

Innovative cocaine and poly drug abuse prevention programme
Experts' seminar Report

Florence, Italy, 20th to 22nd June 2013

Executive summary

The experts seminar “Innovative cocaine and poly drug abuse prevention programme”, organized by the Italian NGO Forum Droghe, took place in Florence, gathering over 30 people, mainly drug addiction professionals (clinicians or working in harm reduction programs); academics, researchers, NGO representatives. The seminar was introduced by a public presentation of the project (on June 20th morning), addressed to local and regional policy makers, Italian press and drug professionals from the whole region, in addition to foreign and Italian participants to the seminar. The seminar was divided into four sessions. The general aim was to identify the main features of an innovative model of intervention, gathering suggestions from research on “controls” over drug use. A working paper, previously sent to participants to specify the topics of the seminar, was assumed as a guide to the discussion. The working paper is integral part of this report.

During the first session, research on “control” over drug use was introduced as well as the underlying social learning paradigm of drug use explanation, focused on drug, set, setting factors. Studies on controls over cocaine use were examined. This kind of studies also exists for different drugs and the control perspective may be adopted for any drug, either legal or illegal. For this reason, the discussion was not limited to controls over cocaine and stimulants, though focused on them.

The peculiarities of research on “controls” were shown. In opposition to most studies, carried out among problem users in treatment, research on controls aims to gaining more insight into patterns of cocaine use in “natural” settings, among groups normally not associated with problematic drug consumption and not enrolled in drug addiction services. As a result, this kind of research avoids the “worst case” scenario of most intensive drug use (and the consequent medical emphasis on “risks” and “harms” of drug use). Research in natural settings suggests that the “escalation” career is relatively rare, while the most common trajectory of use is *variable*, with a trend towards moderation. Investigating users’ point of view and perception of controlled/uncontrolled use allows to identify “controls” as self imposed behaviours or rules that regulate the locations and the occasions of drug use, the suitable companions, the timing, the amount of substance, etc. These social controls and self regulation strategies represent the set and setting factors, that are able to explain the variability in drug use patterns and trajectories beyond the (immutable) pharmacological factor (drug) and its “addictive” properties. The drug, set, setting paradigm was analysed in opposition to the disease model, focused on chemical “addictive” properties of drugs. The disease (pharmacocentric) model is still dominant, in research as well as in drug addiction services practices.

The second session focused on how findings from research on controls fit with present practices in drug addiction services led by the disease model; and in particular, how self

regulation strategies are presently considered/ignored/ challenged by professionals in drug addiction services. Significant differences were identified between users and drug addiction services perspectives, such as *the different view on drug use careers*. In the disease model a dichotomy is assumed in patterns of drug use and in typologies of drug users: either abstinent or addict; either controlled or uncontrolled use; either controlled users or uncontrolled users. In this perspective, “uncontrolled” users are believed to be (permanently) *unable* to step down from intensive to more moderate patterns of use and to maintain them over time, owing to their personal (biological/psychological) deficits. On the contrary, research in natural settings shows a *continuum* in drug use patterns and trajectories.

Moreover, in the disease model the escalation trajectory is considered highly probable, owing to the addictive properties of drugs, while research on controls shows a general trend towards more moderate patterns of use. The trend towards moderation can be explained through a learning process: from social context and from their own experience, users learn control over drug use by setting rules regarding the drug (the amount and/or the frequency of use); the set (for example: using when feeling well, not using when in a bad mood); the setting (for example: using with friends, not using when working).

Main differences between the traditional model of intervention led by the disease paradigm and an innovative “self regulation” model (led by the “control” perspective over drug use) were outlined. They refer to *areas of change*: while the former focuses on drug use, the latter keeps broader fields in sight, concerning set and setting; *to choice of goals* of interventions in the drug area: the former focuses on abstinence only, while the latter includes stepping down; *to role of services and resolution pathways*: the former ignores natural recovery and assumes treatment as the only pathway to resolution, while the latter takes suggestions from natural recovery and “natural” self regulation abilities; *to users/professionals relationship*: in the former, users are expected to admit their powerlessness over drug use, while in the latter professionals are supposed to support users’ expectancies and beliefs in self control over drug use.

The users/professionals relationship was also examined in clinical settings. “Clinicians cannot decide in place of patients” is a consolidated tenet in clinical activity. Nevertheless, this principle is largely neglected in the field of drug use.

The traditional view of addicts’ loss of control and powerlessness over drugs was criticised in the light of the most innovative psychological Health models. Even in medicine, for patients affected by serious organic diseases, a positive approach is widely adopted. *Prevention*, focused on avoiding risks related to unsuitable behaviours (developed within the medical model) is being replaced by a *proactive* approach, focused on choice (of goals and behaviours), on process (step by step), on promoting “positive identities”. Patients’ abilities and expertise in self-management are emphasized. Nevertheless, self-management still appears as an awkward concept in the field of drugs, and it is only accepted when finalized to abstinence.

