forum droghe
movimento per i diritti
Associazione Non Profit

NADPI - New Approaches in Drug Policy & Interventions

Innovative cocaine and polydrug abuse prevention programme

Experts seminar

June, 20- 21-22, 2013

Centro Studi CISL Via della Piazzola 71- FIRENZE (Italy)

WORKING PAPER

La società della ragione onlus

Introduction

> "*Addiction is progressive, chronic, and fatal! Addiction is a brain disease with a genetic component. Addiction is a family disease.*" (IAS, ND)

With several variations the views of drug use and addiction expressed in the first quote above are embodied in the disease model of addiction. According to the National Institute on Drug Abuse (NIDA), addiction is defined as "a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences." Most mainstream drug treatment is nowadays based the disease model or variations of the 12-Step Minnesota Model and the notions, that "drugs are addictive" and addiction a perhaps irreversible brain disease ("once an addict, always an addict") are well entrenched in *conventional wisdom* (Galbraith, 1958). Nonetheless, the following quote shows that even heavy users of cocaine and heroin attempt to regulate their drug intake. In this case, job considerations result in seriously cutting back cocaine use, even stepping down for a while.

> "*Cor looks good. He wears a nice and clean shirt and clean jeans. He tells he is working as a house painter again after a jobless period. … He says he is doing alright now. However about two months ago he was not. He was in a period of intensive cocaine use. But he realized that he had to cut back his cocaine use to an acceptable amount and although he says this has cost much energy, he stopped taking cocaine for some time. He tells that he is using cocaine moderately now.*" (cocaine and heroin user, Rotterdam, ± 1990 in (Grund, 1993)

The disease model seems a poor fit with the experiences of the average drug user and fails to explain the rich variation in drug use patterns and careers or the *spontaneous recovery* from serious drug addiction (without treatment) (Prins, 1995); Winick, 1962). According to developmental neuroscientist Marc Lewis, the disease model does account better for the neurobiology of addiction than other models and provides a framework for people to explain their addiction and deal with the complex feelings involved – helplessness, guilt, shame, and blame. But, citing natural recovery rates of 50-80% in alcoholics, Lewis argues that, even from the perspective of neuroscience, the phenomenon of addiction does not lend itself to two (qualitatively) different states: disease and non-disease (Lewis, 2012).
This becomes even clearer when we consider empirical social epidemiological and qualitative studies of different drugs. From the spontaneous recovery from heroin addiction among American G.I.s, returning from Viet Nam in the 1970s (Robins, Helzer, & Davis, 1975; Robins, 1993) to the variations in cocaine consumption patterns, documented by the studies of Cohen in Amsterdam (Cohen&Sas, 1994) and Decorte in Antwerp (Decorte, 2000) or studies of ecstasy users (Nabben, Benschop&Korf, 2012) and even heroin and crack-cocaine users (Grund, 1993), these studies document both a rich variety in consumption patterns and in the efforts drug users undertake to regulate or control their intake of drugs. These studies and the example of Cor above also suggest that success in controlling drug use is not merely associated with the pharmacological properties (addiction potential) of a substance, but also with the psychology of the user and the conditions under which these are taken. Cor had "realized"(a conscious process) that he had to cut back his cocaine use but his decision to step down coincided with his new job (a major life event).Most researchers now agree that the

outcomes of drug use are dependent on the interaction of, what Zinberg termed, Drug, Set and Setting (1984), although differences remain over what proportion of the phenomenon is explained by each of the three components or how these influence one another (causality).
Although Zinberg's model closely resembles the classical epidemiological triad of "pathogen, host & environment," drugs are not a pathogen or infection. In contrast with bacteria or viruses (always on the look-out for a good host), drugs are lifeless commodities, only active when we put these in our bodies; what matters is the relationship that we as humans develop with drugs. This relationship could be described in terms of good or bad, healthy or unhealthy, controlled or compulsory, beneficial or not. Furthermore, this is not an isolated relationship, the outcomes of our drug use are contingent on what and how we do in the rest of our daily lives. As these activities may change over time, so may drug use patterns.

In this working paper we look at some of the discrepancies of the disease model of addiction with the experiences of drug users from several EU countries and studies that looked into "non-addicted" or controlled drug use. Based on this discussion, we will formulate some highlights towards an alternative approach to prevention of cocaine and other drug abuse and will suggest guidelines towards an innovative drug policy based on harm reduction approach.
The starting point is a discussion on some key concepts around controlled and uncontrolled drug use.

Section 1: Towards an ecological model of controlled drug use

Experts seminar - **1st session**
Thursday, June 20, 3.30 pm – 7 pm

Research and users' voices
From studies on informal controls: patterns, trajectories of cocaine use, consumers' self regulation strategies
Highlights: What are the most promising findings in view of innovative models in drug interventions?

Key Point 1: The Risks of Drug Use

The risks of substance use are often interpreted in medical-pharmacological or psychological terminology, such as physical dependence and changes in the brain or individual risk factors that contribute or not to (problem) substance use, such as genetic disposition and trauma, or knowledge, attitude and behaviour. Many, if not most studies of drug consumers or prevention and treatment interventions take the disease model of addiction for granted. Indeed, these studies busy themselves with what overall is a minority of drug users – those who got into serious problems with their relationship with drugs at some point in their life. This clearly is also apparent in law enforcement. Both clinicians and law enforcement officers often only see the outcome of worst case scenarios (e.g. Fiddle, 1967).

Worst Case Scenarios are Relatively Rare

As noted, these worst case scenarios are relatively rare, with e.g. 90% of alcohol drinkers consuming this "hard drug" in moderation. But the rate of problem use may differ by substance Where 1.4% and 1.2% of people aged 15-64 years in the Netherlands (some 12 million people) used ecstasy or cocaine in the last month (*EMCDDA, 2011b*), the estimated number of problem users was respectively 45,000 and 600 (Ouwehand et al., 2011). Likewise, studies suggest that trauma and neglect or other mental health problems are associated with problem drug use. The rates of problem drug use[1]furthermore clearly vary between countries. With 3.1 (per 1000 inhabitants), this seems rather low in the Netherlands, and high in countries such as the United Kingdom (9.8) and Italy and Spain (both 8.5) (Van Laar&Ooyen-Houben, 2009). Although these data need to be interpreted with caution because of variations in method and definitions, these differences are striking and pointing towards variations in the cultural assimilation of drug use in the EU member states.

Key Point 2: A complex drug use environment

Indeed, the effects of psychoactive substances in humans are the result of a complex interaction between, what the American psychiatrist Norman Zinberg described in his ground-breaking book with the same title, as Drug, Set and Setting (Zinberg, 1984). Based on

EMCDDA: Definitions of problem and recreational and integrated drug use:
'Problem drug use' is defined as 'injecting drug use or long duration/regular use of opioids, cocaine and/or amphetamines' (EMCDDA, Statistical bulletin 2009). This definition specifically includes regular or long-term use of prescribed opioids such as methadone, but does not include their rare or irregular use, or the use of ecstasy or cannabis.
Recreational drug use … means the use of psychoactive substances to 'have fun' in nightlife (EMCDDA, 2002).

