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# THE MATTERS PAPERS

USERS' VOICES

Experiences and perceptions of European drug users  
on controlling their drug consumption

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## Introduction

In Europe, we have come a long way in developing a common approach to describing drug use based on standardised methods and measures. This approach delivers benefits in allowing a simple shared language for the European policy debate. It does, however, bring with it the risk that we oversimplify and ignore diversity in the European drug scene. Under the umbrella term 'drug use' or 'drug problem', we refer to a complex set of behaviours and experiences — different substances and different patterns of use, different motivations and different consequences. These behaviours are all influenced by the prevailing culture of the country concerned as well as by individual and family circumstances. The ways in which people who have developed some degree of dependence on drugs or alcohol manage and overcome their cravings is a phenomenon that continues to challenge drug researchers, policymakers and service providers because drug users are not a homogeneous group; on the contrary, drug and alcohol consumers differ remarkably in regard to their patterns of use and their social positions both within and across European countries.

In Europe and the United States, there has been a tendency to overestimate the pharmacological properties of psychoactive substances and underestimate the influences of social, psychological and cultural aspects on drug use and on individuals' efforts to control it (Strang et al., 2012). There is a substantial body of evidence to show that the power of psychoactive drugs is mediated by users' norms, values, practices and circumstances. A review of the evidence base around recovery has found that several decisive ways of achieving a drug-free life and becoming an integrated member of the community are related to individual characteristics and broader social policies and conditions that lie outside the scope of drug treatment and policy (Zinberg, 1986; Best et al., 1999; Eisenbach-Stangl et al., 2009). A classic study by Waldorf and colleagues pointed out 'how users think about and behave towards drugs matters a great deal' (Waldorf et al., 1992). Both quantitative population surveys and qualitative studies show that some individuals discontinue use of a particular substance after one or two experiences; others consume occasionally or for a limited period of time whilst others consume more regularly. Among regular users, only a proportion goes on to develop chronic problems of dependence and seek formal treatment. Qualitative interviews provide a valued channel for the expression of the different trajectories of different substance users.

A refocus on the total needs of the individual as a whole was enshrined when a new agenda for public health and healthcare provision was set by the Ottawa Declaration of the World Health Organization in 1986 (WHO, 1986). Quotations, gleaned from interviews with substance users in Europe, help to focus on their total needs by providing glimpses into the different ways individuals attempt to control or reduce their consumption of drugs or alcohol. This paper does not attempt to assess the relative efficacy of any specific drug or alcohol approach or intervention: its purpose is to highlight the fact that there is enormous heterogeneity in different individual experiences and the quotations used give voice to some of these very different experiences. In this way, quotations provide important insights and meaning into the figures on prevalence of drug use and treatment statistics.

Quotations from different individuals in 16 countries over the period 1993–2012 are included. Some are taken from chronic, long-term and marginalised drug users and some are from individuals who, at the point of interview, have managed to limit their substance use and do not fulfil common medical criteria for dependence or problem use, although quotations from the

problem users tend to dominate. In addition, some quotes are taken from social researchers engaged in research with drug users. The paper does not claim to provide a comprehensive overview of all the major issues for substance users attempting to control or reduce their consumption and the quotations inevitably reflect the research available in the countries and the period in which the interviews are set.

Three major issues emerge from the research on people attempting to manage and overcome their cravings for psychoactive substances. Firstly, the following quotations give voice to some of the triggers that prompt an individual to decide to reduce or stop consumption and/or to seek help. Secondly, they give voice to positive experiences gained from some interventions and support. And, thirdly, they describe some of the obstacles that get in the way when individuals try to change their behaviour.

Each section of this paper will be preceded by one or two key statistics (or other research findings), and, although the quotations that follow may highlight a need to develop more robust and detailed research on a key issue, the overriding objective is to give voice to individuals who are attempting to control their consumption.

## Methods

The quotations that have been selected come from a range of sources: local research studies, reports and websites of non-government organisations (NGOs) reports and websites, articles that have been published in peer-reviewed journals, government reports and other grey literature. Most of the quotations were collected during research interviews, mainly with users themselves, and some were taken from service providers. Non-English language quotations were translated into English by the national focal points or experts submitting them and others were translated and edited at the EMCDDA. The source of each quotation is provided in the endnotes and, whenever possible, the gender and age of the interviewee, the substance use with which he or she is concerned and the country in which the interview took place are added at the end of each quotation. Some words in the quotations have been rewritten to use accepted spelling and to make the text easier to understand, and any information added by the interviewers has been placed in square brackets.