Once again, the shift to innovative approaches is a challenge in the field of drug use, for the lasting influence of both the disease and the moral models.

As a consequence, a wider perspective into health models and psychosocial constructs is essential, to get rid of the moralistic perspective on drugs. A blueprint for an innovative operational model was drafted at the end of the second session.

The third session dealt with the control perspective and its impact on drug policies, harm reduction policies in particular.

Prohibition stems from the traditional social representation of “powerless” users “under the influence” of harmful addictive properties of drugs. Users are assumed not to be able to “tame” drugs through social/informal controls. As a result, legal controls remain the only chance to keep drugs at bay. On the contrary, research on controlled use, as discussed in the first session, shows informal/social controls do exist both for legal and illegal drugs: informal controls (rituals and social prescriptions) shape cultures of “safer use”, that sustain individuals in developing control over (the risky chemical properties of) drugs. But legal controls (i.e. prohibitionist legislations aimed at eliminating drug availability and drug use) do not allow rules of safer use to circulate widely into the mainstream culture. Moreover, most legal systems work *to destroy* conditions for individual drug use control (through the risks of illegal markets, the threat of criminal prosecution, marginalization and discrimination).

Shifting to a different social representation of users as capable to be “over the influence” (of drugs) may have a relevant impact on drug policies. Harm reduction, as an *alternative* to the traditional paradigm focused on *elimination* of drug availability and drug use, may be the policy framework where the control perspective can find its proper place. To this purpose, Harm Reduction is to be seen as a comprehensive drug policy approach aimed at sustaining cultures of safer controlled use, to support individuals in developing their own self regulation mechanisms: an innovative paradigm *in place of* both the moral and the disease paradigms. Harm Reduction has since been considered as a pragmatic set of interventions for users “unwilling or unable to achieve abstinence”: a sort of “ancillary” drug policy pillar, to be implemented *in addition* to the other traditional pillars (law enforcement, prevention, treatment). In other words, Harm Reduction has been developed *within* the disease model, not as an *alternative* to it. Such is the case for Methadone Maintenance programs, developed in the fatalistic view of addiction as a “long term chronic relapsing illness”. Even more significant is the case for decriminalisation of drug use, based on providing “therapy in place of punishment”, from the assumption “users are not criminals but ill people”. Decriminalisation and Harm Reduction have worked hand in hand, and Harm Reduction has facilitated the shift from the “crime” to the “illness” paradigm. The pitfalls of the disease model in the field of drug policies were thoroughly examined.

1st session

“Research and users’ voices. On the concept of control”

From studies on informal controls: patterns, trajectories of cocaine use, consumers’ self regulation strategies

(Input by Tom Decorte and Jean Paul Grund)

Scientific knowledge and “drug rhetoric”

Before showing the main findings from studies on users’ perception of controlled/uncontrolled cocaine use, preliminary questions were examined regarding scientific knowledge and professionals’ expertise on drug use. The illegal status of substances brings outstanding consequences on research. Drug use is a “hidden knowledge”: neither users have interest in providing accurate information, nor experts in analysing the taboo of drug experience (owing to the scientific fear of “high”). As a result, most research originates from “captive samples”, i.e. from very problematic users enrolled in drug addiction treatment and/or from users referred to drug services in place of punishment. The experts “tunnel view”

on a minority (and on a limited type) of drug users leads to a limited conceptualization of drug use: the focus of most research is on chemical properties of drugs, deterministically identified as explanatory of the drug addiction phenomenon. In such a “pharmacocentric” perspective, drug addiction is viewed as a chronic brain disease, which cannot be cured but only life long treated through life long abstinence (it is worth noticing the analogy between the modern brain research and the theory of alcoholism, inaugurated at the beginning of XX century). The pharmacocentric disease model is deeply connected with the social representation of “evil” illegal drugs: as such, it lies at the heart of the “drug rhetoric”. To counterbalance drug rhetoric, a different kind of research has to be developed: more qualitative studies are needed, adopting users’ perspectives on drug use.

Beyond the disease model: focus on environmental factors

Other significant features of the disease model were examined, in opposition to the control perspective. Among them, the biomedical focus on *risks* of substance use, while, in an insider perspective, *advantages*, as well as disadvantages, are crucial to understand the drug experience. In fact, the complex balance of advantages and disadvantages gives account for the function of drug use within the wider context of user’s life.

