaine users recruited outside captive populations – that is, studies based on samples of users who have not been enrolled through drug addiction services – has been carried out in many European countries and outside Europe. These studies show a variety of patterns and trajectories of use other than "addictive" use.

Similar studies have been conducted on users of different drugs, such as amphetamines and cannabis, with analogous results.[2] The reason for most controlled use lies in a wide set of self-regulation rules users tend to apply to keep drug use at bay and prevent the disruption of everyday life. This perspective is noticeably at odds with the point of view of drug addiction professionals, who tend to focus on addiction as a disease, resulting from the chemical properties of drugs combined with biological, psychological and social deficits of users. It also challenges the social representation of drugs as intrinsically out-of-control substances and of drug users as helpless under the influence of drugs.

By taking cues from users' self-regulation strategies, it is possible to design innovative operational models for drug services as well as drug policies, strengthening Harm Reduction as an alternative approach to the disease model. This paper illustrates this paradigm shift of moving the main purpose away from elimination and towards regulation of drug use, with the aim of encouraging users' informal controls while reducing the harm caused by punitive laws and policies.

### Key points

- The social image of cocaine users not in treatment focuses on "escalation towards addiction", whereas overall self-regulation is the rule rather than the exception.
- The drug addiction programmes currently available are unsuitable for many users, since they are based on a disease model of addiction.
- an alternative operational model of intervention, involving "demedicalization", empowers users and is based on their self-regulating abilities.
- The self-regulation model can contribute to the re-launch of Harm Reduction as an overarching concept in drug policies, going beyond public health.

## What is known about the use of cocaine and stimulants?

According to the European Drug Report 2013,[3] it is estimated that about 2.5 million young Europeans used cocaine in the last year (1.9 per cent of this age group), but in some countries (Denmark, Ireland, Spain and the United Kingdom) the prevalence of use in the last year is higher, ranging from 2.5 to 4.2 per cent.

As for ecstasy, it is estimated that 1.8 million young adults used ecstasy in the last year, with national estimates ranging from under 0.1 to 3.1 per cent. While ecstasy prevalence

is reported to be declining after a peak in the early 2000s, cocaine use is relatively stable, with modest declines or stabilisation in higher-prevalence countries (after a peak in 2008-09), though some countries, like France and Poland, reported increases in 2010.[4]

Taking into account the general population rather than young people, figures from the World Drug Report 2013 show that the prevalence of stimulants use in the last year is even lower, ranging from 1.2 per cent in west-central Europe to 0.2 per cent in eastern/south-east Europe for cocaine; from 0.8 per cent (western Europe) to 0.5 per cent (eastern Europe) for ecstasy; from 0.7 to 0.2 per cent for ATS (Amphetamine-Type Stimulants, excluding ecstasy).[5]

As the figures quoted from the EMCDDA Report show, the most recent data focus on the young and on last year prevalence, but these figures do not provide answers to important questions about more or less intense patterns of use or the continuation of drug use into adulthood. A more sophisticated method has been developed to look at drug use more in depth: using the full indicators of prevalence (lifetime, last year, last month drug use), it becomes possible to calculate the "last month continuation rate" – the proportion of lifetime users that continue to use monthly – in order to learn how many people who have experimented with certain drugs have become regular users and for how long.[6]

The continuation rate for cocaine indicates that only a minority of young experimenters will continue to use the drug with regularity. Most of them will stop at some point in their lives. This pattern is very similar for ecstasy, but differs from what we see with alcohol, which may be described as a "continuing" substance: most people who have tried alcohol will keep on drinking for their whole life.

More importantly, much has been learned about the link between cocaine use and the habit of party-going (attending parties, pubs, bars) in the nightlife scene: cocaine users have a much more intense nightlife than the general population and they keep up this lifestyle until adulthood. This highlights the relevance of carrying out studies within the specific cultures or subcultures of substance use.[7]

In short, there are good reasons to define cocaine and other stimulants as party drugs, and their use is generally limited to a specific period of life.[8]

It is commonly believed that the most important risk of using drugs is that experimentation will lead to chronic use and eventually to heavy use and addiction. The findings from the simple epidemiological data do not confirm this fear. The policy implications of these results will be discussed later.

It is worth noting that most recent epidemiological surveys are limited to "last year prevalence": not only do they not offer any information about patterns of use and their evolution over time, they are also unable to shed light on the meaning of the experience of drug use in the context of users' lives or on the reasons for changes in patterns of use. This kind of knowledge can only be provided by qualitative studies, aimed at exploring drug users in general – and cocaine users in this particular case – within their culture and presenting drug users' own views on their drug use. Studies of this type have been carried out for many decades and a considerable amount of research is now available in many countries.

