Cocaine and stimulants, the challenge of self-regulation in a harm reduction perspective

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ABSTRACT

A significant body of research on cocaine users recruited outside the "captive" populations (i.e. studies from 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. The reason of most "controlled" use lies in a wide set of self-regulation "rules" users "naturally" apply to keep drug use at bay and prevent the disruption of everyday life. Not only is this perspective at odds with the "pathological" perspective of professionals, focused as this is on "addiction" originated from the chemical properties of drugs and individual psychological deficit; it also challenges the social representation of drugs as intrinsically "out of control" substances and of drug users' helplessness under the influence of drugs.

The paper describes the workstream Innovative cocaine and poly-drug abuse prevention programme, developed in 2013 by the Italian NGO Forum Droghe within the European project New Approaches in Drug Policy &Interventions (NADPI), aimed at linking findings from research on "controls" to operational models in drug addiction services.

Through a critical overview of the disease model and taking cues from users' self regulation strategies, a new "self regulation" operational model has been developed, focused on users' control abilities; and on social context and setting of use, following the drug/set/setting paradigm.

The self regulation model may be seen as a development of the Harm Reduction approach to drug policies, aimed at decreasing the negative consequences of drug use without necessarily reducing the consumption of drugs.

Key words: Drug related Harm Reduction, Controlled /uncontrolled use of illicit drugs, Users ' self regu-lation strategies, Trajectories of drug use, Settings of drug use

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DOI: ***10.2427/11175***

INTRODUCTION

The "Innovative cocaine and polydrug abuse prevention programme" was carried out in 2013 within the project *New Approaches in Drug Policy &Interventions* (NADPI)[1] (with the financial support of the *Drug Prevention and Information Programme of the European*

[1] NADPI project: applicant TransNational Institute (TNI) NL, partners: International Drug Policy Consortium (IDPC) UK, De Diogenis Association, Greece, Forum Droghe, Italy

Union and the Ngo La Società della Ragione). It has been developed with the aim of linking findings from research in "natural settings" from community based samples of cocaine users to models of intervention in drug services, in an effort to innovate the offer of programmes.

A significant body of research on cocaine users recruited outside the captive populations (i.e. studies from 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 large variety of patterns and trajectories of use other than "addictive" use. The reason of most "controlled" use lies in a wide set of self-regulation "rules" users "naturally" apply to keep drug use at bay and prevent the disruption of everyday life. Not only is this perspective at odds with the "pathological" perspective of most professionals, focused as this is on "addiction" originated from the chemical properties of drugs and individual deficits; it also challenges the social representation of drugs as intrinsically "out of control" substances and of drug users' helplessness under the influence of drugs.

In 2010 -2011, after carrying out a research on "controlled/uncontrolled" use of cocaine among Tuscan users in natural settings, Forum Droghe has been developing a project to link findings on "controls" to operational models in drug services, shifting the focus from users' powerlessness (under the influence of drugs) to their self regulating abilities in regard to the influence of drugs. In 2013, this process has been widened at the European level, through the quoted NADPI project.

Through a critical overview of the disease model of addiction and taking cues from users' control strategies, a new "self regulation" operational model has been developed. Not only is the new model in accordance with findings from studies on controls, it is also in line with the proactive approach, widely implemented in the whole health care system. Another innovation of the self regulation model stems from a reconsideration of the drug/set/setting paradigm of drug use, posing a major emphasis on setting and social context, as fundamental variables to explain the variety of patterns of drug use and of pathways of resolutions.

The self–regulation model is embedded in Harm Reduction, while taking some of its cornerstones in new directions. It can innovate drug services as well as drug policies, shifting the main purpose away from elimination to "regulation" of drug use, with the aim at fostering users' informal controls while reducing the harms of punitive legislations and policies.

LINKING REASERCH, THEORY AND MODELS OF INTERVENTION IN DRUG SERVICES

The impetus for our work has come from dissatisfaction both with most research in the field of drugs and with (most) models of intervention in drug services.

As for research, the reasons for disagreement have been widely illustrated by Tom Decorte: because the illegal status of substances makes it difficult to create community based samples, most studies rely on data from the so called "captive populations", i.e. people recruited trough the drug control system (justice or prison institutions, drug addiction services). But this particular group is not representative of the majority of socially integrated drug users and offers a biased picture of drug use in terms of patterns of use and problems related to drug use: in short, a "worst case scenario" of patterns of drug use and their evolution over time. More important, science itself has focused disproportionately on these captive samples, so as to contribute to this worst scenario representation of illegal drugs use. Under the influence of the dominant societal "moral" attitudes towards drug use, "the scientific gaze has especially focused on the *risky aspects* of being high, and more specifically on the medical risks of intemperance and excess, on the psychological risks of escaping reality". As a result of the exclusive concentration on risks of drugs, the moral/medical concept and theory of addiction have been developed [1].