Pharmacocentrism was first criticized by Norman Zinberg (1979, 1984): in suggesting a new paradigm, based on multiple interacting factors (drug, set, setting), Zinberg recognized setting as the “forgotten” factor. In Zinberg’s view, setting includes rituals and “social sanctions” on drug use: social controls give reason for the overwhelming majority of users that are able to keep their drug use under control. The effectiveness of social sanctions in controlling drug use is modulated by additional factors such as availability of drugs and “life structure” of users: both these variables affect individual’s ability to comply with social controls and social regulation processes (Grund, 1993). Social controls, in their interaction with drug availability and “life structure” are the main variables influencing individual self-regulation. Multiple environmental factors influencing the efficacy of self regulation are taken into account in the “risk environment” framework (Rhodes, 2002, 2009; see in detail: working paper, pp.8,9). This framework conveniently shifts *the focus from individuals to social situations*, processes and structures in which people participate and communicate. This is a crucial point of difference from the disease model, both in the first version (i.e. I disease model, focused on properties of substances), and in the second version (i.e. II disease model, focused on *individual biological/psychological at risk -to develop addiction- characteristics*). The relevance of setting and social context have important consequences for an innovative model of intervention.

Main findings from cocaine research

Highlights from cocaine studies were shown¹. Among the main findings: 1) informal drug control mechanisms, as reported by users, involve multiple areas and circumstances, such as: the setting and situations of use, the activities that should take priority, the persons (not) to use with, the maximum number of times one should use cocaine in a given time period,

¹In particular: Decorte (1996-97), *The taming of cocaine* (ethnographic study in Antwerp nightlife among 111 experienced cocaine users), Decorte (2002-2004), *The taming of cocaine II* (first follow up), Decorte (2008-2009), *The taming of cocaine III* (second follow up).

relationships with non users, frequency of use, appropriate feelings when using, suitable and unsuitable combinations of cocaine with other drugs, route of ingestion, appropriate dose, how to manage financial consequences of cocaine use, how to avoid police attention 2) Cocaine use shifts from one level to another through time, both upward and downward, but *medium and high levels of use do not last*: for example, in the 2008-2009 follow up study in Antwerp, 26, 8% reported no cocaine use in the last five years, 55, 4% did not use the last three months, 19,6% uses cocaine at least once a month, none of the respondents report daily use. In opposition to the disease model, *in the long term prevalent trajectories run downward*. 3) Drug use careers are dynamic and patterns of use vary with role transitions and with changes in life circumstances and life engagements. The dynamical aspect of careers is in relationship with the (changing) function of drug use within the variable context of life experiences. 4) Users' control develops from an on going process of learning from experience, similar to learning processes for any other human activity. It is a "trial and error" process: again, the nature of process gives reason for the variability of patterns and careers. 5) As a result of a learning process, control over drugs largely depends on developing knowledge on drugs. But formal drug policy (prohibition) works against this kind of knowledge. This leads to a "generational forgetting" of safer use rules: a gap in intergenerational communications, which increases the environmental risks. The relationship between formal and informal controls was introduced and later discussed. 6) "Stepping down" and "temporary abstinence" appear as "natural" strategies aiming to achieve control after periods of diminished control. This topic was largely investigated in the second session in relationship, when discussing the choice of goals of interventions. 7) Control is related to the function of drugs: *applying user based rules of control is the only way to maintain the reasons and pleasures of drug use* (Cohen, 1999). When drugs become dysfunctional, patterns of use are changed, mitigated or abandoned.

Discussion

- 1) *About the disease model*: the shift from the "moral" criminalizing model to the disease model has had some advantages in prompting more humane drug policies. Though the moral and disease models share the same objective (reduce until *eliminate* drug supply and drug demand), the disease model differs from the moral model for its focus on treatment. As such, it has implemented medical treatment (methadone maintenance, in particular) and has expanded the network of drug services. A concern was expressed about the new emphasis on users' self-regulation capacities, whether it may contribute to a set back in the development of medical treatment.
- 2) *About the concept of control as suitable/unsuitable to "most intensive" users* (addicts). Though in principle the continuum of control was agreed upon, it was argued that the main feature of addiction is just "loss of control" (rather than "diminished control"). Some consequences were examined: if control over drugs may be described as the search for balance between benefits and adverse consequences, do the concept of "benefits" and "pleasure" fit with addict's experience? Questions were also raised whether the concept of control fits with intensive modes of assumption, like cocaine injecting and free basing.
- 3) *Ideas for a new model of intervention*. *Informal controls are topics that are worth to be discussed between professionals and users*. Often users are not fully conscious of rules, for social sanctions for illegal drugs have no circulation in the mainstream culture. As a

result, the first step in an intervention aimed at supporting self- regulation would be to increase awareness on the regulating process. *Consequences from adopting users' view:* while in a sanitary (Public health) perspective the emphasis is on risks/harms and the objective is reducing drug related harm, users' objective is "maximizing benefits" of drug use. Similarly, the traditional question under the Public Health perspective ("what is a less harmful relationship with drugs?") may turn into "what is a healthy relationship with drugs?" Or, better said: "What is my healthy relationship with drugs?". The latter terminology emphasizes the subjective perspective, in search for "personal boundaries" of controlled use. *Consequences from a new focus on setting and on social conditions of users.* Social policies and welfare benefits may be more relevant than drug policies and drug interventions. In recovery processes, social/economic status is a significant predictor.