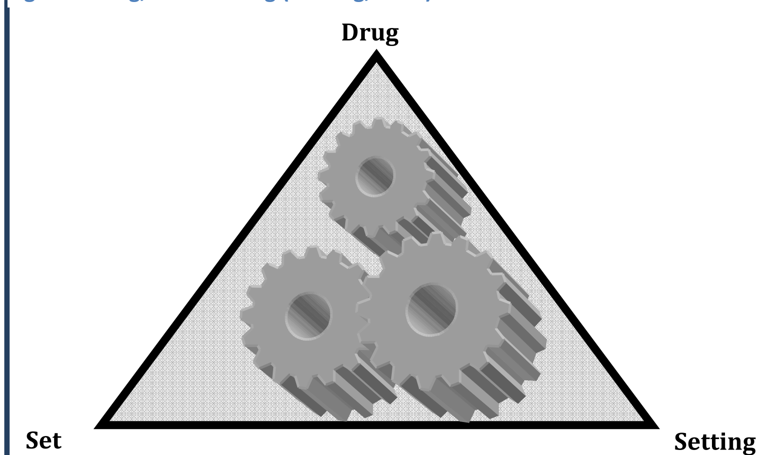
qualitative and quantitative research among users of various illicit drugs, Zinberg suggested that environment variables are crucial to the occurrence and prevention of problematic substance use and the associated risks and problems (Zinberg, 1984; Zinberg &Harding, 1979). Several studies subsequently corroborated Zinberg's findings, looking at for example heroin users (Grund, 1993), cocaine users (Decorte, 2000; Cohen&Sas, 1994; Erickson et al., 1994) or cannabis users (Sifaneck, 1995) The setting, or environment, is furthermore not a static condition, but a complex interactional arena where individuals and groups interact with each other and with structural institutions. Rhodes therefore speaks of a "risk environment" (Rhodes, 2002; Rhodes, 2009).

Key Point 3: In search of hidden knowledge

Use of psychoactive drugs is tied to formal and informal rules and constraints. Legal drugs such as tobacco and alcohol are regulated by formal rules – explicit commandment provisions and (partial) prohibitions. Prohibitions however, offer few opportunities for effective social control and self-regulation in the case of illegal drugs. Likewise, mere prohibitions add little to the collective knowledge of non-problematic use patterns within and between generations. On the contrary, one can observe "generational forgetting" among new generations of drug users, policy makers and society alike (Johnston et al., 2011). Each new generation of illicit drug users is thrown back at itself in acquiring controlled usage patterns. But, as this discussion paper argues, self-regulation strategies are a common feature in most people's use of psychoactive drugs – whether legal or not – and, as the examples presented in this paper show, there is a wide variation in usage patterns. So, how do people prevent that their drug use does not get out of control or results in drug related harm? In other words, how do they guard themselves from their relationship with drugs going sour? What strategies do drug users apply to regulate intoxication and the associated risks, including the risk of dependence or habitual use? What are the connection of self-regulation with regulatory and escalating factors in the setting, or physical, social, economic and policy environment? In the following pages we will discuss a number of studies that have looked at the issues of control and self-regulation.

Key Point 4: Drug, Set &Setting

Figure 1 Drug, Set &Setting (Zinberg, 1984)



Everything man consumes has an effect on the psyche, but some agents have a different effect than others, in others or elsewhere. The use of mind-altering drugs is a complex phenomenon influenced by various factors, which can roughly be grouped into three types of variables, *drug*, *set* and *setting* (see Figure 1).

Drug refers to the specific psychopharmacological properties of the substance being taken, which are often classified in those that

accelerate, slow down or alter the lived experience. Besides, just about all drugs mostly do what they promise; providing pleasure, relief or other complex feelings that people seek. Pleasure tastes like more, and frequent use of any drug can lead to tolerance, withdrawal symptoms (e.g. the ecstasy dip) dependence or, in some cases, drug related harms. But not all drugs are alike. *Set* refers to the brain and genetic or personality factors, or mental health problems, trauma and other stressors (although the latter two could also be classified under environment, depending on the source). *Setting* finally refers to the environment of use. In their detailed study of "controlled" and "compulsive" drug use, Zinberg and his colleagues found that all drug users, to some extent, ritualize their drug intake, and that "controlled use is mainly supported by subcultures of drug using individuals by applying rituals and social sanctions" (Zinberg, 1984).
Rituals are stylized, prescribed 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. Here we present two field notes of the ritual involved in chasing cocaine.

> *"He puts* some *pieces of base on the foil. From his pocket he takes* a *tube and* starts *to* chase *the cocaine* base. *He follows the drugcare fully on the foil. However, the cocaine follows a very whimsical path on the foil. The drop splits up several times and when he* stops *heating the foil it spreads into* a *large* spot. *After exhaling he* starts *again but he first* chases *the offshoots of the spot making it one drop again"* (Fieldnote, Grund, 1993).

This field note shows the concentration and skills involved in smoking cocaine from tinfoil, while the next note presents an example of how subcultural rituals are conveyed among users and that even regular cocaine smokers take an active interest in their health.

> *"One of the [men] was explained a part of the cocaine chasing ritual. One of his friends put a lump of base on the foil and then with a lighter ... he melted the lump from above and let just a little smoke come from it. "This is what you do to take the ammonia rests out of it. It's better for your lungs and you taste the difference," one of his other friends said* (Fieldnote, Grund, 1993).

Social sanctions refer to the norms on how, or whether, a particular substance should be used. Social sanctions include both informal and, often unspoken, values or rules of conduct, shared by a group, and formal norms, as in legislation and policy.

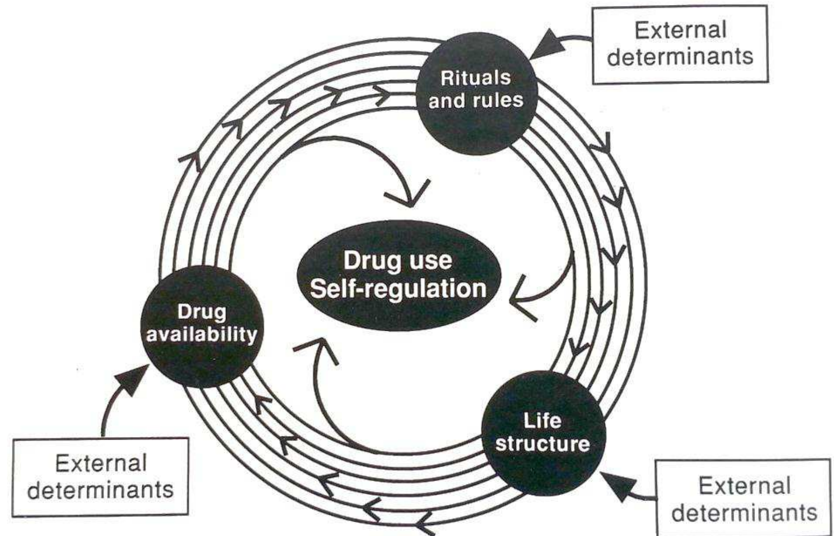
> *The young man prepares the cocaine and shares it with his mate. One of the other men at the table who just finished his cocaine, asks him "Could you spare me a knife tip?" The young one excuses himself for being not able to help him. But one minute later he grabs a knife from the table and takes a little bit of cocaine base of his foil to put it on the foil of the guy who had asked for it, saying:"Sorry, I can't miss more, we already have to smoke from it both"* (Fieldnote, Grund, 1993).