Nonetheless, studies in natural settings and from drug users' own point of view are still unconventional, probably because users are considered as "deviant" in the prohibitionist culture. For this reason, the impact of their findings on drug policies and operational models in drug services is constantly underestimated, if not ignored altogether.

One final point: it is difficult to reach cocaine users in their natural settings of use, because

of the illegal status of drugs. Users will hide their habit to avoid detection in order to stay away from criminal sanctions and social stigmatization. Therefore, most of the current knowledge on drug use comes from drug addiction professionals and from findings based on the most accessible and visible subgroups of drug users (mainly heavy users from recruited in treatment programs and/or users in therapeutic alternatives to incarceration). This carries the risk of generalising from a partial picture of (intensive) patterns of use.[9]

## Main findings from research on cocaine use in natural settings

Neither epidemiological surveys nor in-depth qualitative studies confirm that the highest risk for cocaine users would be to develop addictive patterns of use. A look at the trajectories of drug use as they emerge in some recent studies is clearly revealing: the "escalation" trajectory (that is, a slow and steady increase in drug use) is reported by a very small minority of users.

The most frequent trajectories are discontinuous/intermittent/varying (periods of heavy use alternating with periods of occasional use or abstinence) and up-top-down (escalation until "peak use" followed by stepping down).[10] On the whole, the prevalent trajectories appear variable, with a downward rather than upward trend.

In one of these ethnographic studies, conducted in Antwerp, about half of all users reached a high level of use in their period of heaviest cocaine use, but the overwhelming majority did not maintain that high level. The follow-up study shows that for a majority of users, interviewed twelve years later, regular use of cocaine did not result in "loss of control" or in any disruption of daily life engagements.[11]

This does not mean that cocaine use does not carry considerable risks: they do exist, and users are usually well aware of the possible negative effects of cocaine, particularly adverse physical and psychological effects. But the very awareness of these risks helps users to keep cocaine use under control.

## The concept of control

The concept of control applied to cocaine use goes against the dominant social representation of illegal drugs as intrinsically "out of control", making it difficult to understand. On the other hand, the same concept is perfectly clear when applied to alcohol: in European societies, people are perfectly aware that the large majority of alcohol users control alcohol use to avoid "escalating" to alcoholism; moreover, they are not surprised if some people go through periods of heavier drinking and "step down" to more moderate use later, following changes in life circumstances.

To give an example: stepping down to more moderate patterns of alcohol use often happens to young people when they grow older and leave behind the party-going nightlife style in order to become more involved in their working careers. In other words, it is common sense that drinking alcohol is a complex experience, influenced by both social/environmental and by individual/psychological factors: the addictive chemical properties of the substance have a role, but only a limited one.

The qualitative research mentioned above highlights that factors other than pharmacological ones play an important role for illegal drugs as well as for legal drugs: the variability of patterns of drug use is related to changes in life circumstances and life engagements. Most users seem aware of this link, as illustrated by the words of these cocaine users interviewed in a study in Turin:[12]

> "In the period I had a job, I used cocaine intensively, every Saturday for four or five

> weeks consecutively, but I slowed down later on. I went back to an intensive use when I began to attend university, and stepped down to occasional use again soon afterwards."
>
> "I went through one year of intensive use, followed by a step down period. I reached my peak use when I was 25, but it only lasted one year or less."

These dynamic cocaine-use careers are also related to a process of learning from experience, as in many other human experiences. Again, users appear conscious of this process, as shown by these quotations from studies in Tuscany and Antwerp:[13]

> "I have a more conscious use, which simply comes from experience as for all things in life. It works like that: **you just learn how to control your use**."
>
> "I now know what it is. What it's like with that high and so, what it is good for, what it isn't good for, in what circumstances I prefer to use it and eh. What is good stuff, what is bad."

Most cocaine users learn to control the drug by setting a wide range of self-imposed rules concerning the drug itself (for example: choose the quality, the amount, the frequency of use), the "set" or physical and psychological conditions for uses (for example: only using when feeling well, avoiding use when in a bad mood), and the "setting"; the context of drug use (for example: using with selected people, using at the weekends only, not using with strangers, not using at work).

A clear and comprehensive definition of control is offered by Peter Cohen: "controls on drug use are defined as self-imposed behaviours or rules that regulate the selection of locations of drug use and companions of the user, normatively determine the amount of drugs used, moods fit for use (or unfit)."