2nd session

Self regulation strategies, from natural settings to drug services.

Either abstinent, or addict? Either controlled, or uncontrolled users? How the variable drug users' careers challenge the "all or nothing" dichotomy
(Input by Grazia Zuffa, Maurizio Coletti)

While the previous session tried to highlight the theoretical differences between the disease and the control perspective, this session was intended to go more in depth into present practices in drug services; and to highlight how the control perspective challenges these practices.

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

- *Offer of programs: prevalence of long term intensive treatment.* As a result of focus on addiction (as chronic, relapsing disease), addicts are supposed to need help from professionals, in view of *long term intensive* treatment. This offer is particularly unfit to cocaine users. Paradoxically, less intensive programs for less problem users seem to challenge drug services practices.
- *Target: users diagnosed as drug dependent and supposed to be in permanent loss of control.* From focus on individual deficits, control is rather seen as a property of a specific category of users than as a dynamic process concerning all users (though at different levels) under the influence of multiple interacting factors (see above). This suggests a dichotomous categorization of users: either controlled (i.e. individuals who are assumed to be *able* to control drugs), or uncontrolled users (who are assumed to be *unable* to control drugs, i.e. affected by permanent loss of control). The analogy with the second disease concept for alcohol is evident: either moderate drinkers or alcoholics (supposed to be permanently *unable* to drink moderately).
- *Goals:* abstinence is the goal of choice, as a consequence of the exclusive attention to risks of drugs. Stepping down is (at best) a second choice goal, for users *unable* to maintain abstinence: once again, the emphasis is on individual deficits.

Challenges from the control perspective

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- *Offer of programs and target.* As shown in the previous session, “variable” trajectories (periods of intensive, or more intensive, use, followed by step down and/or temporary abstinence, in an upward-downward route) are common. This shows a continuum in control (in opposition to the above dichotomous categorization of “controlled” versus “uncontrolled” users). In the long term, users tend to more control over drug use. These findings suggest a *much wider offer of interventions, addressed to a much wider range of clients*, at different stages in the continuum of control. This means *widening the target* to clients who may go through periods of less controlled use, to support them in stepping down; but also *reconsidering the traditional target* of more problem users already enrolled in treatment, beyond the fatalistic view of addiction as “permanent loss of control”.
- *Self- efficacy versus powerlessness.* Both less problem clients and more intensive users (the so called addicts) might benefit from treatments that convey them greater power and self control. The discovery of self regulation mechanisms seems to corroborate psychological tenets about the relevance of clients’ beliefs in their capacities and the value of enhancing self efficacy for overcoming problems.
- *Goals: the stepping down controversy.* The main discrepancy between users and professionals’ strategies seems to occur in goals of interventions. Following users’ experience in regaining control after more intensive “peak” periods, “stepping down” and “temporary abstinence” should have a prominent role as goals of choice in interventions. It is worth noticing that in users’ experience, abstaining from drugs as a stepping down strategy has a totally different meaning from “committing to long life abstinence”, as intended in traditional treatment. Anyway, stepping down and temporary abstinence seem to be the “natural” pathway to long term (or even life long) abstinence and professionals should be aware of it. Nevertheless, stepping down is not considered as a valid choice in interventions. Moreover, it is often negatively interpreted as “denial” of the severity of the problem.

Stepping down as a “natural recovery” strategy was also examined and the topic of goals was further addressed under the aspect of client/professional relationship.

Self regulation strategies and “natural recovery”

The link between control over illicit drug use and “natural recovery” (i.e. recovery without any professional intervention) is evident, the latter being the ultimate proof of users’ abilities to be “over the influence” of drugs. Clearly, gathering evidence on natural recovery is crucial for a model of intervention aimed at supporting users’ “natural” strategies; on the other hand, natural recovery is a main challenge for one of the tenets of the disease model: help by professionals is supposed to be essential for intensive users (addicts).

Interesting suggestions on natural recovery come from alcohol studies. From epidemiological surveys on alcohol use in US, data were shown about improvement and pathways of recovery in one year follow up among drinkers diagnosed as “alcohol dependent” (according to DSM IV) (NESARC 2005, reported in S.Peele, 2007). Only about a quarter of “alcoholics” were ever treated (1.205 out of 3.217), while a higher percentage of treated (28%) than untreated (24%) people continues to be alcoholic. As expected, treated alcoholics show a higher rate of abstinence as recovery strategy (35% versus 12% of untreated), while untreated people are

more inclined towards stepping down (“drinking without dependence”: 64% of untreated, versus 36% treated). Nevertheless, “drinking without dependence” is the prevalent outcome both for treated and untreated alcoholics. Coming to a conclusion: the typical outcome for alcoholism seems to be “improving while continuing to drink” (Peele, 2007). Stepping down is confirmed as a natural “self regulation” and “self recovery” strategy, which appears to be more effective than the disease theory’s prescription of abstinence. As for the consequences in interventions: the clinical perspective shows its limitations and the traditional hierarchy of goals needs to be revised, also for more intensive users.