This field note refers to the rules and its exceptions that govern the collective use of drugs. According to Grund (1993) and other researchers, sharing drugs is a strong norm among drug using peers.

Both rituals and social sanctions (rules) are aimed at managing the process of and around the use of drugs. Important is that rituals and social sanctions surrounding drug use include both rational and non-rational elements. Because the rituals of controlled and compulsive users are often very similar, these different users distinguish themselves mainly by the different social sanctions they abide with. It is therefore important to clearly distinguish the two terms because "the distinction between drug rituals and social sanctions is one of behaviour versus belief, or practice versus dogma" (Zinberg&Harding, 1979). Zinberg and colleagues emphasized that drug, set and setting are not independent influences, but represent an intricate interplay. Therefore, the fit between pharmacology and personality differs between individuals and cultures, and between locations and times.
Zinberg places particular emphasis on social rules and rituals, but other researchers suggest that the effectiveness of social sanctions in controlling drug use is modulated by additional factors such as their availability and the life structure of their users, both of which affect the individual's ability to abide with these social regulation processes (Grund, 1993; Faupel, 1987); Decorte, 2000). Self-regulation furthermore goes beyond limiting the quantities of drugs that one consumes. It also concerns the prevention and control of drug related problems (Grund, 1993). Qualitative results from a recent study of AoD use among nightlife participants in The Hague suggest that party drug users take several precautions and abide with several 'rules' in order to guarantee a good night out without problems. However, individual behavioural measures to reduce the negative consequences of AoD use – sticking to personal limits, regularly drinking non-alcoholic beverages during the night, taking food during the night; taking rests between periods of dancing and using *chill-out* rooms, reported by about 2 in 3 respondents – were much more common than social controls, such as planning and negotiating drug use together in advance or correcting friends who use too much (1 in 4 respondents) (Dekkers et al., 2011).

The availability of drugs does not only affect the extent, but also the nature of substance use, such as the route of administration or the degree of secrecy surrounding it. Scarcer drugs are more often administered by more efficient modes of administration, such as injecting or smoking cocaine, potentially leading to greater health damage. When drugs are scarce or novel, rituals increase in importance and become more rigid, while social sanctions are less well developed and supported. When in the late 1980s ecstasy spread in the club scene of Amsterdam, patrons on the drug switched en masse from alcohol to mineral water. Later on, when clubbers were acquainted with the drug's effects, their beer drinking patterns returned to 'normal' again.

Figure 2 Interactions in the Setting of Psychoactive Drug Use



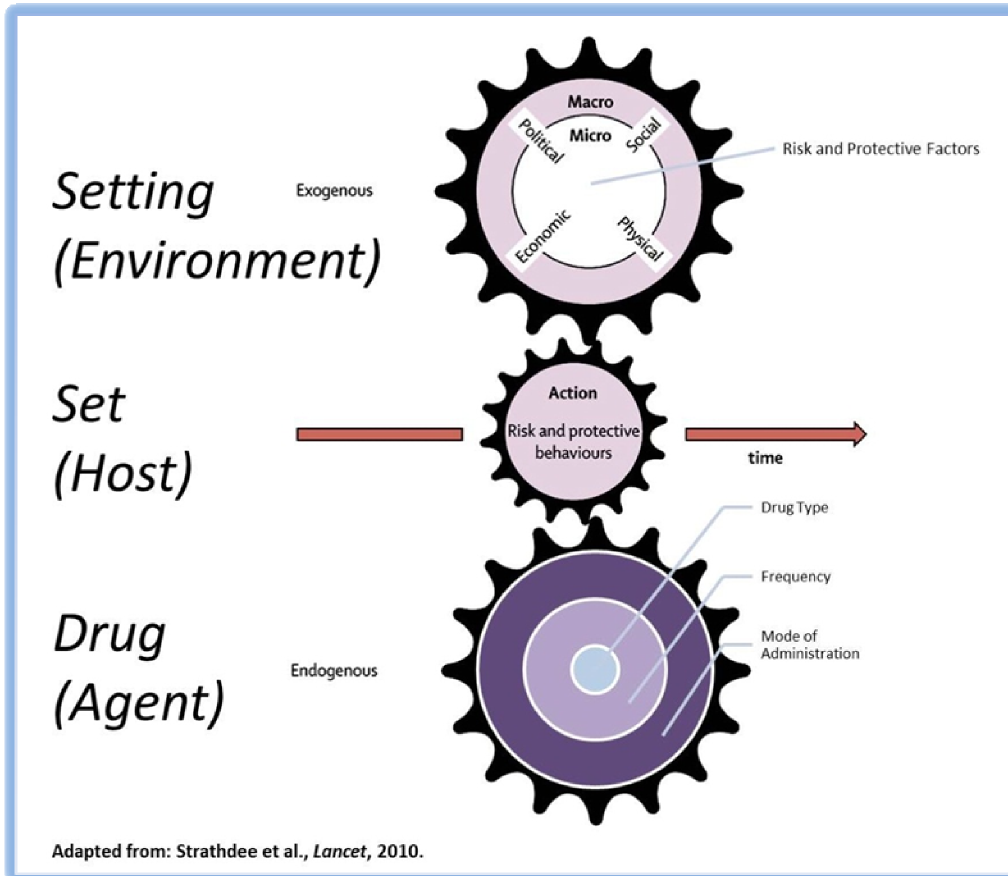
If a substance use is prohibited and anonymity thus important, rituals and rules focus more at the preservation of anonymity and avoiding contacts with law enforcement than on safe use (Grund, 1993). From the perspective of the drug user these concerns then may outweigh health concerns (Connors, 1992). Next to economic considerations, the life structure of people who use drugs and situational factors play a role of significance in upholding rules and rituals, and thus also in the occurrence of drug related problems. Faupel (1987) described successful addict thieves who kept their use under tight control until they made a big sting, making plenty of drugs available, subsequently axing the need for regular (criminal) activities and thus eroding the importance of regularity, rituals and rules. Grund described cocaine dealers house in Rotterdam as "small entrepreneurs with a full agenda, who smoked much cocaine, but seemed to experience few mental health problems." This is in contrast to problematic, often homeless, users on the street, who use much less cocaine, but presented with much more cocaine-associated psychological problems (Grund, 1993). Both authors emphasize the interplay of these environmental variables and Grund suggests that the dynamics between these three clusters of environmental variables (availability/access, rituals and rules, and life structure) largely determines the effectiveness of self-regulation processes (Figure 2) (Faupel, 1987, Grund, 1993).

Key Point 5: The risk environment

The risk environment is a simple heuristic for the examination of the multiple environmental factors that may contribute to health risks (see
Figure 3). According to Rhodes (2009), the risk environment consists of four types of environmental risk factors exogenous to the individual –physical, social, economic and political-- that may exercise their influence on two-levels.