The disease model of addiction can be considered as the "worst scenario" theoretical approach to drug use. Not only is all drug use interpreted with an eye to its negative evolution to addiction; addiction itself is seen as a primary serious disease with scarce if any chances of recovery. According to the National Institute on Drug Abuse, addiction is a "chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences". In most

drug addiction services, operational models are based on the disease model and on the notions that "drugs are addictive" and addiction is a largely irreversible brain disease (once an addict, always an addict).

Clearly, if the addiction concept stems from a biased science and lacks in rigor, any treatment approach will suffer from the same. The shortcomings of the operational models in drug services are evident: not only does the disease model seem a poor fit with the experiences of the majority of drug users who do not escalate to addiction; also, it fails to explain the spontaneous recovery from drug addiction without treatment, as it will be later examined [2-4]. More important, people diagnosed as addicts and enrolled in treatment are made more powerless to manage their life than other clients of medical treatment. "Addiction medicine will often take over and decide about what intervention to make, stemming from a vision on addiction that makes the concerned person *incapable of self management*" [5].

In considering the link between research, theory and operational models, we have looked at a different kind of research, at innovative studies in "natural settings" on "non captive" populations, aimed at realizing users' world as they see it. From users' point of view, the concept of "control" is crucial and keeping drug use under control appears as one of their fundamental concerns, in order to avoid disruption of everyday life engagements [6-7]. We have focused on cocaine use, as this substance has become more popular among young adults in recent years, while the offer of programmes in drug services seems particularly unfit to cocaine users. Though the number of clients entering treatment for cocaine abuse has increased until 2008/9, a decline is shown in following years: this trend is common to all higher prevalence countries in Europe [8]. Though studies on controls have been led on many different drugs [9-11], research on cocaine use has been particularly developed, with important follow up studies [12-15]. In 2008/9, a qualitative study was carried out in Italy (Tuscany) on 115 "experienced" cocaine users: this is the first study on controls ever led in Italy.

What is users' perception of controlled/uncontrolled use? How do certain users achieve control over their cocaine use? How are they able/unable to maintain it along the time?

Are they able to step back to more moderate patterns of use after a period (or more periods) of more intensive/less controlled/addictive use?

Answering these questions is important not only for theoretical purposes, but also for more effective and theoretically grounded operational models in drug services. As Norman Zinberg points out at the beginning of his fundamental work, which laid the foundations of the social learning paradigm of drug use: "Only after a long period of clinical investigation, historical study, and cogitation did I realize that in order to understand how and why certain users had lost control I would have to tackle the all-important question of how and why many others had managed to achieve control and maintain it".

CHALLENGING THE DISEASE MODEL OF ADDICTION

The main feature of the disease model is the "pharmacocentric" focus on addictive properties of drugs: addiction stems from the chemistry of drugs and from individual deficits, i.e. individual *risk factors to develop the disease*. In the most recent version of the disease model, the bio-psycho-social model of addiction, also social risk factors are quoted, though they are seldom taken into account in the operational models of drug services. Anyway, the biological factor- i.e. the chemical properties of drugs – remain as the main agent of addiction. As we can see, the bio-psycho-social model of drug addiction is quite similar to the second disease concept for alcohol and alcoholism, which pointed the finger at those individuals who become alcoholic in addition to the chemical properties of the substance [16]. Addiction, as well as alcoholism, is characterized by permanent "loss of control" over the substance. As a result, once a drug consumer has escalated to an intensive, "uncontrolled" pattern of use, he/she is assumed to be addicted to the drug and the disease cannot but follow a progressive course (the motto: once an addict, always an addict). Drug addicts, as well as alcoholics, are assumed to be unable to step back to moderate, controlled patterns of use. The consequence is an "all or nothing" perspective: either abstinence or addiction, either you are a "controlled user" or an "uncontrolled user" (an

addict). In other words, "control" is supposed to be an individual property, in relationship to (largely immutable) individual characteristics.