Limitations of clinical perspective

The clinical perspective has a general limitation, due to the limited typology of people seeking treatment (most intensive users). The addiction as a disease theory provides a tautological explanation for the supposed permanent “loss of control” of addicts: “you lose control because you are an addict, and you are an addict because you lose control. When you try to argue, your denial proves the opponent’s position” (Denning et al. 2004). Similarly: “you are an addict because you have lost control and you cannot achieve it again; if you do, it means you are not an addict” (another version for the well known “Head, I win; tails, you lose”). The disease paradigm seems to be a serious obstacle to taking research in natural settings into consideration.

For clinicians working on drug addiction, there are more reasons for not being able to escape the limitations of clinical perspective. The influence of the “moral” model is relevant: identifying abstinence as the only form of recovery is congruent with the concept of “salvation” from the moral threat of drugs. The “moral” burden is also evident in the drug terminology: from “junkie”, to addict, to “problem” user: all these terms are stigmatizing, though at different levels. All of them claim abstinence, as the only acceptable change. Addicts in treatment are like “filthy shirts” in the washing machine: the sentence well shows the ideological peculiarity in the drug field.

About the patient/clinician relationship

Not only the clinician’s limited concept of change is at odds with users’ perspectives; first and foremost, the role of therapist as “saver” prevents users from playing a role in deciding the prospect and the objectives of change. The clinician/patient relationship is unbalanced by principle. As a result, “good” patients/clients will “accept” and submit to any and all therapeutic instructions; while “bad” patients/clients will “decide for themselves”; by doing so, they refuse “redemption”.

The only way to reconcile self-regulation with the clinical approach is to look beyond the drug field, reconsidering the *general framework and principles of help professions*, out of the ideological perspective of the moral/disease theories. In other health fields than drug addiction, a wide range of goals of interventions may be considered, from “cure” to “care”- it was observed. Moreover, following a general principle in clinical practice, good clinicians are not supposed to decide *in place* of clients; instead, they are expected to work *with* clients, to clarify their prospects of change, to help them to set their own goals, to support them in achieving the chosen goals.

Discussion

To facilitate exchange of views among participants, discussion took place in small groups. Among the main topics:

- *About the dominance of the disease model.* The dominance of the disease model is connected with the leadership of medical doctors in drug services. A multidisciplinary practice is needed, with more professionals from psychological and social disciplines. The role of NGOs was stressed in de-stigmatizing drug use and in providing information and counselling to users who “do not feel like patients” and do not want to enter treatment. Though the number of cocaine users enrolled in drug services has increased since the nineties, nevertheless they are a minority among drug services patients.
- *Other shortcomings in drug services practices.* The disease model emphasizes the diagnosis, as well as rigid protocols and procedures. This makes services “impersonal”. Moreover, users have to deal with different professionals when contacting drug services and every time they have to tell their story once again.
- *About the target.* When a cocaine user seeks (or should seek) help from services? At what stage of his/her drug career? When trying to answer these questions, some stressed the difference between “more controlled” clients (users who are in control of drugs most of the time) and “less controlled” patients. They probably need different programs- it was argued- though all led by the “self regulation” model.
- *Distinguishing between prevention and treatment.* The client’s demand for treatment makes the difference, some argued. If the demand for treatment does not exist, the (selective or secondary) “prevention” pillar may be implemented, with actions ranging from 1) information 2) counselling 3) peer support and other low threshold activities. If the demand for treatment does exist, the “therapy” pillar calls for a well structured setting and the role of clinician is crucial in assessing the case by examining key factors such as 1) whether drug use is disruptive or compatible with patient’s life engagements and activities 2) whether drug use has a self medication function.
- *Focusing on prevention at any step of drug use career.* A different point of view on the above topic was also shown. The Transtheoretical Model of Change (TTM) suggests to broaden our perspective beyond traditional treatment for specific diagnostic categories to prevention, which implies being proactive: 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). See also Working Paper, p.15.
- *On client/professional relationship.* This topic was again deeply discussed, because the present situation is considered highly unsatisfactory. Professionals in drug services have a dominant (if not exclusive) role in deciding the type of treatment and in setting the goals of interventions. All participants agreed on the necessity of a more balanced relationship. This is not a question of “democracy”, it was argued. It depends whether users’ experience (on drugs and on their lives) is accepted (or not) as a form of expertise. When all the knowledge and the expertise are supposed to belong to professionals only, there is no basis for a “balanced” relationship. A shift was suggested, from diagnostic procedures to “self definition” of clients in their relationship with drugs. Clients and professionals should build together their own “approach” or even “paradigm”: a common framework to “read” (interpret) the particular user’s experience. It is a crucial a question whether a more balanced clients/professionals relationship can be developed in formal drug services or not: informal interventions

run by NGOs seem a more favourable context to experiment innovation. Users' voices should deserve more attention, in evaluating drug services as well.