The *micro* risk environment focuses on personal decision making and the influence of common norms and practices, e.g. in networks of drug users. The macro risk environment aims to describe structural factors, such as laws and their implementation, economic conditions and broader cultural beliefs or practices (Rhodes, 2002; Rhodes, 2009). This framework is useful because it is shifts the focus of attention from individuals to the social situations, processes and structures in which people participate and communicate (Rhodes et al, 2009). Eventually, it provides a framework for policy evaluation.

Figure 3The Risk Environment of Psychoactive Drug Use



Conditional causality in a challenging 'living' world

At its core, the risk environment is about complexity and contingent causation (Glass & McAtee, 2006), the phenomenon that in many social and health problems, causation is conditional. The risk environment puts particular emphasis on the interaction between the individual, his or her immediate social environment and the structural determinants of risk behavior and drug-related problems, such as the (drug) economy and (drug) policy. The concept allows for sufficient space for exploration of how structural forces influence the lived experience at local level differently (Duff, 2007) and it prevents that individuals are put away as largely passive and therefore complicit in the structural determinants of social problems and health damage (Fitzgerald ,2009). In other words, we react to and anticipate on our environment and thereby we change it.

From risk environment to enabling environment: lessons for drug policy

A 'risk environment' approach aims to understand the environmental determinants of risk behavior and associated harms and to apply this knowledge towards developing an *enabling environment* for reducing these problems. It seeks to shift the focus of change from the individual to the social situations and structures in which people participate (Rhodes, 2009) and fits in well with calls for a paradigm shift in Public Health from behavioral to ecological change strategies (Susser&Susser, 1996; Diez-Roux, 1998). A risk environment approach thus helps us understand the conditions that make an environment susceptible to drug-related harm, and vulnerable to its effects (Rhodes, 2009).

Finally, such an environmental approach points to the parallels and linkages in how health and vulnerability in general, and drug-related harm in particular, are influenced by context. The risk environment approach therefore emphasizes the importance of *non-drug* and *non-health* interventions to reduce such problems. This shifts the focus of change strategies for drug use or other health problems to broader issues such as self-determination or empowerment and, subsequently, human rights in drug policy. Vulnerability to drug-related harm is closely related to more general inequalities in health, social and material conditions (Rhodes, 2009).
In conclusion, the Drug, Set & Setting perspective fits rather seamlessly with that of the Risk Environment. Where the first approach stresses the interaction between pharmacology, psychology and environment, the latter provides a nuanced framework for interpreting the ecological influences that codetermine patterns of substance use and self-regulation. Both approaches distinguish various types of micro and macro influences that are associated with human drug use, but subject to an environment where multiple biological, psychological and social factors meet and exercise mutual influence (see Section 3).

Section 2: Control and self-regulation – Shifting the perspective in drug services provision

Experts seminar - **2nd session**
Friday , June 21, 9.00 am – 1 pm

Self regulation strategies: from natural settings to drug services
Either abstinent or addict? Either "controlled" or "uncontrolled" users? How the variable drug users' trajectories challenge the "all or nothing" dichotomy
Highlights: congruities/discrepancies between users and professionals perceptions and beliefs

Experts seminar - **3rd session**
Friday, June 21, 3 pm – 6.30 pm
Learning from controls
From help to "powerless" addicts to support for users' skills: corner stones for a proactive model of intervention
Highlights: Models in "informal" and "formal" services: the continuum in control and the expected continuum in models of intervention in the drug facilities system

Key point 1. About the variability of drug users' careers

> *I reached my peak use when I was 25, but it only lasted one year or less*

Following the disease model, many drug professionals assert that once a drug consumer has escalated to intensive, "out of control" patterns of use, he/she is addicted to the drug and the addiction disease cannot but follow a progressive course (the motto: *once an addict, always an addict*). In fact, the main symptom of the disease of addiction is just the (permanent or recurrent) "loss of control" over the use of alcohol and drugs. In the disease model, addiction

stems from both the pharmacological properties of drugs and from the (largely unalterable) bio psychological characteristics of individuals: the result is an "all or nothing" perspective: either abstinence or addiction, either you are a "controlled user" or an "uncontrolled user" (an addict).

Nonetheless, these assumptions do not seem to fit with the experience of drug users, as reported in the large body of research on "controls" over drug use. For example, most users interviewed in a recent study on controls over cocaine use report "varying " careers (i.e. a broad spectrum of drug use careers):

> *I only used occasionally at the beginning, then 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* (Cocaine user, T1F, Turin) (Ronconi, 2010)

> *In the period while I was working, I used cocaine intensively, every Saturday for four or five weeks consecutively, but I slowed down later on. I got back to an intensive use of the drug when I started to attend university, to step down to occasional use soon again* (Cocaine user,T3F, Turin) (Ronconi, 2010).

More recent studies on cocaine consumption in natural settings offer an overview of the prevalent trajectories of use. For example, in a study carried out in Tuscany (Italy) among regular cocaine users, the most reported trajectory was "intermittent" (*Periods of heavy use followed by periods of occasional use*) (31,9%), followed by "up-top-down" (*I escalated until "peak" use then backed off*) (23,4%) and "varying" (*My patterns of use have varied significantly over the time*) (21,3%): on the whole, 76,6% reported a discontinuous drug use career (Bertoletti, Meringolo, 2010). In another study among experienced cocaine users in Antwerp, about half of all users reached a high use level in their period of heaviest cocaine use, but the overwhelming majority did not maintain that high level (Decorte, 2001). Data show that cocaine use may escalate, but it does not escalate indefinitely: the discontinuous careers of cocaine users may be explained by the combination of drug, set and setting variables (see above, p. 4-6).

From diminished control to increased control and vice versa: how to become a controlled cocaine user

The above research findings suggest drug users experience their careers as a dynamic process in continuous evolution. This challenges the dichotomy controlled/uncontrolled use, as well as controlled/uncontrolled users. Rather, drug use patterns fluctuate along a continuum, from diminished control to increased control and vice versa.
One more corner stone of the disease model needs to be argued: as a result of the focus on the harmful/addictive properties of drugs, users are assumed to escalate along a continuum of risks and harms when moving up from experimental to regular use (significantly designated as "chronic use"). This assumption is not supported by the quoted studies. Instead, cocaine users report an increased mastery and control over drug use, due to a process of learning. They learn from their own experience how to maximize "advantages" of drug use, while minimizing "disadvantages" to both their health, their life engagements and significant relationships.

I now know what it is. How 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" (cocaine user, Antwerp) (Decorte, 2001)

I am able to take the appropriate steps, 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 (cocaine user, Tuscany) (Bertoletti, Meringolo, 2010)

Key point 2: Users' self regulation strategies: congruity/discrepancy between users and professionals perceptions

I never use when I have to meet my children

As shown above, most drug users learn control over drug use by setting rules regarding the drug (for example, on the amount they consume, and/or the frequency); the set (for example, using when feeling well); the setting (for example, using with friends, not using at work etc.)