These controls aim at structuring drug use within the wide field of everyday life engagements and "one could see the complexity of these lives as the main engine of control over drug and alcohol use."[14] These self-imposed rules try to identify "functional" versus "non-functional" drug use: when drug use starts to be non-functional or even dysfunctional within the complexity of life, it is moderated and even abandoned.

These findings contrast with the dominant social image of illegal drugs. In western societies the concept of "functional use" is evident when applied to alcohol, as this substance is highly ritualised and a wide range of social rules is available in the mainstream culture, indicating appropriate and "functional" drinking behaviour. This implicitly means that alcohol is socially viewed as a substance with "advantages" (as well as disadvantages).

The same idea is less acceptable – or even unacceptable – when applied to illegal drugs, which are supposed to be intrinsically "dysfunctional" and "disadvantageous". The knowledge from users' perceptions is ignored: users report many advantages from cocaine use, mainly feeling high, getting an energy boost, relaxing and facilitating communication.[15]

The refusal to consider this side of illegal drug use is an important obstacle to its comprehension: if drugs have no advantages, people have no reasons to choose to take drugs: if they do, it can only be because they are under the influence of the addictive properties of drugs. This negative perspective on drugs, ultimately inspired by a "moral" attitude towards psychoactive substances, prompts the view of drug use as pathological as well as the image of drug users as passive and powerless. In a circular reasoning, the "pathologization" of drug use leads to social expectations of "loss of control" over drugs. Such expectations can run the risk of operating as a self-fulfilling prophecy, which

weakens rather than supports users' self-regulating abilities.

One of the main consequences of the pathological approach is the expectation that users will be unable to "step down" to more moderate patterns of use when they have reached a peak of intensive (addictive) use. This is in contrast with variable trajectories of drug use, as reported in research carried out in natural settings.

Nonetheless, pathological expectations stem from the moralistic attitudes towards intensive drug use that pervade mainstream culture. As Norman Zinberg points out, "The cultural insistence on extreme decorum overemphasizes the determinants of drug and set by implying that social standards are broken because of the power of the drug or some personality disorder of the user. [It ignores the finding that] ***intoxicant use tends to vary with one's time of life, status, and even geographical location***."[16]

## The disease model

The pathological view of drug use is still dominant, at least in official mainstream culture, and plays an important role in drug policies – an issue that will be examined later. Moreover, the "disease model" is the leading approach used in treatments available in drug addiction services.

The term "disease" was first used in reference to alcoholism in the early nineteenth century, but the theoretical basis for the disease model was developed by E. Morton Jellinek: addiction is seen as a primary disease, characterised by loss of control and denial of the severity of the disease itself.

The theory of addiction has been extended from alcohol to other psychoactive substances: addiction stems from both the pharmacological properties of drugs and individual susceptibility to developing the disease. Recovery is a lifelong process of containment that can be achieved only by lifelong abstinence from all substances. Once again, there is a reciprocal influence of moralistic attitudes towards drugs and the theory of addiction: the ultimate aim of both the moral approach and the disease model is to eliminate drugs instead of regulating their use.[17]

One of the main tenets of the disease model is the dichotomous approach: either drinking or sober, either abstinent or addicted, either controlled use (adopting permanent moderate patterns of use) or uncontrolled use (in permanent loss of control).

The unilateral focus on individual bio-psychological features ignores the role of environmental conditions (such as life circumstances, change in life engagements etc.), although consideration of these is crucial in order to realise that control is a dynamic process concerning all users (though at different levels) rather than a property of a specific group of users. The dichotomous approach is clear in the words of the pharmacologist Gian Luigi Gessa, who divides cocaine users into two distinct categories: "dependent" cocaine users (who use regularly and moderately), and "addicted" cocaine users, who have escalated to intensive use and are therefore assumed to be under the influence of drugs all the time.[18] But all illegal drug use is predestined to be viewed from the disease perspective. As a result, even moderate use becomes "pathological" and moderate users are labelled as "dependent", as the categories mentioned above make clear. (This is the main difference from alcohol: moderate drinkers are not usually "pathologized".)