## 1. Triggers that prompt an individual to decide to reduce or stop consumption and/or to seek help

Among those people who try an illicit drug only a proportion become regular users. And among regular users of licit and illicit drugs, many report controlling their substance use by setting rules, for example, on the amount they consume, the frequency with which they consume or the context in which they consume. However, a proportion of regular users develop compulsive patterns of use and require treatment or other forms of support (Reynaud-Maurupt and Hoareau, 2010). Help-seeking behaviour by substance users remains poorly understood. Much of the research in this field is descriptive and the findings do not provide clear, universally applicable, causal explanations of how or why some people manage to limit their use of psychoactive substances and others do not. Nor can researchers accurately explain why certain individuals seek help and others do not or predict when they will do so, although accessible services clearly play a major part.

The variable patterns of substance use are evidenced in the prevalence estimates that are routinely reported. For example, it is estimated that:

- Around 78 million Europeans have used cannabis at least once in their lifetime (lifetime prevalence 23.2 %) but a much smaller number (only 22.5 million) have used it in the past year (last year prevalence 6.7 %). Among the past-year users only a small percentage use daily (EMCDDA, 2011a).
- Around 14.5 million Europeans have used cocaine but only 4 million have used it in the past year and few of these are dependent or use cocaine intensively (EMCDDA, 2011a).
- The average prevalence of the most severe forms of drug use in the European Union and Norway is estimated to be between 3.6 and 4.4 cases per 1 000 population aged 15–64, which corresponds to around 1.3 million problem users (1) (EMCDDA, 2011a).

(1) Defined as injecting drug use or long duration/regular use of opioids, cocaine and/or amphetamines.

Studies of heroin clients in treatment dominate the qualitative drugs research literature, but with a recent increase in clients being offered treatment for cannabis problems more qualitative research work on cannabis users is being published. There is much less research among those who control their drug use without the help of drug treatment services. The quotations collected for this paper lend support to findings of a unique study by Patrick Biernacki in 1986 that compared heroin addicts who recovered through treatment facilities with those who overcame their addiction without treatment. He described three main ways in which people resolve to stop using drugs. (i) A small number limit their drug use without making a firm decision to do so. These people simply drift away from drug use and get involved in other things and never develop a strong commitment to the illicit world of addiction. (ii) For others, ideas of stopping or reducing drug use develop rationally and are stated explicitly. Realisation of the need to change behaviour often occurs after an accumulation of

negative experiences, along with some significant and disturbing personal event, which is usually expressed in terms of serious conflicts between continued drug use and other desires. (iii) A third category involves people who have hit rock bottom or experienced an existential crisis. Their decision to change behaviour emerges out of highly dramatic, emotionally loaded, life situations (Biernacki, 1986). More recent studies report that individuals in this third category are often in socially marginalised or disadvantaged groups and males usually outnumber females (Prinzleve et al., 2004). The following collections of quotations about triggers that prompt individuals to decide to reduce or stop consumption and/or to seek help are divided into these three main ways in which a person might stop using drugs.

## Stopping or limiting use without making a firm decision to do so

For people who limit their drug use without making any firm decision to do so, self-imposed controls that limit their consumption to specific social settings are commonly cited:

*I never think about using cocaine in the middle of the week, if there are no festivals or parties. Cocaine only makes sense at night in a party, when you go out, not on a normal working day. I can't imagine myself sniffing in the toilet of my house.*

COCAINE USER, SPAIN [1] (?)

And:

*I've never taken coke on my own. It's a social happening. I've sometimes finished a leftover, but that's all.*

COCAINE USER, NETHERLANDS [1]

Research among khat users in the UK distinguished 'normal' users from more problematic daily users:

*But if it is chewed everyday then it becomes not normal.*

YEMENI MALE AGED 18-24, UK [2]

In Sweden, a drug user replied to a question about why he has not become hooked on drugs saying:

*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.*

SOCIALLY INTEGRATED RECREATIONAL DRUG USER, SWEDEN [3]

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(?) Numbers in square brackets refer to the quotation source, listed on pp. 29-31.

## Realisation of the need to change behaviour

For other substance users, a realisation of the need to change behaviour and decisions to stop or reduce their consumption develop rationally and are stated explicitly. Commonly cited reasons relate to values that they recognise as being undermined by drug use, such as work achievements, family relations and having disposable income.

A young man in the UK describes his realisation that his cannabis use was affecting his work:

*It (smoking cannabis) makes me lazy. I wasn't getting my work done.*

MALE, 16 YEARS OLD, UK [4]

Danish research on pathways from recreational drug use to regular or problematic use describes a young man's realisation that his weekend drug use had spiralled out of control:

*My everyday life was f\*\*\*\*-up because of the things I did at the weekends. It was like arriving too late at work, losing track of everything, forgetting things...You forget birthdays, forget appointments and forget to deliver things back. You don't talk to your family: you have had four different jobs in four months. There is not much fun in your life anymore.*

MALE, 20 YEARS OLD, DENMARK [5]

Valued relationships are also cited as reasons to reduce or stop drug use. A French male heroin user who enrolled in a drug treatment programme said:

*I have a relationship that has lasted for five years and was told 'if you can stop, if you can find a job, we live together'.... I had a project, a goal, a friend. I told myself if I do not take this opportunity I may not get another chance.*

MALE, 41 YEARS OLD, RECEIVING BUPRENORPHINE TREATMENT, FRANCE [6]

In Portugal, a young problem drug user says:

*One happy day, when I got up from bed and looked at myself in the mirror, I decided that enough is enough...I had enough of giving trouble to my parents and told them that I wanted to be admitted (to treatment).*

PROBLEM DRUG USER, PORTUGAL [7]

Women frequently mention that their ability to look after their children had been compromised by drug use and cited the importance of their role as mothers as a reason to change.