I've never taken coke on my own. It's a social happening. I've sometimes finished a left over, but that's all (Cocaine user, The Netherlands) (EMCDDA, 2012)

I never use when I have to meet my children, I have always behaved like that (Cocaine user L5M, Turin)

I never (use)at work, presently, but I did before. It was not bad at first, I work in a bar, so it was nice, I was talkative, I trotted about but then I got scared, a lot of brooding going on in my head. I stopped with it (Cocaine user T7F, Turin)

I use when I am happy. I need to have a good feeling with myself (Cocaine user, Tuscany)

Everyday "life structure" (Faupel, 1987), which includes the regular activities that structure our lives – work, relationships, other commitments, domestic activities- is another important determinant of control.

I think it's because I have a stable ground to stand on. Additionally, I reflect a lot about myself the whole time, so when it gets too much I back off (Recreational drug user, Sweden) (EMCDDA, 2012)

"Temporary" abstinence is often quoted as one of the most frequent and efficient control strategies. Users may choose abstinence as a conscious step-down strategy, after a period of intensive use, perceived as loss of control; or they simply "drift out" drug use, as cocaine is no longer "attractive" and/or it does not longer "fit in" their lives.
"Temporary abstinence" may lead to a new, often more controlled, phase of drug use; sometimes it may evolve into permanent abstinence: in any case, it is a different path from the commitment to a "long life abstinence" as a "choice of (sober) life", as pursued in treatment programs.

I have been abstinent many times, it is difficult to say the number. Many periods of several months (cocaine user, T3F, Turin)

From seven grams a day to nothing. Last time it happened like that, I got fed up and I quit straight away. I stopped even if I knew my usual dealer had two kilos in stock. But I had enough, it is now two years since and I have never happened to give any thought to it.(Cocaine user, L3F, Turin)

Professionals' perspectives may differ considerably from the perceptions of drug user. Major discrepancies occur:

- on the relevance of setting factors (of life engagements in particular), in modulating drug use. Following the disease model, setting factors are often neglected as all life problems are assumed to stem from drug use: hence the common "rule" *take care of the drug problem before you address any other life issue.*

- on the appreciation of "step down" strategies and "controlled use" as valid and viable goals in treatments. In many professionals' opinion, "controlled use" is a temporary step leading to chronic use unless users go back to abstinence quickly. Stepping down may only be accepted for "chronic" users, who have "failed" several other treatments. In this perspective, controlled use is a "last resort", while abstinence remains the "mission" of services.

Drug services are supposed to protect health, so how can we pursue a collateral mission of "controlled use"?(Drug services professional, Italy)[2]

In our experience, controlled use is just a momentary phase in a developing process either towards abstinence or towards "chronic use" (idem)

The utmost discrepancy seems to occur on "temporary abstinence". Following the disease model, many professionals rather focus on "relapse" than on drug users' capacities to shift to abstinence and stay abstinent for a period of time (sometimes for long periods). Even if they resume with more controlled patterns of use, this is hardly appreciated (due to the well known "all or nothing" perspective). People use drugs (as well as they resume using drugs)for "reasons"[3]. These reasons are seldom investigated by professionals due to the fixation on the addictive properties of drugs: as a result, relapse cannot but be considered as evidence of the "loss of control", that is of the disease of addiction

Key point 3: Drug services in search of clients

They tell us they are strongly unwilling to get into drug services because they do not want to be labeled (as addicts)(a Harm Reduction professional, Florence)

[2] "Nuovi modelli operativi per giovani consumatori invisibili", Training program for innovative models of intervention on drug use, focus group with drug facilities' professionals, Final Report (paper)

[3] For example, "pleasure" is a "reason" for drug use, which is hardly considered in drug interventions. On the other hand, drugs are often used to soften pains from some difficulties in life. These are reasons, even if some of the effects may be negative (Denning P. et al., 2004)

Research shows many cocaine users are able to maintain steady control on their drug use but many other go through periods of perceived diminished control, as seen above. Nonetheless most of them are unwilling to seek help from drug services, for many reasons. First of all, they want to avoid the label of "addicts" and do not accept one of the tenets of the disease model: *admit that help is necessary because you are powerless over drugs*.
Not only this assumption is at odds with these users' perceptions, it is also challenged by research, which shows that many who not define themselves as addicts often stop using in problematic ways (or quit completely) without any outside help[4].

> *Not thinking about themselves as an "addict" undoubtedly contributed to their capacity to control their drug use* (Researcher, UK)

Moreover, 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.

> *Many people report they have been feeling forced to sign a treatment "contract" they did not want to and did not agree with* (a Harm Reduction professional, Italy)

The lack of choice for drug users in the types and goals of interventions appears an important barrier to accessing drug services and also inhibits referrals from "informal" harm reduction interventions to more "formal" treatment programs.

Key point 4: Basics for an innovative model of intervention

> *When we meet people who have gone through periods of abstinence or of more moderate use in the past, we do not focus on their recent "relapse", but we help them to rehearse their self regulation strategies* (a professional from an innovative cocaine treatment centre, Italy)

A shift is needed in enrolling users in the drug system of care. In many drug services, drug users are supposed to get *external help* after they have admitted their helplessness. Instead, they should receive *support* from professionals to enhance their own strategies of self regulation.
A similar shift is expected in therapeutic setting, from the traditional patient/therapist relationship(the latter assumed as the only "expert"); to a "partnership" between user and professional, *the latter being required to acknowledge the former's expertise* and to assist her/him in clarifying his/her *relationship with drugs and in setting the goals of interventions.*
This approach allows to broaden the range of available interventions, introducing "light", short *forms of counselling*; once again, in opposition to another corner stone of the disease paradigm: long term intensive treatments are required, as a result of the assumed severity of the disease of addiction. This leads to rigid models of interventions, not *tailored on users' needs*.

[4]See the quoted studies on controls over drug use. For example, in the Antwerp study, 29,7% of the cocaine users' reported to have quit cocaine (Decorte T., 2000). See also literature on "natural recovery", in particular Waldorf D. et al., 1991.

It is worth noting how the "control" perspective fits with the behavioral model of change (TTM): focusing on the process of change and the entire person instead of simply the diagnostic label, we can broaden our perspective beyond traditional treatment for specific diagnostic categories to prevention, which implies being proactive (in contrast to the reactive nature of treatment): 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) (Di Clemente, 1999). As a result, interventions focused on "controls" are able to "*cross the targets*": even more problematic users, enrolled in long term intensive drug treatments with poor compliance and poor results, may benefit from them.

To summarize: Key messages

a)Users are their own experts
b) Drug use has advantages as well as disadvantages
c) Ambivalence is a normal feeling in the decisional balance between reasons for change and reasons against it
d) Any positive change is the basic goal
e) Take your time is the basic rule
f) Setting the time and the goal of the intervention is up to the user
g) Users are able to make decisions and are responsible for them

Questions to participants:

Questions addressed to seminar participants:
1.Can you identify similar profiles of cocaine users and similar careers of consume among your patients/clients?
2.From your professional experience, can you report one case study about "controlled use" as goal of treatment?
3.Most of the above quoted users are unwilling to seek help from drug services, even in their periods of less controlled use: what is your experience about cocaine users seeking help from services?
4.Looking at the above key messages, do you agree with all of them? If some of them are controversial, can you explain the reasons?
5.Which of the above key messages are applied in the services where you work?