In a similar way, the regular use of illegal drugs is usually labelled as "chronic" use, disregarding patterns of use. More important, the focus on "loss of control" leads to underestimating the self-regulation abilities of users (intensive users in

particular) to improve by "stepping down" to more moderate patterns of use. This happens in spite of the evidence from epidemiological surveys and other research. With regard to alcohol, for example, data from the US National Epidemiological Alcohol Survey concerning outcomes for both treated and untreated alcoholics tracked for a year were examined by Stanton Peele, who underlines that the majority of both treated and untreated dependent alcohol users is reported as being "in remission" because they were "improving while continuing to drink".[19]

Nevertheless, in order to comply with the model, most drug addiction professionals establish abstinence as the only valid goal of treatment, quite often against the user's will. The consequence is that therapist-driven goals arouse resistance in the client, reducing the probabilities of positive outcomes. On the contrary, the best outcomes in treatment occur when the goals are chosen by the client. Nevertheless, it is quite common for users to be pressed to sign a treatment plan they do not agree with.[20]

## Discrepancies between the points of view of professionals and users

Though many cocaine users are able to maintain steady control over their drug use, many others go through periods of perceived diminished control, as evidenced by the variable trajectories described above. Nonetheless, most of them are unwilling to seek help from drug services even in the phase of more intensive use. First and foremost, they want to avoid the label of "addicts" and are reluctant to be enrolled in intensive long-term treatment (the most common kind of treatment available in drug addiction services).

Secondly, they do not appear to agree with one of the tenets of the disease model, which maintains that help is necessary because drug users are powerless over drugs. Not only is this assumption of "powerlessness" a poor fit with users' perception; it also undercuts users' self-efficacy, paradoxically reducing rather than enhancing their coping abilities. This will be discussed later in more detail.

The main discrepancy between professionals and users is with regard to the appreciation of step down strategies and controlled use as valid and viable goals in treatment. In many drug addiction professionals' opinion, controlled use is only a temporary step in the escalation to chronic use, unless users switch to abstinence. Stepping down to more controlled use may be seen as an acceptable goal only for so-called chronic users who have not benefited from abstinence-oriented treatments.

From this perspective, controlled use is a second choice, while abstinence is confirmed as the "mission" of services. The widest discrepancy is registered on the assessment of temporary abstinence, which is one of the most frequent and efficient control strategies users adopt when they realise they are overstepping their bounds and drug use risks taking priority over other activities and life engagements (such as a job, family life etc.). In keeping with the disease perspective, many professionals focus on "relapse" rather than on cocaine users' capacity to shift to abstinence and to stay abstinent for a period (sometimes for long periods) of time.

## Towards the "normalization" of illegal drugs and drug interventions

Developing an alternative to the disease model has many advantages. First and foremost, it makes it possible to broaden the range of available interventions and to increase the number of users in contact with drug services. For many of them it would be helpful to receive more information or counselling to maintain or regain a controlled pattern of use. More problematic users,

already enrolled in treatment but with poor results and poor compliance, may also benefit from a different approach.

Raising the target for the number of users in contact with drug services does not mean a (further) medicalization of drug use. On the contrary, it might contribute to the "de-medicalization" of operational models in drug services, following a process of "normalization" of the same drug services in the context of the health care system.

The concept of normalization has many meanings. Usually, it evokes the social and cultural accommodation of a certain behaviour (drug use in this case), which develops into a wider social acceptance of something which was previously seen as deviant.[21] In the field of illegal drugs, normalization may also mean the "alignment" of illegal drugs to legal drugs (alcohol), using a similar paradigm to explain the use of psychoactive substances.

The social functions of alcohol use are clear, especially in southern European countries where alcoholic beverages are integrated in family life and social contexts. This level of integration implies that in European culture alcohol cannot be reduced to a "psychotropic agent", and neither can its use be explained through the effects of its pharmacological properties alone. From this perspective, "normalizing" illegal drugs means recognising the role of the environment and social context in shaping drug use, as is the case with alcohol use.

There is one more important area of normalization, concerning drug interventions. Lessons learned from a long tradition of psychological research should be applied to the field of drug use, consistent with clinical practice in other problem areas. For example, contrary to the disease model, supporting users' self-regulation abilities is in line with findings from psychological research which have shown the value of beliefs and treatments that enhance self-efficacy and allow clients greater power and self-control.[22]

Following this path, suggestions from the most recent approaches in health-care can be taken up to design new practices in drug services. Such approaches corroborate the self-regulation model. In particular, the working assumption that the client is able to implement self-management is widely accepted both in psychology and in medicine, even for patients with serious health problems.

For example, the Health Promotion Model, formulated in developmental psychology, aims at promoting positive identities, focusing on the positive sides of human experience. As a result, clients are seen as "experts" drawing expertise from their own life experience.[23] Self-management programmes are embedded in this theoretical background. Though this approach is widely applied in several kinds of health programmes, it is rarely accepted in the field of illegal drug use or only partially implemented, exclusively for clients in abstinence-oriented programmes.