A Finnish study of motherhood in the context of drug abuse and child welfare services reported one user as saying:

*I went myself there right away when I heard I was pregnant, I mean I first called the child welfare office and I went to chat with an officer and I said that what on earth will I do, I mean I've stuffed myself with amphetamines for the past three months and now suddenly I'm pregnant.*

FEMALE AMPHETAMINE USER, FINLAND [8]

A British heroin-using mother said that although the treatment service provided to her at an earlier stage was good, she wasn't able to control her drug misuse because she:

*...wasn't ready to change.*

The trigger for her came four years later when:

*Claire decided enough was enough. She had gone on holiday with her kids and had to take a supply of heroin with her. However she didn't have enough and spent most of the holiday withdrawing and feeling unwell. She had to make a decision, carry on and not be able to enjoy things like holidays or get off heroin.*

FEMALE, CASE STUDY OF HEROIN-USING MOTHER, UK [9]

For men also, the arrival of children can bring a change in perspective:

*When my son was born I was still on heroin and I soon stopped. I could stop even perhaps much faster and without treatment because there was a child to think of.*

MALE, 22 YEARS OLD, RECEIVING BUPRENORPHINE TREATMENT, FRANCE [6]

The financial burden of drug use is also often cited as a reason to stop. In a study of Irish cannabis users, one young man said:

*I couldn't buy anything for myself, you know, because like all my money would have gone on cannabis so I wouldn't have money for things that you have to save up for to buy... like a new TV or something like that.*

MALE, IRELAND [10]

Longitudinal research with cocaine users in Belgium found that realisation of the need to change behaviour is often linked to the time dimension and specific points in a drug 'career'. For example, during an interview in 1996, a respondent reported that he thought cocaine use improved his work but during a follow-up interview some years later he disagreed strongly with this view (Decorte and Muys, 2010).

The following quotation from a Spanish drug user illustrates the impact of the time dimension on individuals' perceptions about their own drug use:

*At the beginning it's different... You aren't so tired or burnt out. Then you realise you're going down a dead-end street.*

INJECTING DRUG USER, SPAIN [11]

However, the speed with which an individual drug user might develop problems and make a decision to change behaviour varies according to a wide range of individual, psychosocial, environmental and economic circumstances.

## People who have hit rock bottom or experienced an existential crisis

For a third group of people who have hit rock bottom or experienced an existential crisis, the decision to stop commonly emerges out of dramatic, emotionally loaded, life situations.

A Czech study reported a woman saying:

*I got pregnant with the guy...and ...I underwent an abortion... and it broke me physically... I didn't recognise it though....I know it was one of the main reasons why I gave up everything. I stopped smoking, drinking, going to pubs, smoking weed.*

FEMALE, 27 YEARS OLD, FORMER CANNABIS SMOKER, CZECH REPUBLIC [12]

Suddenly seeing oneself in a new and very negative light can trigger change:

*You see yourself portrayed in a way that you could never have previously imagined and say 'no it's not possible'. But in fact we see that it is indeed possible, it's actually like here and now ...but a spark that remains says no!*

MALE, 32 YEARS OLD, RECEIVING BUPRENORPHINE TREATMENT, FRANCE [13]

A Dutch former cannabis user describes his view on the importance of recognising how seriously harmful drug use can be:

*What struck me was that actually only those people manage to definitely stop were those who became aware that the decision to stop smoking dope is about something very serious.*

MALE FORMER CANNABIS USER, NETHERLANDS [14]

In France, a female user said she sought treatment when:

*I saw all that I had lost: my student life, my love life, my privacy...  
That's when I started to want to stop.*

FEMALE, 24 YEARS OLD, RECEIVING BUPRENORPHINE TREATMENT, FRANCE [6]

A young woman in Ireland described the impact of a very negative experience whilst smoking cannabis on her decision to stop:

*If I smoked it, I know it would just send me like absolute scared s\*\*\*less,  
I think.*

FEMALE, FORMER CANNABIS SMOKER, IRELAND [10]

## 2. Positive interventions and support

In Europe, approximately 460 000 persons were registered as entering drug treatment services in 2009 (based on data reported to the EMCDDA from 29 countries) (EMCDDA, 2011a). Provision of the different treatment modalities in each country is influenced by several factors, including the organisation of the national healthcare system, but detoxification, pharmacological treatment, including opioid substitution, psychosocial interventions and social reintegration are the main modalities used.