Section 3: Beyond medicalization of drug use: social representations of drug use and developments in drug policies

Experts seminar- ***4th session***
Saturday, June 22, 9.00 am – 11.30 am

Beyond medicalization of drug use
Social representations of drug use and developments in drug policies

Highlights: Harm reduction: from "fourth pillar" to overarching concept in drug policies
Guidelines for innovative models and policies

Key point 1:Another description, another social construction: drug users beyond "pathology and criminalization lens"

Policy has to learn from research in order to abandon the current ineffective and ideological approach.
But from which kind of research? The majority of research projects look at drug use through the so- called "pathological and criminal" lens. What we know about drugs concerns a minority of drug users, ones who have had contact with drug institutions, drug services or prisons. In other words, consumers who have been somehow "institutionalized".

> *There is an incredible amount of information available from all kinds of institutions. Several agencies are involved in tracking drug users, and prosecuting, judging, punishing or treating users of recreational substances. But the data from the formal control system are not complete. The problem is not only that official data are an underestimation of the phenomenon, in terms of prevalence or volume, but more importantly that the part of drug use we can see, is biased, incomplete and not representative of the total phenomenon (which we don't know) (Decorte, 2010)*

The description of 'minority' drug users has become the global one and it is functional to current drug policies, which are based on formal controls, legislative controls in particular: an approach and a response that strengthens and ratifies the description itself, in a sort of vicious circle.
The consequences are hazardous, not only because of risks of stigmatization, criminalization and pathologization of all users, but also because this social construction of drug use is often interiorized by many users themselves, with the result of weakening their opportunities and possibilities of managing and controlling their own use.

> *The more we treat drug problems as if they were the domain of inadequate, sick or helpless people, the more people will present themselves within that framework, and the more we will produce and encounter drug users who fit that description.(Davie, 1992)*

So, innovation in, and reform of current drug policies has to start from a deeper, and less ideological understanding of the phenomenon, and – acknowledging the findings of the extensive body of research on the subject of self-regulation –re-think the basic assumptions of

drug policy, which are fundamentally flawed and not supported by empirical research and adopt an approach which accounts for the complexities involved. A new and different dialogue between policy and research needs to be developed, beyond the dominion of pharmaco-centrism, addiction and the brain disease paradigm and, of course, the criminal approach.

Policy has to learn from users. PWUD have various competencies, strategies and knowledge. What they lack is respect, citizenship and voice. Policy can learn from them, their self-regulation strategies and their social, cultural and informal controls. This learning needs a non -criminalizing and non-pathological approach that recognizes users' voice and citizenship, facilitating dialogue, promoting opportunities and places where this dialogue could happen, within a human, civil and social rights perspective.

Key point 2:Shifting to a policy for a "harm minimizing environment" . Context – the environment – is a critical variable of safe or unsafe drug use.

Following Zinberg's approach, drug use is a matter of drug, set and setting (*see Section 1, page 4-5*)
Drug-related harm, risk and vulnerability are the product of what Rhodes (2009) terms the "Risk Environment" and drug policy is a key "macro risk factor" within this perspective (see section 1). Further macro risk factors are, for example, drug (related) legislation, social constructions and the perception of drug use, health determinants, social and health structures, inequalities in health, social and material conditions. These variables influence the lives of PWUD in various ways. They may synergize into both positive or negative drug related effects or harms, and affect empowerment skills and possibilities and the options for self-regulation of drug use.
Current drug policies contribute to the maximization of drug related harm, only rarely the environment is considered as the starting point for a less punitive, human rights-based approach in drug policy.
Removing the primary environmental drivers of drug related harm due to the context and its variables (e.g. criminalization, stigma), and supporting an enabling environment, which stimulates individual self-regulation strategies and (sub)cultural norms that support safer drug use, would be a priority for a drug policy reform

Key point 3: Futility and dangerousness of the dominion of formal controls

The dominant drug paradigm is built on an "alliance" of the disease model and the criminal approach, which is at the heart of drug legislation in most European countries. This counterproductive alliance has resulted in the "externalization" of the control and regulation of drug use: the control is shifted from those directly engaged and involved (the consumers themselves) and relegated to health and legal systems and penal institutions. This approach has two different consequences.

The first: *poor outcomes.*

Research on informal controls on drug use and self- regulation strategies show in a very clear way that users don't really "make use" of the formal controls for themselves, just to use in safer way, but on the contrary the only lesson learned is how to avoid and limit the negative consequences of formal controls (sometimes even giving up caring, when they are not sure they are able to "control" the results of the relationship with services and professionals).

*I have never said to myself "I don't use 'cause it is illegal"! But I pay attention not to use in dangerous places, in public places, or where the police usually control... (*cocaine user, T2F, Turin)
To be honest, I don't mind the law… it is not a problem for me, I don't say "oh, there is a legal risk, so don't use cocaine..." I need my driving license, of course, and so I never use in my car, and that's all... if I go and buy cocaine I don't use on the road or in a garden, I always go home and there I'm calm...yes I know the law, and I know the penalties, but I'm able to avoid the risks, I'm capable of not being caught out like a fool. (cocaine user, S5M, Turin) (Ronconi, 2010)

The second: Formal controls maximize harm

Formal controls may become drivers of harm (maximizing the harm), because breaking the rules may result in extremely problematic behaviors. Another consequence: formal controls weaken and obstruct the socialization of informal controls, making users think that they are "learned helpless", and weakening their attitude to self control. So, the incapacity of self - regulation becomes a sort of "self-fulfilling prophecy"

Many state drug control systems based on prohibition are focused predominantly on destroying conditions for individual drug use control. Such prohibition regimes assure the continuation of massive marginalization, incarceration, and discrimination of users and suppliers. Communicative structures of drug users are constantly threatened, reducing their efficiency as vehicles of safe use knowledge (Cohen, 1998)

The classical 'addiction-as-disease' model implies the necessity of denying the existence of personality and environmental characteristics that exert sustained control over the use of drugs. This paradigm may stimulate the user's dependence of external control mechanisms. The individual is thus offered a possibility to avoid any responsibility and is supported in the idea that drug use cannot be controlled and thus should be banned or discouraged through punishment and/or treatment (Decorte, 2010)

Such an approach has the consequence of also obstructing the development and communication of informal rules among users, failing to reinforce safer use. Policymakers have to consider that the most important research findings on self-regulation and controlled use demonstrate that the "alliance" between formal and informal controls in promoting a more effective self regulation doesn't work and, on the contrary, produces negative effects.