There is no apparent reason for this limitation apart from the moralistic bias surrounding illegal drug use. Therefore, self management should be implemented for all clients in a "normalizing" approach to drug interventions. Similarly, having a wide range of different intervention goals (from abstinence to stepping down), as hypothesized in the self-regulation model, is consistent both with users' experience and with the concept of change as a long-term, step-by-step process, in accordance with recent psychological theory and research.[24]

## Beyond the disease paradigm: cornerstones for a self-regulation model

A critical overview of the disease model and the above overview of the most innovative

approaches in health programmes are the foundations of the self-regulation model. A detailed exposition of the new operational model may be found in *Beyond the disease model, new perspectives in Harm Reduction: towards a self-regulation and control model - Operating Guidelines*).[25] This paper will only highlight its main features: the focus on 1) *users' abilities*, in accordance with the proactive approach and the promotion of competence and wellbeing; and 2) the *social context and setting of use*.

The first tenet leads to many innovations in drug interventions, including offering various self-management programmes and short-term interventions aimed at "supporting" users' competencies (instead of "helping" otherwise powerless patients); the widening of targets for clients at different levels of control over drugs; a more balanced client/professional relationship, so as to build a partnership between users' and professionals' expertise; and the widening of intervention goals to take into account any positive step along the continuum of drug use, but also any positive change in the whole life experience of users.

The prominence of social context and setting of use has many implications in understanding drug use and in the practice of services. Users do not live in a social vacuum: individual personality characteristics may be important, but so too are subcultures of drug use, rates of unemployment, alcohol and drug policies, stigmatization and discrimination against users. As a result, a shift is needed from a clinical individual perspective to a community approach.[26] For example, advocacy work should be a core action in the new model as users' awareness of their rights is a form of control over their lives.

Once again, the relevance of a solid "life structure" (the regular activities and engagements that structure daily life) in learning control over drug use is to be stressed. As Tom Decorte and Marjolein Muys point out when summarising findings from their follow-up study, "one of the most important phenomena keeping users from becoming chronically dependent is involvement in a social network and in competing activities and interests . . . because users are anchored in their lives and identities, because they have a stake in conventional life, they are able to limit their cocaine use."[27]

The crucial role of social context in shaping drug use is confirmed by research in different fields, such as studies and reviews on the link between drug problems and socio-economic deprivation. While recreational drug use is no more prevalent among socially excluded groups than in more affluent groups, the most damaging patterns of drug use and their worst consequences are concentrated in deprived neighbourhoods.[28]

These findings carry important policy implications: broad social policies are crucial for drug users and they can be more effective than drug interventions in strengthening users' life structures. In most European countries, there is a "hyper-specialized" approach to drug users' health problems, due to one of the disease model tenets – "address the drug problem first". Bearing in mind the relevance of social context, the emphasis on "hyper-specialization" should be reduced. Instead, access to welfare benefits should be the same for drug users as for any other citizen, but at present in many countries these benefits are even off-limits to drug users unless they quit drugs. Linking drug policies to welfare policies should be a core issue in innovating the former.

## Rethinking Harm Reduction from a self-regulation perspective

The self-regulation model is embedded in Harm Reduction, while taking some of its cornerstones in new directions. At present, Harm Reduction is mostly known as a set of public health programmes, such as needle

exchange for injecting drug users, overdose prevention, and methadone maintenance treatments.

Still, Harm Reduction is not only the implementation of public health principles in the field of drug use. It is also an *approach* – to drug use as well as drug policies – aimed at decreasing the negative consequences of drug use, without necessarily reducing the consumption of drugs. It is an alternative approach to policies focused on reducing the prevalence of drug use with the final aim of eliminating it.

More importantly, Harm Reduction originated in grassroots advocacy among drug users themselves, prompted by self-help initiatives aimed at protecting users' own health. Therefore, the emphasis on drug users' abilities in the self-regulation model is consistent with the founding principles of Harm Reduction: recognising drug users' competencies in controlling the risks of drug use, countering the social image of helpless and powerless addicts, while creating the environmental conditions to maximise users' control abilities and minimising the negative (environmental) conditions that inhibit those abilities.