This section presents quotations that illustrate the importance of these services for users trying to reduce or stop their substance use. Family and friends also provide important sources of support and encouragement. Problem users who have managed to maintain good relationships with family and friends not involved in the world of addiction are more able to realise their new identities through the support of non-users than those who have not (Clarke, 2009). Objective and timely information about risks of substance use and the range of available services is also cited as a valued resource.

### Specialist drug treatment services

Drug treatment services in Europe are provided in a variety of settings: specialist treatment units — including outpatient and inpatient centres, mental health clinics and hospitals, units in prison — low-threshold agencies and office-based general practitioners. Active involvement of drug users in tailoring drug services can be traced back to the Netherlands in the 1970s when it was recognised that, by providing a better understanding of what works and what does not, users can help shape services to meet their needs (Lloyd, 2010).

Qualitative research within specialist treatment settings in Europe has highlighted a range of different aspects as being particularly helpful to the users of these services. For some, it is the prescription of psychoactive drugs that provides relief from the chaos of daily lives dependent on drugs from illicit sources, particularly for opioid users. For others, it is the psychosocial support, monitoring and practical help such as with housing or finding work that is highly valued. And speed of access to treatment and support is also an important factor. However, interviews with drug and alcohol users reveal the way in which an intervention may be viewed differently at different time periods in an individual's life. At one point in the 'career' of a substance user, a specific intervention may have no positive effect on his/her consumption whilst a few years later the same intervention may facilitate a radical change.

A commonly made observation is that:

*If you do not want it for yourself, you won't succeed, in the end, no one can force you.*

YOUNG DRUG-USING OFFENDER, BELGIUM [15]

## Opioid substitution treatment <sup>(3)</sup>

Opioid substitution treatment is now a key evidence-based approach and available in all EU countries. Overall, it is estimated that about half of the European Union's problem opioid users have access to substitution treatment but coverage in Europe varies between countries. Over the past decade, the number of clients accessing substitution treatment increased in the majority of countries (EMCDDA, 2011a).

Many long-term problem opioid users report that substitution treatment, indirectly, brings a certain feeling of peace of mind and body, because they are no longer confronted with the immediate consequences of their drug use (such as the financial problems or feeling sick). Their days are no longer dominated by their need to look for drugs. This is illustrated in interviews with long-term methadone clients. In Belgium, an interviewee said:

*Because of my methadone, I had more moments that I was able to deal with it. Without methadone, I was deeply unhappy and depressed. With methadone, step-by-step things were getting better. I became more stable. Certain feelings were paralysed, that's my experience, a certain inner warmth. Even when I was feeling completely on my own, methadone made this feeling less intense.*

MALE, 36 YEARS OLD, BELGIUM [16]

In the UK, a prison inmate receiving substitution treatment said:

*They give you what you need and the doctor listens to you and he will give you what you're more comfortable with — subutex or methadone.*

MALE PRISONER RECEIVING SUBSTITUTION TREATMENT, UK [17]

In Germany, a young opiate addict says:

*Substitution at the moment simply ensures that I can live without illicit drugs ... Now I feel safe at my 10 ml methadone and I try to minimise risks. For sure, I still have some plans for my life.*

FEMALE, 25 YEARS OLD, OPIATE ADDICT SINCE SHE WAS 16, GERMANY [18]

For some drug-using parents, receiving substitution treatment can be a means to prevent their children from being taken away and placed in foster families:

*I set my alarm one hour in advance for seven o'clock. I know it takes one hour before my methadone starts to work and at eight o'clock I take my daughter to school.*

MALE, 39 YEARS OLD, BELGIUM [16]

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<sup>(3)</sup> This refers to the use of prescribed opioids, most commonly methadone, followed by buprenorphine.

## Psychosocial support

Whilst earlier policies in EU countries were primarily aimed at increasing the number of people accessing drug treatment, notably opioid substitution treatment, some of the new policies have a stronger focus on service quality and psychosocial interventions — including cognitive and behavioural approaches and contingency management techniques — have become key elements in substitution treatment (WHO, 2009).

In France, a man in treatment noted the value of psychosocial support regularly received from treatment staff as well as the substitution treatment he received:

*It helps because there is a human relationship with a person. You feel less alone. I tried to stop myself, it did not work. Then there is the Subutex product and at the same time, moral support ... yes.*

MALE, 32 YEARS OLD, RECEIVING BUPRENORPHINE TREATMENT, FRANCE [6]

In a UK study of injecting heroin addicts, one said:

*It is not just about the drug. I mean that is important, but it's about the support and everything else that goes with it... the whole programme. I've now got a flat as I said, a part-time job, and things are just looking good. I've started seeing my kids briefly, although they're in Scotland, I've got contact and my parents, my mum, dad, and things are just going good.*

PATIENT, RECEIVING HEROIN SUBSTITUTION TREATMENT, UK [19].