- *On the concepts of users' experience/expertise.* Undoubtedly, user's experience is a form of knowledge on drug use. To become expertise, some argued, users have to be fully aware of their experience and its meaning in the context of their lives. Also, knowledge from users' experiences needs support: i.e. more information on drugs and their effects, more communication among users about safer use rules.

Learning from controls

From help to "powerless" addicts to support for users' skills: corner stones for a proactive model of intervention

(Input by Patrizia Meringolo)

A theoretical overview on the proactive approach: why patients are the experts

To analyse the proactive approach in its main features, a basic distinction between Health models has to be established: on one hand, the "Prevention" model, developed within the disease theory and focused on problematic behaviours and related risks to be avoided (prevented); on the other, the "Health Promotion" model, developed within Developmental Psychology, based on plastic behaviour. The Health Promotion model aims at "promoting positive identities", focusing on "positive sides of human experience". Even in troublesome life circumstances and health conditions, attention is directed to "remaining abilities and competencies" to be promoted: this is the core principle of the "proactive model". As a result of focus on abilities, patient is seen as an "expert", having a fundamental expertise on his/her life. The self- management concept and the self- management programs are embedded in this theoretical background.

Noticeably, the psychological "proactive" perspective has been adopted even in medicine. For example, the Stanford Patient Education Research Center is part of the Department of Medicine at the Stanford University School of Medicine (Palo Alto, California). For over three decades, they have developed, tested and evaluated self- management programs for English and Spanish speaking patients with chronic health problems. The programs are intended to help people to gain self- confidence in controlling their symptoms and in managing the effects of their health problems on their lives.

The *Health system of care* (a wider concept and practice than that the cure or treatment system) operates at different levels (individual, community, policy levels), by supporting self- management, activating community resources, promoting appropriate policies.

Both TTM and Self Management models are proactive: while the former emphasizes the process and the individual's choice, the latter highlights both individual's expertise and social empowerment, following the tenet: "patients can better understand their illnesses than professionals and professional care has a limited role".

Coming to conclusions: the value of clients' expertise and abilities in self -management is widely accepted, both in psychology and in medicine, even for seriously illnesses.

Nevertheless, in the field of drug use, this assumption is still largely opposed. Proactive approach and self -management are applied with peculiar "moral" limitations: for example, self- management is only accepted if finalized to abstinence. Similar "moral" limitations are found in other constructs. For example, the psychological concept of "resilience" originally meant the ability "to cope with problems": but in the field of drugs, it has been incorporated into the "just say no" prevention perspective and changed into "ability to say no to drugs",

Once again, models of intervention in drug addiction are influenced by the moral view on drugs. Quite often, professionals are not aware of this ideological burden. A wider perspective on psychosocial paradigms and their applications in other fields than drug use is an essential part of training for drug professionals.

Discussion

- *Harm Reduction and Health Promotion.* Questions were raised on Harm Reduction, which has been since developed as a prevention strategy (the so called secondary prevention) in the framework of the medical model. How can it be implemented in a Health Promotion approach? How can self- management be applied in supporting controls in drug use?
- *Methadone Maintenance and self- medication.* Methadone Maintenance was quoted as the main example of self- medication. Methadone Maintenance is one of the main programs of risk prevention, applied with strict rules in drug services (dosage, compliance etc.) according to the medical model. But many consumers use “grey methadone” following their own rules and purposes (usually at lower doses). Can these experiences of self-medication be reevaluated and offer suggestions for forms of MM self- management?
- *Poly drug use and self- management.* Poly drug use is seldom analysed under users’ perspective and ratio, i.e. trying to identify the *different functions played by the different drugs*. The term itself, poly drug use, suggests a “multiple” stigmatization of users. On the contrary, different substances are often used to balance/mitigate the effect of other drugs: for example, cannabis helps to relax so as to counteract the effects of cocaine and other stimulants. Similarly, heroin is used to mitigate cocaine effects.
- *Multidrug use and stepping down.* Shifting to less risky drugs may be a form of stepping down: from cocaine to cannabis, for example.

To summarize. A blueprint for an innovative operational model in drug services

- *Support rather than help.* Interventions should be intended as a *support to self-regulation strategies*. This suggestion comes from research both on controlled use and on “natural recovery”: Resolution can occur through several pathways, mostly through “natural” pathways (Tucker, Donovan, Marlatt, 1999).
- *Assessment and self definition versus diagnosis.* Assessing user’s career is a crucial phase of intervention and it is different from diagnosis. While diagnosis is considered a “preliminary step” to treatment, the phase of assessment is integral part of the intervention. Assessment calls for an “exploratory” attitude, to help user to look into his/her drug experience and into his/her career and reconsider it in the wider context of the whole life experience. The phase of assessment should include the “self definition” of the client’s problem (see above p.9).
- *Identifying advantages of drug use as well as disadvantages.* Both of them are essential to understand the function of drug use. Moreover, change is a result of the “decisional balance” between costs and benefits of the present behaviour and clients should be aware of both sides of the balance to make a choice.