While Harm Reduction as a set of public health programmes has been widely developed both in Europe and at a global level since the 1990s, the Harm Reduction approach has hitherto remained backstage. Paradoxically, the establishment of Harm Reduction as the fourth pillar of drug policies – in addition to the traditional three pillars of prevention, treatment and law enforcement – has weakened Harm Reduction as an approach and as the overarching concept of drug policies which was meant to have a consistent impact on the other pillars, so as to change the objectives and strategies of drug control.

Of course, the establishment of the fourth pillar has shown significant advantages, in spreading prevention measures such as needle exchange and introducing low threshold facilities into the drug services system, as well as promoting a scientific cost-effectiveness approach to drug interventions while reducing the moralistic hostility to non-abstinence-oriented programmes. But in many countries the fourth pillar of Harm Reduction has become a sort of ancillary partner of the treatment pillar, without any impact on formal drug services, which are still dominated by the disease model of addiction. In short, Harm Reduction is seen as a last resort for chronic users who are supposed to be *unable* to enter treatment or to comply with traditional treatments. This represents a step backwards to a *disempowering* way of viewing drug users, in a complete reversal of perspective.

The control and self-regulation model can re-launch Harm Reduction as the leading approach in the whole network of interventions, from prevention measures to self-management, brief counselling, more structured programmes and Harm Reduction psychotherapy.

The emphasis on *control* is key to clarifying the theoretical background of Harm Reduction, shifting from the *negative* (risky/harmful) properties of substances to the *positive* individual and – importantly – environmental resources that enable someone to be "over the influence" of drugs. In addition, it can contribute to overcoming another shortcoming of having Harm Reduction confined to a specific "pillar": the overemphasis on the harm of substances while neglecting the harm of policies, and punitive laws in particular. Instead, in the words of the International Drug Policy Consortium, "Harm reduction approaches also seek to identify and advocate for changes in laws, regulations and policies that increase harms or that hinder the introduction or efficacy of harm reduction interventions".[29] To these one might add policies that hinder, or even destroy, users' self-regulation mechanisms.

Research on controls offers a clue for a clearer assessment of the harms caused by drug policies. Drug control systems based on prohibition work to dismantle the conditions for individual drug use control by incarcerating, marginalising and discriminating against users. The stigmatization and punishment of drug use undermines users' life structure and their anchoring in life engagements, depriving them of those "stakes in conventional life and identity" which allow them to limit their drug use.[30] Furthermore, "communicative structures of drug users are constantly threatened, reducing their efficiency as vehicles of safe use knowledge."[31]

To reiterate, Harm Reduction is an alternative approach to policies focused on reducing the prevalence of drug use until it is eliminated. Research on controls has demonstrated the relevance of cultures of safer and healthier use in regulating – rather than reducing and eliminating – drug use itself.

The comparison with alcohol makes it possible to appreciate how the anchoring of its use in everyday family life and in social rituals works to support moderate patterns of use. Historically, in the so-called "wet" cultures (in the Mediterranean countries, for example), high risk patterns of alcohol use are less frequent than in the "dry" (Northern) cultures, though the prevalence of alcohol use is much higher. From a public health perspective, supporting the cultural accommodation of illegal drugs should be the priority, through the development of rules about use, dose and safer settings of use, and the communication of these rules among users. Drug policies should enhance – or at least allow – this communication, instead of banning it on "moral" grounds. As Zinberg has pointed out: "Ironically, the efforts to eliminate any and all use work against the development of control by those who decide to use drugs anyway."[32]

## Conclusion

The self-regulation model can re-launch the potential of Harm Reduction, both in drug services and in drug policies. With regard to the former, facilitating the development of controls and helping them to circulate widely among users should be the "mission" of drug services and drug prevention programmes. The role of services in sustaining users' communicative structures may be crucial, as rules for safer use of illegal drugs are confined in user subcultures, precisely because of their illegality.

This is especially important for stimulants and cocaine in particular. Not only does this substance have a long history, with different social images, different patterns of use and modes of consumption at different levels of risk; it has also been widely studied from the user's point of view. This knowledge should be an important resource for drug policies as well.

The challenge for Harm Reduction from a self-regulation perspective is to facilitate the environmental conditions for minimising risks and harms, empower users' competencies and skills, and implement broad social policies that aim to help users to hook into opportunities for conventional lives.

## Notes

1. Grazia Zuffa is a PhD psychologist working in the field of drug policy and research. She is a founding member of the Italian NGO *Forum Droghe*. This briefing is one of the outputs of the work stream *Innovative cocaine and polydrug abuse prevention programme* from the project New Approaches in Drug Policy & Interventions, with the financial support of the Drug Prevention and Information Programme of the European Union and La Società della Ragione. It summarises the main results from the Experts Seminar held in Florence (20-22 June 2013).