Such dichotomous approach, which tends to divide individuals between controlled users (permanently able to apply a certain control) and uncontrolled/addicted users (permanently unable to apply control), is not confirmed by studies in natural settings. On the contrary, a large *variability of drug use patterns* is shown in the careers of most cocaine users. For example, in the cited study carried out in Tuscany (Italy) among regular cocaine users, the most reported trajectory was "Periods of *heavy use* interchanged with periods of occasional use" (31,9%), followed by the "up-top-down" trajectory - I escalated until I reached a "peak", then I have stepped down- (23,4%) and "My patterns of use have varied significantly over the time" (21,3%): on the whole, 76,6% reported an irregular, oscillating drug use career [17]. In a study among experienced cocaine users in Antwerp, 50.5% reported a "varying" trajectory, while 26.1% the "up-top-down" [18]. The unfavourable expectations about moderation outcomes among heavy/addicted users are also challenged by a large body of other studies – in particular large sample surveys of alcohol and drug use- showing that "natural resolutions" – i.e. resolutions without treatment - are far more frequent than commonly believed [19-20]. For example, for alcohol, Stanton Peele has recently examined data from US National Epidemiological Alcohol Survey concerning outcomes of 4422 alcoholics tracked for a year. Only 1205 of them were treated. The majority of both treated and untreated dependent alcohol users has been reported "in remission".

It is worth noting that the definition "in remission" included two possible outcomes: "abstinent" or "drinking without dependence". The rate of people "in remission" was even higher for untreated drinkers (76% versus 71%), though the rate of "abstinence" was higher for treated people. But even among treated people, the prevalent outcome was "drinking without dependence". As the author sarcastically argues: "Considering both the treated and untreated populations, the typical outcome of alcoholism in the United States is to improve while continuing to drink. The good news is that majority of alcoholic Americans ignore the disease theory's prescription of abstinence, and they gain benefits from doing so" [21].

The disease model's unfavourable expectations about users' abilities to step back are mirrored in the negative outcome for "regular" users' evolution in drug use: an escalation in risks to become addicted is assumed from experimental to regular use (significantly designated as "chronic use"), as a result of the main focus on the harmful/addictive properties of drugs. On the contrary, studies on controls (over cocaine, but also other drugs) show a tendency towards "moderation" and progressive lower levels of use [22]. For example, in the quoted Tuscan study, nearly half participants (47,8%) reported a daily cocaine use during their "peak" period of most intensive use, while only 0,9% (1 participant) was having a daily use during the last six months. On the whole, the large majority of participants (62.6%) was using occasionally at the time of the interview (during the last six months) [23].

HOW TO BECOME A "CONTROLLED" USER

Why drug use "careers" are so variable? Why do the majority of alcohol and drug users not develop into compulsive users? And, even when they do, how are they able to step back to more moderate patterns of use? Finally, why this evidence is ignored by most drug professionals, under the influence of the disease model of addiction?

The environmental factors - such as life events, changes in relationships, life commitments, life styles- give account for the *variability* of drug use, together with a large range of *controls* (self imposed rules) drug users apply to accommodate drug use within a much wider field of life engagements". Most drug users apply 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, using in the weekends only: not using at work etc.). The process of *learning from one's own experience* is evident in the very words of some interviewed cocaine users:

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 (cocaine user, Antwerp) [24].

I am able to take the appropriate steps, I have a more conscious use, which simply comes from experience as for all things..it works like that..you learn the tools for control (cocaine user, Tuscany) [25].

Again, the ability to "stick to" the self imposed rules so as to "self regulate" drug use is in relationship to environmental factors: among them, a solid everyday "life structure" which includes the regular activities that structure everybody's life – work, significant relationships, various commitments, domestic activities – is a crucial determinant of control [26].

One of the reasons why drug professionals have so much difficulty in assuming the control perspective lies in the fact that the disease model largely ignores the role of setting and the environmental factors, the very variables that give reason for the dynamic course of patterns of use. In fact, setting is "the forgotten factor", as Norman Zinberg wrote. He also identified the reasons for this theoretical flaw in the influence of moral attitudes over the pathological expectations: "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 (neglecting that) intoxicant use *tends to vary* with one's time of life, status and even geographical location" [27].

DISCREPANCIES BETWEEN USERS AND PROFESSIONALS PERSPECTIVES

The cited studies on controls over cocaine reveal that users are able to apply a multiplicity of self imposed rules and strategies to prevent that drug use takes priority over other life activities and engagements. When drug use risks to interfere with the complex structuring of daily life engagements, drug use is usually changed, moderated and suspended.