- *Be aware of success, stress the positive and client's resources.* This is a main point of difference from the traditional model. As a result of the focus on *relapse* (the term itself comes from the medical model), periods (sometimes long periods) of controlled use or even of abstinence are underestimated or misunderstood. Under the self regulation perspective, it is important to focus on periods of more control over drug use beginning from the phase of assessment of the client's drug experience. It is a crucial question of preserving self –efficacy. Not only: focusing on periods of more control is consistent with the very perspective of control: *in order to understand how and why the user has reduced his/her control over drugs, it is preliminary to understand how and why he/she had previously achieved control and maintained it for some time.*
- *Any positive change* is the goal of intervention. Change is a *step by step process*, and change takes time. It is important to be fully aware of the (small) steps of change (and professionals' support may help to identify the process) (see also working paper, p. 15).
- *Setting the goals.* It is important to keep *broader goals* in mind beyond the *drug* area. Change may be pursued in any field of life experience. The *drug, set, setting model* is a useful blueprint both for assessing client's situation in every area of his/her experience, and for deciding which area is more convenient to address for change.
- *A balanced client/professional relationship.* The above discussion (see p.10) suggests that setting goals of intervention is up to the client, who is supposed to be *able to take decisions*. This ability is the necessary basis for client's *responsibility* for these decisions. Professionals' role is essential in clarifying the background for the decision and in helping to identify the steps to reach the chosen goals. Some participants described the phase of setting goals as a "negotiation" between client and professional. The term "negotiation" needs further review².
- *Stressing the role of setting and life structure.* Due attention is to be given to "life structure", as an essential factor of control.
- *Information and Advocacy work for the rights of clients.* It should be a core action, as a result of the focus on "life structure". Clearly, to be aware of their rights and to claim them is a form of users' control over their life.
- *Innovating the whole offer of interventions.* It is essential to have the new model implemented in the existing services without creating new additional services: the aim is to innovate the whole offer of interventions. As examined above (pp. 8,9), following the proactive approach, the new model is meant to "cross the targets" as well as "cross the prevention/treatment pillars". How to apply the new model in different settings (low threshold services, counselling, brief interventions, therapeutic settings) is the future challenge for the work on the self- regulation model.
- *Changing the mission of services.* The new self-regulating model should not be seen as the "last resort", to be implemented after the "mission" of services (identified in the goal of abstinence) has failed. In this light, the mission of services should be thoroughly reconsidered. The control perspective as well as the whole Harm reduction approach should be taken "out of the backstage".

² The term "negotiation" may evoke the client and the professional "pulling the rope" at opposite sides. Following the Motivational Interviewing principles, "the least desirable situation..is for the counselor to advocate for change, while the client argues against it"(Miller W.R., Rollnick S., 2002, Motivational Interviewing, second edition, The Guilford Press, New York, p.39)

- *Welfare policies and the network of drug services.* As discussed above (p.5), social policies may be more important for users' "life structure" than drug treatment. *Linking drug policies to welfare policies should be a core issue in innovating drug policies.*

4th session

Beyond medicalization of drug use

Social representations of drug use and developments in drug policies

(Input by Susanna Ronconi and Franz Trautmann)

From the working paper(pp.17/22), key point 5 ("Harm Reduction", beyond the fourth pillar) was examined in detail.

Harm Reduction may be seen either as a set of interventions, mainly addressed to high risk users; or as a drug policy paradigm, aimed at reducing risks of drug use (instead of eliminating it), focusing on users as social actors and policy makers.

At an institutional level, HR has been developed in the former version, as a mix of services, interventions and actions, implemented within the disease model (or in parallel to treatment led by the addiction paradigm). In this light, Harm Reduction has been seen as a "last resort" for users who have failed abstinence oriented programs. This "ancillary" perspective has facilitated the introduction of HR in the drug addiction system of services and, later, its promotion to "fourth pillar" of drug policies. Nevertheless, these developments have overshadowed HR as an alternative paradigm to both the moral and disease models,

A historical overview of drug policies paradigms in the last decades of XX century was shown. Since the sixties/seventies, a shift took place, *from the crime to the health paradigm*. It was a process towards a new perception of the drug problem, involving a change of essence (drug use is not a crime but a health issue), a change of objective (harm reduction instead of abstinence), a change of approach (regulation instead of prohibition). While in principle the Health paradigm is different from the disease model, nevertheless there is just a small step *from the health to the illness paradigm*. The picture of "addiction" as "illness" appealed to public opinion and it was well accepted by medical professionals. Harm Reduction embraced this picture, as we can see from the strong support to methadone maintenance, seen as a treatment/harm reduction measure for "chronic and relapsing" addicts. The shift from guilty criminals to patients (i.e. users "victims of the disease of addiction") prompted a more humane drug policy and decriminalization has worked hand in hand with the development of HR programs.