2. In 1976, Norman Zinberg carried out a pioneering study on controlled use of drugs, recruiting cannabis, psychedelic and opiate users: see N. Zinberg (1984), *Drug, set, setting*, Yale University Press, New Haven and London. For cannabis see also Cohen, Peter, & Arjan

Sas (1998), *Cannabis use in Amsterdam*. Amsterdam, Centrum voor Drugsonderzoek, Universiteit van Amsterdam; Reinarman, Craig, Peter D.A. Cohen & Hendrien L. Kaal (2004), The Limited Relevance of Drug Policy: Cannabis in Amsterdam and in San Francisco. *American Journal of Public Health*, 2004; 94:836–842. For amphetamines, see: Uitermark, Justus, & Peter Cohen (2004), *Amphetamine users in Amsterdam. Patterns of Patterns of use and modes of self-regulation.* http://www.cedro-uva.org/lib/uitermark.amphetamine.html

3. http://www.emcdda.europa.eu/attachements.cfm/att_213154_EN_TDAT13001ENN1.pdf

4. European Drug Report 2013, 34-37.

5. World Drug Report 2013, annex 1, V).

6. See Cohen, P. (1999). Shifting the main purpose of drug control: from suppression to regulation of use. Reduction of risks as the new focus for drug policy. *The International Journal of Drug Policy*, *10,* 223-234.

7. For example, the (partial) shift away from the traditional "wet culture" of alcohol use among young people in southern Europe can only be fully understood in connection with the change in youth lifestyles (with a prominent role for "nightlife" and "party-going" styles). See Beccaria, F. (Ed.) (2010). *Alcol e generazioni*. Rome: Carocci Editore.

8. See Cohen, P. (2004). Le droghe ricreative. In F. Corleone and G. Zuffa (Eds.), *La ragione e la retorica.* (pp. 57-65) Ortona: Edizioni Menabò., (Data from the Cedro National Prevalence Study 1997 and 2001 - Licit and Illicit Drug Use in Amsterdam.)

9. For an in-depth discussion about research among users of illegal drugs, see T. Decorte (2010), Come si diventa un consumatore controllato, in G. Zuffa (ed.), *Cocaina, il consumo controllato*, Turin, Edizioni Gruppo Abele, 191-217.

10. In a study of 111 experienced cocaine users in Antwerp, only 3.6 per cent reported the "escalation" trajectory: see Decorte, T. (2001). Drug users' perceptions of controlled and uncontrolled use. *International Journal of Drug Policy*, *12,* 297-320. On the same research, see also Decorte, T. (2000). *The taming of cocaine.* Brussels: VUB University Press. In an Italian study of 115 cocaine users in Tuscany, the rate for the escalation trajectory was reported at 13 per cent: see Bertoletti, S. and Meringolo, P. (2010). Viaggio fra I giovani consumatori invisibili di cocaina. In G. Zuffa (Ed.), *Cocaina, il consumo controllato,* cit.. In the Antwerp study, the most common development pattern was up-top-down (26.1 per cent), while in the Tuscan study it was "intermittent" (25.2 per cent), immediately followed by up-top-down (20.9 per cent). A fundamental study for the theoretical developments is Cohen, P. and Sas, A. (1994), *Cocaine use in Amsterdam in non-deviant subcultures*. Amsterdam: CEDRO. For an overview of studies on controls, see Zuffa, G., Grund, J.P. and Meringolo, P. Towards an Ecological Model of Self-Regulation & Community-Based Control in the Use of Psychoactive Drugs. *Repertoire of Scientific Literature*.

11. Decorte, T. and Muys, M. (2010). Tipping the balance. A longitudinal study of perceived "pleasures" and "pains" of cocaine use. In T. Decorte and J. Fountain (Eds.), *Pleasure, Pain and Profit*. (pp. 35-54). Lengerich: Pabst, Wolfgang Science.

12. Ronconi, S. (2010). Non solo molecole. Evidenze biografiche e stereotipi chimici. In G. Zuffa, *op. cit*., pp. 109-158.

13. The first quotation is by a cocaine user from Tuscany, the second from Antwerp. See: Bertoletti, S. and Meringolo, P. (2010); Decorte, T. (2001).