Key point 4:Shifting to a policy supporting self regulation drug skills

In many respects the European Community is committed to an open society in which an increasingly retreating government emphasizes individual liberties and responsibility, good citizenship and self-regulation in transparent social and economic relationships. In an open society, creating happiness ought not to be a task of the government and its agencies, but to support individuals and their social associations in the prevention and reduction of problems they encounter in the pursuit of happiness. But there are significant barriers between theory and reality, not only in law or public health but also in thinking. While evidence-based decision and self-regulation are making headway in every conceivable policy issue, drug

policy seems much less bound by the rules of rationality. Just as overt expressions of (deviant) sexuality, manipulating one's own consciousness – except perhaps by religion and alcohol – often remains something poorly understood and feared, and is therefore rejected by large sections of society. Important is that the (illegal) status of drugs, and the resources that a society employs to enforce this status, has consequences for the actual drug use experience, the potential for drug related harm, as well as for the ability to exercise control over one's personal drug use.

> *In so far as a state has a role in drug control, it should focus on the prevention of risks. The state can play an important role in fostering user based controls on drug use. A state can do so by letting conditions emerge that allows the user of drugs to maximize his or her considerable powers of control (Cohen, 1998)*

No objective dealing with health and wellbeing of people is attainable without the pro-active empowerment and consent of the people themselves and without recognizing and improving their own competencies and individual resources.
The objective of empowerment of drug users' skills, competencies, cultures and resources should become a "Red Tread" in policy reform. The perspective is shifting from formal control for suppression of drug use to informal social controls for self- regulation. This perspective involves not only the legislative level but also the priorities, missions, objectives and approaches of the drug services system and of the community based welfare systems

Key point 5: Harm reduction, beyond the "fourth pillar"

Harm reduction (HR) strategies and interventions traditionally recognize and improve users' competencies, skills, knowledge and peer communication. HR itself has two birthdays: a formal and institutional one (the famous Merseyside program) and a "bottom up" one (the actions of the users in the Netherlands)
At an institutional level HR has become a mix of services, interventions and actions, often losing its characteristics of a global approach to the drug use phenomenon. This process is consistent with the disease model: harm reduction interventions are often only considered when "regular treatment" has failed. This "ancillary" perspective of HR has facilitated the introduction of HR facilities in the drug addiction services system. Nevertheless, it leads to many shortcomings, the main being the risk of losing the potentiality (and the power) of HR as an overarching concept. Sometimes and somewhere, HR has become a sort of "ancillary partner" of the disease approach. If the "fourth pillar", with its pragmatism and technicality has become part of the drug policy in many European states, not the same has happened for the HR as a global approach, and this means dis-empowering its potential in governing many other aspects (and preventing many other risks) of the drug phenomenon.
It is important to note that HR looks at drug related harms as embedded, progressive and connected to many variables, and this means that harms and risks are not a "destiny" – nor a linear and rising trajectory – but on the contrary a process where there is always the possibility to act by establishing a hierarchy of priorities and aims, beyond the imperative of abstinence (or drugs suppression). There are many example of HR as a global approach, not only in the fields of health or social drug policies: the reduction of harm due to the illegal market; the limitation of the negative impact due to the law and order approach in the communities; the HR community based policies in cities and towns, where it is necessary to build social negotiation processes and opportunities for conflict mediation, and in general it is

necessary to limit the social harm related to drug use in open "drug scenes". In all these contexts, HR becomes a social and global policy, which bases its action on a description of drug users as "social actors" not as a hostile and deviant group.
It is time to go beyond the "tactic" of the "fourth pillar" and try to develop in many concrete ways the "strategy" of HR as a holistic approach.

> *Importantly, harm reduction involves the recognition that the overall reduction of the scale of drug markets and use is not the only, or even the most important, objective of drug policy. Individuals and communities must therefore be provided with information and tools for reducing the risks associated with drug use. A variety of interventions fall into the category of harm reduction. These include the dissemination of information on how to reduce risks associated with drug use (often through peer-led outreach), the provision of services which increase the safety of people who use drugs such as needle and syringe exchange programs and safer injecting facilities, and a range of drug dependence treatment options including the medical provision of substitution for opiate dependence, psychosocial interventions or mutual aid groups. 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 and health services for people who use drugs (IDPC)*

Key point 6:Social and health policies: toward "normalization"?

With regard to social and health policies, the great differences among welfare and drug service systems in European states makes it difficult to generalize. However it is important to note that in many countries there is a strong "specialization" of services and resources dedicated to drug users, and that this hyper-specialization has often the outcome of a further stigmatization of the users-clients. This is also an important reason why many users who would benefit from some counseling or simply some information, actually avoid formal drug services. If it is true that problematic use implies specific answers to specific problems, it is also true that in many cases drugs are not the principal cause of health or social problems, but there are some other causes that drug users share with many other non-drug-user citizens. In health and social policies, it is perhaps necessary to better balance the outcomes of this "specialist approach", this hyper-specialization, in the direction of a "normalization of the welfare system" for drug users, a less selective and less excluding welfare, where access to benefits and services is not based on moral values and criteria.

Questions to participants:

1. How to develop a process towards a more fruitful dialogue between independent research and policy?
2.How to support a more wide and fruitful dialogue between users and policy?
3.Is it time to go beyond the "fourth pillar" towards HR as a global approach? Which priorities and steps?
4. Which link do you see between the topics above and a drug law reform?

To summarize: key questions

1.What would that be a "healthy relationship" with drugs? How to operationalize this concept - or a revised definition – in drug services interventions – prevention, treatment, harm reduction?
2.What are promising drug interventions that could stimulate self-regulation and controlled drug use? How to advocate for and implement such approaches?
3.Given the complex drug use environment, described in this discussion paper, what aspects of public policy should be included into drug policies built around self-regulation and social control, as opposite to legislative control only?

References & Reading suggestions

Bertoletti S., Meringolo P. (2010), Viaggio fra i giovani consumatori invisibili di cocaina, in Zuffa G., cit., pp. 163-190
Cohen P. (1990), *Drugs as a social construct*, Dissertation, University of Amsterdam (www.cedro-uva.org)
Cohen, P., (1998), Shifting the main purpose of drug control: from suppression to regulation of use, http://www.cedro-uva.org/lib/cohen.shifting.pdf
Cohen P., Sas A. (1994). Cocaine use in Amsterdam in non deviant subcultures, in *Addiction Research*, vol.2, n.1, 71-94 www.cedro-uva.org/lib/cohen.**cocaine**.html
Connors, M. M. (1992). Risk perception, risk taking and risk management among intravenous drug users: Implications for AIDS prevention. *Social Science & Medicine*, *34*(6), 591–601. doi:10.1016/0277-9536(92)90187-U
Davie J.B. ,(1992), The myth of addiction. Reading: Harwood Academic Publishers.
Decorte T. (2000).The taming of cocaine. Brussels, VUB University Press.
Decorte T. (2001), Drug users' perceptions of controlled and uncontrolled use, in *International Journal of Drug Policy*, 12, 297-320
Decorte T, (2010), "On becoming a controlled user. Reflections on the pitfalls of a biased drug science, in Zuffa G, 2010, Cocaina. Il consumo controllato, EGA
Dekkers, C., Van Dijk, A., Grund, J-P., Burger, I., Ariëns, G., Hesseling, R., Hendriks, V.M., Van der Meer, C.W., Reinerie, P. (2011). Het Haags Uitgaansonderzoek 2006-2009: het genotmiddelengebruik van uitgaandejongeren in Den Haag. Den Haag: Commissie MORE.
Denning P., Little J., Glickman A. (2004), *Over the influence*, New York/London, The Guilford Press
Diez-Roux, A. V. (2007). Integrating social and biologic factors in health research: Asystems view. *Annals of Epidemiology*, *17*, 569–574.
Di Clemente C. (1999), Prevention and harm reduction for chemical dependency. A process perspective, in Clinical Psychology Review, Vol.19, 4, June, 473-486
Di Clemente, C., Marden Velasquez M. (2002), Motivational interviewing and the stages of change, in Miller W., Rollnick S. (eds) cit.
Duff, C. (2007). Towards a theory of drug use contexts: Space, embodiment and practice. *Addiction Research and Theory*, *15*, 503–519.
EMCDDA (2009), Statistical bulletin 2009
EMCDDA.(2002). Drugs in beeld. Recreatief druggebruik — Eenbelangrijkeuitdagingvoor de EU. Drugs in Focus, briefing 6, Nov-Dec, 2002.