A young drug-using offender in the UK expressed appreciation for the practical help that was provided by the treatment staff:

*They've helped me a lot, because when I first came here I was homeless. It was them who got me a place in a hostel.*

YOUNG DRUG-USING OFFENDER, UK [20]

A young Finnish drug user who was pregnant talked about how much she appreciated the individualised support she received from her social worker:

*She came with me to the doctors and I didn't have to worry about anything.*

PREGNANT DRUG USER, FINLAND [8]

Psychosocial support may also be provided as an alternative to substitution treatment and it is commonly cited as a resource and encouragement for people stopping, or reducing, their substance use. For example, an Irish service user said that she preferred psychosocial support to substitution treatment:

*I'm happy that I did it that way. I'm not dependent on anything now. I don't need any medication, I don't need any doctor. I need to go to counselling and I go to counselling.*

FEMALE, EX-HEROIN USER, ABSTINENT FOR SIX MONTHS, IRELAND [21]

Others talk about the value of support from people facing similar problems. For example, clients in therapeutic communities describe the highly valued psychosocial support gained from peer relations in the community. For example a Slovakian drug user said:

*Back then, I deemed the relationships with lads (drug users) outside as important, but now, when I lost everything and I have only them (those in the therapeutic community), I value the relationships here.*

MALE, CLIENT IN THERAPEUTIC COMMUNITY, SLOVAKIA [22]

A young Portuguese man describes the relief from isolation offered by the therapeutic community he is in:

*...now that I no longer have to isolate myself, I can appeal to anyone for help, there is honesty. ... the mere fact that we speak and expose the problem already relieves the anxiety and stress.*

MALE, 30 YEARS OLD, ALCOHOL AND HEROIN CONSUMER FOR 14 YEARS, PORTUGAL [23]

A young woman who graduated from a residential therapeutic community programme in Bulgaria said:

*I succeeded to prove to myself and to others who believe that there is no such thing as an ex-dependent that this is a myth...There is no dependence for life. You just have to say 'I need help'.*

FEMALE, 25 YEARS OLD, EX-HEROIN USER, BULGARIA [24]

## Family

There were numerous quotations that illustrate the importance of family support. For example:

*Looking back the support of my family was extremely important also during my time of drug use: that they did not condemn and shun me.*

FEMALE, 25 YEARS OLD, OPIATE USER SINCE THE AGE OF 16, GERMANY [18]

A young former heroin user acknowledged the important role her father played when she was about to give up her treatment:

*By day four/five I wanted to give in. I really did think I couldn't do it: my whole body ached and I had had no sleep since I started it...My dad was phoning every day, telling me how proud he was of me. He made me realise that I was strong enough and I don't think he knows that if it wasn't for his encouraging words I don't know if I could have seen it through.*

FEMALE, EX-HEROIN USER, UK [25]

In France, a man receiving methadone maintenance treatment said:

*It was my mother who got me out of everything. Thanks to her: firstly because she took me back home. As soon as I started methadone she took me back home. She gave me a bit of confidence. She gave me her keys, she didn't monitor me. She showed she still had doubts and was afraid.*

MALE, 34 YEARS OLD, RECEIVING SUBSTITUTION TREATMENT, FRANCE [6]

Another relied on his grandmother:

*To really stop I went to lock myself in at my grandmother's, no one had my details. My grandmother knew, she let no person call, and here I am.*

MALE, 32 YEARS OLD, RECEIVING SUBSTITUTION TREATMENT, FRANCE [6]

In Austria a respondent said:

*Even though I've had a difficult relationship with my mother, I knew at the time I could call and she would come.*

FEMALE DRUG USER, 40 YEARS OLD, AUSTRIA [26]

In Spain, a drug user relied on his sister:

*My sister has helped me many times. For example, on days I've wanted to use drugs, I've spoken to her and have been able to refrain from buying.*

MALE, PROBLEM DRUG USER, SPAIN [11]

Another drug user in the UK notes that he is:

*Grateful...for the fact that I was not so obsessed with myself, not so out of it on substances, that I missed the one word of generosity my mother was able to say.*

MALE, UK [27]

## Friends

A woman trying to reduce her substance use noted the value of sharing the difficult period with a friend:

*A girlfriend of mine went through something horrendous at the same time. The two of us spent two weeks kind of slobbering on the sofa and watching lots of movies so the two of us together we were going through a similar thing. That was quite helpful at the time.*

FEMALE, USER OF OVER-THE-COUNTER MEDICINES, UK [28]