"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 a long-period or permanent abstinence: in any case, it is a different path from the commitment to a "long life abstinence" as a "choice of sobriety", pursued by drug professionals.

Drug Professionals' perspectives may differ consistently from drug users perceptions and strategies. In the Working Paper "Innovative cocaine and polydrug abuse prevention programme" (2013), major discrepancies were identified in:

- The irrelevance of setting factors (life structure and life problems other than drugs), in planning interventions. Life problems are often neglected by drug professionals because all problems are assumed to stem from drug use. Hence the "rule" in most drug services: "take care of the drug problem first".

- The (lack of) appreciation of users' "step down" strategies and the consequent reluctance to establish "controlled use" as a valid and viable goal in treatments. In many professionals' opinion, "controlled use" is a temporary step leading to chronic use unless users go back to abstinence. Step down may only be tolerated for "chronic" users, who have "failed" several treatments. In this perspective, controlled use is a "last resort", while abstinence remains the mission of services. The utmost discrepancy seems to occur on "temporary abstinence": many professionals rather focus on "relapse" than on drug users' capacities to shift to abstinence and to stay abstinent for a period of time (sometimes for long periods).

- The assumed users' powerlessness over their drug use leading to one of the tenets of the disease model: *admit that professional help is necessary to recovery*. Not only is this assumption in contrast with the perception of most drug users; it is also in opposition to widely agreed and evidence based therapeutic principles aimed at increasing clients' self esteem and their

sense of their own effectiveness, rather than emphasizing their helplessness. The presumed users' powerlessness has an impact on the professionals/users relationship: while the opinion of patients in setting the goals of treatment is increasingly accepted in medical care for many health problems, drug services clients have usually no role in choosing the therapeutic programs and in establishing the goals of interventions [28].

FOLLOWING THE PROACTIVE APPROACH: FROM HELP TO SUPPORT

Developing an alternative to the disease model has many advantages. First and foremost, it allows 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. But also more problematic users, already enrolled in treatment but with poor results and poor compliance, may benefit from a different approach.

Research on controls as well as the most innovative approaches in Health care - such as the Health Promotion Model underlying the self management programs – suggest the main features of the new operational model: the focus on users' control abilities, shifting from help to powerless addicts to support to clients' competencies; the new prominence of environmental factors, social context and setting of use.

The operating guidelines, elaborated in the workstream "Innovative cocaine and poly drug abuse prevention programme", offer a detailed blueprint to the self regulation model [29]. Innovation involves *a larger offer of programs and a wider target*: implementing short term, non intensive interventions, consistently with the more positive perspective on drug use evolution over time and widening the target to clients in any point of the continuum of control; the *goals*, pursuing "any positive change" in drug use (such as "controlled use" and periodical abstinence) but also in users' entire life experience; a "balanced" *client/professional relationship*, so as to build a partnership between professionals and users by recognizing reciprocal competencies and expertise.

Supporting users' self regulation strategies is consistent with the *proactive* approach, in alternative to the *reactive* nature of treatment for specific diagnostic categories in the disease model: interventions may occur in many steps and life circumstances, with a wide range of different goals, in accordance with the concept of change as a long term and "step by step" process [30].

HARM REDUCTION AND THE SELF REGULATION MODEL

The self regulation model may be seen as a development of the Harm Reduction approach to drug policies, aimed at decreasing the negative consequences of drug use without necessarily reducing the consumption of drugs. It means a shift from policies aimed at eliminating both drug offer and drug demand, to regulation policies, focusing on set and setting variables to limit risks. The self regulation model is consistent with the *bottom up* approach of Harm Reduction, emphasizing drug users competencies in controlling drug use and reducing risks, while creating the environmental conditions to maximize users' control abilities and minimize the negative environmental conditions and influences [31].

Studies on controls show that drug users have various competencies and innovative drug policies should foster user-based controls on drug use. Instead, many drug control systems are focused on destroying the environmental conditions for individual drug use control. This happens through punitive legislations, incarceration, marginalization. But also the social image of users as "helpless addicts", as fostered by the disease model of addiction and entrenched in conventional wisdom, contributes to disempower drug users. Enabling drug users' skills and competencies; implementing broad social policies aiming at helping users to hook into opportunities for conventional lives; supporting communicative structures among users; promoting cultures of safer use: all this is key to re-launching Harm Reduction as the innovative approach in drug policies.

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