EMCDDA. (2011), Europees Waarnemingscentrumvoor drugs en drugsverslaving. Jaarverslag 2011. Stand van de drugs problematiek in Europa. Lissabon..
EMCDDA (2012), Thematic Papers. Users'voices. Experiences and perceptions of European drug users on controlling their drug consumption
Erickson, P.G., Adlaf E.M., Smart R.G., Murray G.F. (1994), *The steel drug. Cocaine and crack in perspective*, Lexington Books. New York.
Faupel C. (1987), Drug availability, life structure and situational ethics of heroin addicts, *Journal of contemporary ethnography*, 15, 395.
Fiddle S. (1967).Portraits from a Shooting Gallery. New York: Harper and Row.
Fitzgerald, J. (2009). Mapping the experience of drug dealing risk environments: Anethnographic case study. *International Journal of Drug Policy*, *20*, 261–269.
Galbraith, J.K. (1958). The Affluent Society. Boston: Houghton Mifflin Harcourt
IAS (ND, website) 12 Step Testimonials. The Institute for Addiction Study.http://www.12steptestimonials.com/Meetings.htm (Accessed at 22-03-2013)
Grund JP, Kaplan C., De Vries M., Rituals of regulation: controlled and uncontrolled use in natural settings, in Heather N., Wodak A., Nadelmann E., O'Hare Pat (eds) (1993), *Psychoactive drugs and harm reduction: from faith to science*, London, Whurr Publishers;
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/)
Johnston, L.D., O'Malley, P.M., Bachman, J.G., Schulenberg, J.E. (2011). Monitoring the Future.National Results on Adolescent Drug Use. Overview of Key Findings. Ann Arbor: The University of Michigan Institute for Social Research (http://www.monitoringthefuture.org/pubs/monographs/mtf-overview2011.pdf)
Heather N., Miller W.R., Greeley J. (eds) (1991), *Self control and addictive behaviours*, New York, Pergamon
IDPC – International Drug Policy consortium, Harm reduction, http://idpc.net/policy-advocacy/global-advocacy/system-wide-coherence/harm-reduction
IDPC – International Drug Policy consortium (2012), Drug policy guide, http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition
Laar, M. van, &Ooyen-Houben, M. van (Eds.). (2009). Evaluatie van het Nederlandsedrugsbeleid. Utrecht: Trimbos-instituut.
Lewis, M. (2012) Why Addiction is NOT a Brain Disease. Mind the Brain – PLOS Blogs, November 12, 2012 http://blogs.plos.org/mindthebrain/author/mlewis/ (Accessed at 22-03-2013)
Marlatt G.A. (ed) (1998), *Harm Reduction. Pragmatic strategies for managing high risk behaviors*, New York, The Guilford Press
Miller W., Rollnick S. (eds) (2002), *Motivational Interviewing. Preparing people for change*, New York, The Guilford Press
Nabben T., Benschop A. &Korf D.J. (2012). Antenne 2011.Trends in alcohol, tabaken drugs bijjonge Amsterdammers. Amsterdam: Rozenberg Publishers.
Ouwehand, A.W., Wisselink, D.J., Kuijpers, W.G.T., van Delden, E.B., Mol, A. (2011). KerncijfersVerslavingszorg 2010. Landelijk Alcohol En Drugs Informatie Systeem. Houten: Stichting IVZ
Prins, E. H. (1995). Maturing Out: An empirical study of personal histories and processes in hard-drug addiction. Retrieved from http://repub.eur.nl/res/pub/21449/

Rhodes, T. (2002), 'The `risk environment': a framework for understanding and reducing drug-related harm', *International Journal of Drug Policy* 13(2), pp. 85-94.
Rhodes, T. (2009), 'Risk environments and drug harms: A social science for harm reduction approach', *International Journal of Drug Policy* 20(3), pp. 193-201.
Robins, L. N. (1993). The sixth Thomas James Okey Memorial Lecture. Vietnam veterans' rapid recovery from heroin addiction: a fluke or normal expectation? *Addiction (Abingdon, England)*, *88*(8), 1041–54. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/8401158
Robins, L. N., Helzer, J. E., & Davis, D. H. (1975). Narcotic use in southeast Asia and afterward. An interview study of 898 Vietnam returnees. *Archives of general psychiatry*, *32*(8), 955–61. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/1156114
Ronconi S. (2010), Non solo molecole, in Zuffa G. (a cura di), cit., pp. 111-159
Ronconi S. (2011), *La percezione dei consumatori di cocaina circa l'uso "controllato" e "incontrollato". Una ricerca qualitativa a Torino*, Rapporto, I dossier di Fuoriluogo (www.fuoriluogo.it)
Sifaneck S. (1995). Keeping off, stepping on, and stepping off: The stepping-stone theory reevaluated in the context of the Dutch cannabis experience. *Contemporary Drug Problems, 22*.483-512.
Susser, M., &Susser, E. (1996). Choosing a future for epidemiology: From black boxto Chinese boxes and eco-epidemiology. *American Journal of Public Health*, *86*,674–677.
Tatarsky A. (2002), *Harm Reduction Psychotherapy*, Lanham, Rowman &Littlefield Publishers
Tucker J.A., Pukish King M. (1999), "Resolving alcohol and drug problems: influences on addictive behavior change and help seeking processes", in Tucker J.A., Donovan D.M., Marlatt G.A. (eds), *Changing Addictive Behavior*, New York London, The Guilford Press,
Waldorf D. et al., (1991), *Cocaine changes. The experience of using and quitting*, Philadelphia, Temple University Press
Winick, C. (1962), Maturing out of narcotic addiction, U.S. Bulletin on Narcotics, 14, 1-17
Winick, C. (1964), The life cycle of the narcotic addict and addiction, U.S. Bulletin on Narcotics, 16
Zinberg N.E., Harding W.M. (1979), "Control and Intoxicant Use: a Theoretical and Practical Overview. Introduction", in *Journal of Drug Issues*, 9, 121-143
Zinberg, N. (1984), *Drug, set and setting*, New Haven and London, Yale University Press.
Zuffa G. (a cura di) (2010), *Cocaina, il consumo controllato*, Torino, Edizioni Gruppo Abele