14. Cohen, P. (1999), p. 230.

15. See, in particular: Decorte, T. and Muys, M. (2010), p. 42.

16. Zinberg, N. (1984). *Drug, set and setting. The basis for controlled intoxicant use*. New Haven and London: Yale University Press. (p. 8)

17. For the connections between the moral and the disease models, see Marlatt G.A. (1996), Harm Reduction: come as you are, Addictive Behaviours, 21, 6, 779-788

18. G.L. Gessa (2008), *Cocaina,* Rubbettino Editore, Soveria Mannelli, 61"

19. Peele, S. (2007). Addiction as Disease. Policy, Epidemiology, and Treatment Consequences of a Bad Idea. In J. Henningfield, P. Santora and W. Bickel (Eds.), *Addiction Treatment. Science and Policy for the Twenty-First Century*. (pp. 153-165). Baltimore: Johns Hopkins University Press. In the 2005 NESARC survey quoted by Stanton Peele, outcomes for 4,422 alcoholics were tracked for one year. Among them, only 1,205 underwent treatment. To be defined as "in remission", two possible outcomes were considered: "abstinence" or "drinking without dependence". The rate of people "in remission" was higher for untreated drinkers (76 per cent versus 71 per cent), though the rate of "abstinence" was higher for treated people. In any case, even among treated people, the prevalent outcome was "drinking without dependence".

20. This is often reported by harm reduction professionals when they try to refer cocaine users to treatment services, as in the quoted study on cocaine users in Tuscany. For a critical overview of the disease model, see also: Denning, P., Little, J. and Glickman, A. (2004). *Over the Influence. The Harm Reduction Guide for Managing Drugs and Alcohol.* New York and London: The Guilford Press; Denning, P. and Little, J. (2012). *Practicing Harm Reduction Psychotherapy. An Alternative Approach to Addictions.* New York and London: The Guilford Press.

21. On the concept of normalization, see: Parker, H., Aldridge, J. and Measham, F. (1998). *Illegal Leisure. The normalization of adolescent drug use*. London: Routledge.

22. Bandura A (1977), Self-efficacy: toward a unifying theory of behavioral change, Psychol Rev, Mar,84(2),191-215. For an overview on addiction therapies see: Rotgers F., Morgenstern J., Walters S.T. (eds) (2003), *Treating Substance Abuse, Theory and Technique*, The Guilford Press, New York London; Peele S. (2004), *Seven tools to beat addiction,* Three Rivers Press, New York

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26. For an overview of community versus clinical health psychology, see Orford, J. (2008). *Community Psychology: Challenges, Controversies and Emerging Consensus.* Chichester: John Wiley & Sons.

27. Decorte, T. and Muys, M. (2010), p. 52.

28. Stevens, A. (2011). *Drugs, Crime and Public Health. The political economy of drug policy*. London: Routledge. In particular, see chapter two: "Afflictions of inequality? The social distribution of drug use, dependence and related harms".

29. IDPC, *Drug Policy Guide*, March 2012.

30. See Waldorf, D., Reinerman, C. and Murphy, S. (1991). *Cocaine changes. The experience of using and quitting.* Philadelphia: Temple

31. The quotation is from Cohen, P. (1999), p. 232.

32. Zinberg, N. and Harding, W. (1982). Control and intoxicant use: a theoretical and practical overview. Introduction, in N. Zinberg and W. Harding (Eds.), *Control over intoxicant use: pharmacological, psychological and social considerations*. (pp. 13-35). New York: Human Sciences Press.

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## Transnational Institute

Since 1996, the TNI Drugs & Democracy programme has been analysing the trends in the illegal drugs market and in drug policies globally. The programme has gained a reputation worldwide as one of the leading international drug policy research institutes and as a serious critical watchdog of UN drug control institutions, in particular the United Nations Commission on Narcotic Drugs (CND), UN Office on Drugs and Crime (UNODC) and the International Narcotics Control Board (INCB).

TNI promotes evidence-based policies guided by the principles of harm reduction, human rights for users and producers, as well as the cultural and traditional uses of substances. The project seeks the reform of the current out-dated UN conventions on drugs, which were inconsistent from the start and have been surpassed by new scientific insights and new pragmatic policies that have proven to be successful.

For the past decade, the programme has maintained its main focus on developments in drug policy and its implication for countries in the South. The strategic objective is to contribute to a more integrated and coherent policy where illicit drugs are regarded as a cross-cutting issue within the broader development goals of poverty reduction, public health promotion, human rights protection, peace building and good governance.

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Transnational Institute (TNI)
De Wittenstraat 25
1052 AK Amsterdam
The Netherlands
Tel: +31-20-6626608
Fax: +31-20-6757176
E-mail: drugs@tni.org
www.tni.org/drogas