There are many pitfalls in the health/illness paradigm: first and foremost, it tends to deny patterns of non problem use, such as recreational use. The result is the "pathologization" of any form of drug use. The pathological view is evident in the "diversion scheme" (providing treatment in place of punishment) and in turn it is reinforced by it. The diversion scheme may be a step forward for addicts, but not for users: also, it establishes a new mix of therapy and control in the drug addiction system of services.

More shortcomings of decriminalization were examined: the "victim/user" picture is mirrored by the "criminal/dealer" image. As a consequence, decriminalization (of possession of small quantities of drugs) is usually associated to tougher penalties for production and distribution. This corroborates the link drugs-crime. The tough approach for drug production and dealing fits the conservative emphasis on security. Moreover, drug use decriminalization without addressing prohibition creates the "threshold problem": possession of pre determined quantities of substances is assumed to be for personal use, while possession above the pre

determined amount is assumed to be for dealing and punished in accordance. The unintended consequence is the so called “reversal of burden of proof”, from prosecutor to defendant: people caught in possession of quantities above the threshold have to give evidence for being users and not dealers.

Reconsidering the unintended consequences of the disease paradigm and its adoption in decriminalization and Harm Reduction is crucial for breaking the impasse in drug policy reform.

Discussion

The discussion focused on how to go beyond the disease model and establish Harm Reduction as a drug policy aiming at supporting informal controls.

Among the main suggestions:

- *Highlighting how prohibition maximizes social and health risks* (for example: prohibition helps the shift to riskier routes of assumption to maximize the effects of substances that are expensive in the illegal market; also the shift to riskier drugs is facilitated, following the illegal market trends).
- *Working on social representation of dealers.* Most of dealers behave responsibly with their clients/friends, it was said. Usually, dealers are heavy users trying to fund their drug habit or recreational users who provide the substance to friends and keep a free amount for themselves. In the legalization perspective, part of illegal producers would become legal. LoukHulsman, the prison abolitionist criminologist, was quoted: “We need to make dealers respectable”.
- *Advancing the issue of decriminalization on the supply side.* Steps may be explored to decriminalize/regulate supply of cannabis and of new psychoactive substances. For instance, cannabis self- growing is being developed in several European countries as a legal alternative to illegal markets.
- *Working on the relationship between informal and formal control* to identify adequate policies to support informal control. The negative role of formal/external control in the development of informal/self regulation strategies has been previously introduced (see p. 5). It was argued that not all formal control is detrimental, taking the example of formal controls in methadone maintenance programs: they may help users in the chaotic phase at the beginning of treatment. A distinction was introduced (and agreed upon) between *prohibitionist control and other forms of legal control*, such as norms to prevent driving under the influence of drugs, or youth use of risky substances. As for driving tests, in the prohibition regime this kind of testing is usually aimed at detecting use, not intoxication. Different examples were given for the efficacy of *self control strategies*, such as pill testing, to reinforce knowledge stemming from user’s experience; or alcohol tests, not implemented in the framework of punitive measures, but as self empowering strategy. It was generally agreed that legal controls are necessary in case of risk to other people. Finally, there was general agreement on prioritizing self- control: in this light, a key question was formulated as a guide to policy making: “What formal controls (if any) work to strengthen informal controls?”
- *The role of set and setting factors* was again stressed in identifying policies to support informal control. A good example was quoted from the Balkan countries experience, where women who inject drugs tend to hide themselves: get women’s organizations involved in drug policies is a way to work on the context.

Conclusion

The 4th and final session ended with round the table interventions 1) to evaluate the work done at the seminar 2) to outline further steps

Evaluation of the seminar: strength points and weaknesses

Among the strength points:

- Efforts to link research with operational models
- A theoretical framework was offered both to decode traditional models of interventions in the network of services and to outline alternative models
- The innovative focus on users' perception and point of view
- A thorough review of critical aspects of the disease model (though this work should be examined more in depth)
- Highlighting innovative constructs (such as health promotion) and trying to conceptualize them in the field of drugs
- The discussion has involved all participants

Among the weaknesses

- More work in small groups would have been welcome
- Not enough time was devoted to explore experiences and to give examples of good practices
- Many issues were addressed and there was not enough time to build a shared terminology

Building an innovative self- regulation model: steps forward

- Analysing existing innovative experiences in the network of drug services and making an inventory of these practices
- Going more in depth into different settings of interventions and exploring how the self regulation model can be adapted to them (with particular attention to the implementation of the innovative model in clinical settings)
- Going more in depth into self regulation strategies for different substances
- Going more in depth into multidrug use and its possible use as a step down strategy from riskier to milder substances

Further steps in innovating drug policies

- Breaking the impasse in the decriminalization/medicalization model by promoting more public discussion about the pitfalls and constraints of legal control
- A more in depth review of Harm reduction, of its innovative potential but also of its historical limits in its developments during the past decades.