In Belgium, a study among opiate-dependent individuals noted that becoming socially active had a positive impact on quality of life for the participants. One said:

*Friendship has always been important to me, a good conversation means so much more than whatever form of medication. I can't explain it, but friendship is a sort of recognition for me. It makes me feel I am part of the world again.*

MALE, 38 YEARS OLD, BELGIUM [16]

In Ireland, a problem drug user acknowledges the importance of making new friends:

*Recovery is an individual thing. Recovery isn't just coming off methadone, it's a hell of a lot more than that: it's about occupying time, trying to get back into society, trying to get back to the normal things... it's filling the void that the heroin and everything that comes with the heroin use, the friends, parties.*

MALE AGED 29–33 YEARS, IN METHADONE TREATMENT, IRELAND [40]

## Information

Objective and timely information is also cited as another valued source of support for stopping or reducing substance use. In Belgium, a research study identified prospective clients' need for information about the condition of dependence and what support might be available to them. The researchers write that:

*They thought they didn't need help and didn't know what help was available or thought the threshold was too high to knock. After conversations with the social workers they gained insight into their drug problem and became aware of the impact of their drug use on their lives.*

RESEARCHER, BELGIUM [15]

Information can also help to reduce an individual's sense of isolation.

In the UK a former cannabis smoker expressed relief when he discovered that other people experienced similar symptoms:

*As soon as I appreciated that there were others who were suffering the same symptoms, the same frustrations, I found the process (of stopping cannabis consumption) not only possible but also, in a strange way, enjoyable.*

FORMER CANNABIS SMOKER, UK [29]

A young woman who had found herself dependent on pharmaceutical codeine found support on the Internet and appreciated the anonymity this medium offered:

*I had decided that I was going to stop taking these things and rather than do anything sensible like look into that I just stopped taking them. And after six days of feeling like hell I thought maybe there is something I can do about this, so I googled codeine addiction or something like that, found the forum and never looked back, really.*

FEMALE, CODEINE USER, UK [28]

In the alcohol field, of the 4 000 people who received a self-help leaflet that gave practical guidance about levels of risky drinking, 87 % found the leaflet helpful (Gleed, 2010). One of the interviewees said:

*It gave me an objective point of view about how much one consumes on a daily basis, how much one should consume on a daily basis and perhaps a way of trying to cut it down by stopping one or two days a week, which I thought was a very good way of getting out of the habit.*

MALE, 64 YEARS OLD, UK [30]

## Empowerment

The sense of empowerment gained from, and intrinsically linked to, many of the positive interventions described in the quotations above is in itself an important resource for people trying to reduce their substance use.

A young French buprenorphine client talked about the empowerment gained from feeling respected:

*What really helped me is that now I consider myself as a person and not just as a drug addict. And he helps me to see that, even knowing what he knows about me I think he likes me, he respects me, so that really helps me.*

FEMALE, 24 YEARS OLD, RECEIVING BUPRENORPHINE TREATMENT, FRANCE [6]

Other problem drug users talked about the sense of empowerment gained from achieving negative urine or saliva tests. An ex-heroin user from the UK said:

*From the onset I got urine/mouth swab tested weekly for illicit substances and I was so proud of myself for giving a negative test a week later. The nursing team and my key worker praised me for this and people around me told me I looked a lot better, which boosted my confidence.*

FEMALE DRUG USER IN TREATMENT, UK [31]

An interview study with young offenders also illustrates the value of monitoring whether or not additional drugs are being used whilst receiving substitution treatment.

*It's good because when you see that you have got a negative (test) it really makes you think 'I am really doing well', you know, it is there in black and white whereas if you didn't have test I think people would be lying.*

YOUNG OFFENDER, UK [20]

Others spoke about the value of activities and routines in their life that replaced their drug use:

*I started to work out... I go to the gym and I gained an endorphins habit... I substituted the need to entertain myself. And now, after five years of heavy smoking, I have found a proper girlfriend and that makes me unbelievably happy.*

MALE, 24 YEARS OLD, EX-CANNABIS USER, CZECH REPUBLIC [32]

In the UK, another former cannabis user said:

*When I quit (cannabis) for the last, and final, time I did something that was uncharacteristic for me. I started to plan how I was going to manage my time. I chose five different things that I knew would support my decision to no longer smoke... I started preparing more meals from scratch. I bought a bicycle and began riding it no matter what the weather.*

MALE, FORMER CANNABIS SMOKER, UK [29]

A former homeless drug user in the Netherlands said:

*I'm a volunteer at the local football club, my job coach arranged it. I've got the keys to the dressing rooms of the young teams...*

MALE, FORMER HOMELESS DRUG USER, NETHERLANDS [33]

In Portugal, a young man said:

*I started to develop in myself a non-toxic mentality, meaning I stopped consuming alcohol, drugs, coffee in order to change my mood. I started looking for situations that make me feel good, without the need of 'strange' products, and so I began to appreciate much more being with friends, spending more time with family, enjoying the quiet of home and travel.*

MALE, FORMER DRUG USER, PORTUGAL [34]

A young woman in the UK described the sense of achievement she experienced by managing to remain drug free:

*It's exactly one year since I used illicit substances and this makes me feel brilliant and so proud of myself. I'm now achieving things which a year ago I only dreamed about.*

FEMALE, FORMER HEROIN USER, UK [25]

### 3. Barriers

The barriers that people face when they try to stop or reduce their consumption often offset the positive conditions needed for recovery. For example, lack of access to timely and objective information, lack of user-friendly treatment services, lack of family support, lack of work and homelessness are all cited as obstacles. In addition to these gaps in provision and support, the stigmatising attitudes of others can have a profound impact on the lives of people with substance use problems, leading to feelings of low self-worth and the avoidance of contact with non-users. Since the 1960s, researchers have been highlighting the barrier effects of social stigma on recovery from addiction (Goffman, 1963). A large body of research describes how people with the least stake in conventional, mainstream life are generally at the highest risk for long-term problematic substance use, compelled to remain outside or on the margins (Lloyd, 2010). Other barriers are environmental factors that encourage continued consumption (Anderson and Baumberg, 2006). In the field of substance use prevention, there has in recent years been increased recognition of how such factors promote consumption behaviours. The most commonly cited is the probability of 'bumping into' friends who use psychoactive substances and living in a social environment where such substances are easily available. Another barrier is inaccurate, misleading or subjective information.

#### Social stigma

The take-up of treatment services by substance users and their constructive engagement with the former are closely linked to ways in which the interventions are experienced as stigmatising or not. Attending a drug treatment service may increase stigmatisation if the very act of seeking treatment serves to cement an 'addict' or 'junkie' identity, which can lead to further rejection from family and friends (Calabria et al., 2010).

In Denmark, a drug user in treatment says:

*I just hate standing in that line, it's so shameful. We are like cattle waiting to be watered... In their eyes we are nothing but a bunch of lousy junkies — no respect is shown.*

DRUG USER RECEIVING METHADONE MAINTENANCE TREATMENT, DENMARK [35]

Another said:

*When you're in the chemist, you're ducking and diving watching to see anyone you know. There is a stigma there; people do look down their noses.*

FEMALE, IRELAND [40]

In Romania, stigma in relation to HIV treatment is an obstacle to the effectiveness of the services provided:

*When people come to get their subsidies they stand in the hallway and employees call out, 'Let the AIDS patients come in'...Out of the 55 birth families that we work with there are over 20 who refuse to take subsidies for fear of breaches of confidentiality.*

NGO WORKER, ROMANIA [36]

Stigma may also, to some extent, be self-fulfilling in that the drug user who accepts or internalises this stereotypical 'junkie' identity will then behave in the expected manner.

A French drug user says:

*I feel in relationship with my brothers and sisters that 'you're a former tox.' That's it. I feel bad actually. I am a former addict, I have hepatitis C, I feel bad ... I stink.*

MALE, 39 YEARS OLD, RECEIVING BUPRENORPHINE TREATMENT, FRANCE [13]

The director of an NGO in the UK makes the observation that some heroin addicts:

*... have many and often justifiable fears that they will not be able to get along with people in the conventional world.*

DIRECTOR OF NGO, UK [37]

A proportion of people who try to stop using a psychoactive substance are often doubtful as to whether they can abstain successfully and permanently because they remember past failures to control their consumption. For those who have cut themselves off from family, friends and mainstream social life the situation is often worse.

A recent UK study reported that:

*Not thinking about themselves as an 'addict' or a slave to heroin undoubtedly contributed to their capacity to control their drug use. Specifically several informants reported the use of methadone as indicative of continuing dependence.*

RESEARCHER, UK [38]

## Social environment

Individual substance users who become abstinent without treatment generally cease to associate with regular or heavy users and, in many cases, ending associations with other problematic users is a necessary condition for becoming abstinent.

One of the most commonly cited obstacles for people trying to reduce their consumption is exposure to other drug users in their social environments and regular exposure to temptations to continue consumption. Research in the USA reported that two-thirds of ex-cocaine users said they had stopped going to places where cocaine was being used, or had made conscious efforts to avoid seeing cocaine-using friends. Over 40 % sought out new friends who did not use cocaine. More than 40 % of all ex-cocaine users reported making some sort of geographical move as part of their successful attempt to keep away from cocaine (Waldorf, Reinerman and Murphy, 1991).

A UK study reported that, on release from prison, drug users felt strongly about being re-housed away from their original home address in decent accommodation which would help to give a feeling of 'a fresh start' and make a move away from old habits. For example:

*You can do all of the work in prison only to be left with nowhere to live, leaving you to go to a hostel which is full of drugs. We need more help in resettlement.*

DRUG SERVICE USER, UK [17]

Homelessness presents a major risk of social exposure to drugs or alcohol. Another study in the UK found that:

*Staying in an emergency hostel or night shelter mostly had a very negative impact on levels of drug use. Residents reported increasing drug use, initiation to new drugs, relapsing, and difficulties reducing or giving up drugs whilst living in a hostel.*

RESEARCHER, UK [39]

In a Danish study, a young man who had, in an attempt to cut down on his drug intake, stopped seeing his old network said:

*I still say hello to them when I meet them but it is very superficial...it was all about the (club) drugs, nothing else.*

YOUNG MALE CLUBBER, DENMARK [5]

In Austria, a respondent said:

*I went out of my way to avoid people who lived like I had lived before.*

FEMALE DRUG USER, 40 YEARS OLD, AUSTRIA [26]

## Inaccurate or misleading information

Inaccurate or misleading information also creates barriers for substance users who want to reduce their consumption. Some drug users expressed concern about the lack of information and others their disillusionment with some of the more negative aspects of substitution treatment.

In Denmark, a drug user in treatment said:

*Methadone keeps you from being sick, that's true, but you really get dependent on that drug and, what's worse, you are dependent on the system and all the things that follow, all their demands and rules. You lose your freedom and if you are not strong you lose your self respect.*

DRUG USER RECEIVING METHADONE MAINTENANCE TREATMENT, DENMARK [5]

And in France, a young woman receiving buprenorphine treatment noted that:

*You always hope that it will heal you, and in fact it only postpones real independence.*

FEMALE, 24 YEARS OLD, RECEIVING BUPRENORPHINE TREATMENT, FRANCE [13]

An Irish drug treatment client complained that he was misled about methadone treatment:

*We were told that it wasn't addictive...they were just giving it out to people, the doctors were just writing scripts for money.*

MALE AGED 40 YEARS, IRELAND [40]

In the UK, a khat user found that ignorance about the substance was an obstacle:

*I went to the addiction services, I said 'I have a drug problem, can you help?'... I showed them the khat and they said 'We don't know nothing about this'.*

KHAT USER, UK [2]

## Discussion and conclusions

Over the past decade there has been a major increase in the availability of guidelines for treating drug use and dependence across Europe. This reveals a commitment to improving the quality of treatment, helping practitioners to make more informed choices and, significantly, putting the clients at the centre of the therapeutic process (EMCDDA, 2011b). This development has gone a long way to counteracting the tendency of treatment providers to rely exclusively on personal and professional experience in their treatment of drug users. However, the overarching theme that emerges from the quotations in this paper is that people want a voice in choosing their path to recovery. A recent UK Home Office drug strategy report states that:

*The solutions need to be holistic and centred around each individual, with the expectation that full recovery is possible and desirable.*  
(UK Home Office, 2010)

Quotations, gleaned from interviews with substance users in Europe, help to focus on the needs of drug users and provide deeper understanding of their very individual perspectives and the different ways they might attempt to control or reduce their consumption. Qualitative research that records the personal views and experiences of clients in formal drug treatment services helps to improve services and reveal and interpret what lies behind the treatment service statistics, whereas research among substance users who have not enrolled in formal treatment service settings provides important insights, which can be used to inform prevention strategies and low-threshold services (4).

The quotations that have been used here make an important and universal point about the need for choice. Drug problems are too complex and dynamic for single magic bullet solutions. Even within the lifespan of a single substance user, a specific trigger or intervention can have an impact at one particular point in time and not at another, depending on a wide range of circumstances. The apparently contradictory perspectives and narratives, characteristic of so many substance users, present a challenge to developing a stock of effective interventions and signal how complex 'giving up' a psychoactive substance is for those who want to but find it a struggle.

Social historians have shown that objects of stigmatisation change over time and place. Virginia Berridge, for example, has described how opium use was quite calmly accepted in nineteenth-century English society. There is, therefore, prospect of change for the better for substance users in the twenty-first century and it is increasingly argued that accessible services in mainstream healthcare settings that medicalise rather than criminalise substance use are less stigmatising and more likely to attract those who are able to distance themselves from the 'junkie' status. Others, however, argue that the medicalisation process itself serves to reinforce the chronic and helpless aspects of substance addiction.

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(4) These are services that have removed traditional barriers to treatment to give their clients easier access.

Whichever perspective one takes, the quotations in this paper show that how healthcare interventions are organised and delivered is very important.

*No matter how efficacious a treatment might be, it will produce little benefit to individuals and society if it is inaccessible, or if it is provided in a way that discourages help-seeking behaviour or reduces retention in care. Much better results are achieved by well organised programmes with more comprehensive services.*  
(Strang et al., 2012)

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