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Public policies for people who use drugs: Strategies for the elimination of stigma and the promotion of human rights

Políticas públicas dirigidas a personas consumidoras de drogas: Estrategias para la desestigmatización y la promoción de los derechos humanos

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ABSTRACT This paper aims to provide theoretically informed practical proposals for the improvement of current drug policies, which are based on a biological model of disease and the criminalization of people who use drugs. First, we present alternatives to a biologically-oriented scientific conception centered around neuroscientific postulates, which support the idea that the etiology of addiction materializes in the brain, in favor of models based on the social sciences where context plays a relevant role in the description and management approaches regarding different uses of psychoactive substances. Second, epistemological models and proposals are offered from a practical perspective to sustain or implement policies and programs in accordance with a more sustainable approach based on the elimination of stigma and the promotion of political participation of people who use drugs. In short, drug policies based on human rights.

KEY WORDS Public Health Policy; Harm Reduction; Social Stigma; Human Rights; Medical Anthropology.

RESUMEN El objetivo de este artículo es aportar ideas teóricas y prácticas para la mejora de las políticas de drogas actuales, basadas en un modelo biológico de la enfermedad y en la criminalización de las personas que consumen sustancias ilegales. Para ello, en primer lugar, se ofrecen alternativas para superar las bases científicas biologicistas centradas en los postulados neurocientíficos, que apoyan la idea de que en el cerebro se materializa la etiología de la adicción, y apoyar los modelos basados en las ciencias sociales, en los que el contexto y el aprendizaje social juegan un papel relevante para la descripción, el abordaje y la gestión de los diferentes usos de sustancias psicoactivas. En segundo término, se ofrecen modelos y propuestas epistemológicas, desde una perspectiva práctica, para sostener o implementar políticas y programas acorde con un abordaje más sostenible, basado en la eliminación del estigma y la promoción de la participación política de personas consumidoras de sustancias ilegales, es decir, unas políticas sobre drogas basadas en derechos humanos.

PALABRAS CLAVES Políticas Públicas de Salud; Reducción del Daño; Estigma Social; Derechos Humanos; Antropología Médica.

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INTRODUCTION

To comprehend the current state of drug policies, we should invoke the Prohibition movement that took place in the USA at the beginning of the 20th century, which was based on the rejection of ethnic minorities, their supposed criminality associated with the use of psychoactive substances, and a radical religious Protestant stratum as the explanation for the phenomenon. At present, said policies are still based on repressive legal and biologically-oriented scientific conceptions. The biologically-oriented scientific approach aims to give up social theories that explain the use of substances, focusing on the analysis of the specific context and its interaction with individual differences and the wide variety of substances. The objective is to rule out the possibility of alternative comprehensive models, which may encompass the possibility of responsible management of drug use and which may repel a war against drugs. Research in social sciences helps to show – by delving into different contexts throughout history – how the design of drug policies and the tools used in politics are established by identical political values, in particular, by the specific notion of citizenship and the role of the State prevailing in each country. These governance systems include: organization of political systems, ways in which institutions can operate, balances of power that become stabilized among institutions over a certain time span, legal and administrative traditions, ability of social movements to influence those in power, and the greater or lesser legitimacy of their actions.[1]

Over the past few years, the doubtful effectiveness of this repressive approach has become evident, because not only did it fail to achieve its goals at all but it causes even more severe collateral damage to public health.[2] Some of the consequences deriving from this hegemonic prohibitionist model are: disproportionate imprisonment sentences, deaths on behalf of the fight against drug trafficking, fear of repressive measures as an obstacle limiting access to treatments, exposure to structural violence, discrimination and deprivation of the right to health, strengthening of armed groups, strict regulations for the use of opioids in medical spheres, or torture and sexual abuse.[3]

Within the framework of prohibitionist policies, social and health problems among people who use drugs have been intensified in societies with a weakened welfare state and neoliberal political models that have favored open drug scenes or hidden spaces where vulnerable populations congregate and accomplish covert activities. These "risk environments"[4] are attended by people suffering from poverty and social exclusion, where drug use is molded by social, structural, and environmental factors with the aim of relieving social suffering.[5,6,7] In these hidden spaces, such as shooting galleries and crack houses in the USA and Australia,[8,9] *fumaderos* and *cracolandias* in Latin America[6,10] or *chutaderos* and flat floors where drugs are sold and used in southern Europe,[7,11] people who use drugs are exposed to social and health harms, and to different types of violence as a consequence of social and spatial marginalization and stigmatization marked by the imperatives in social norms.

In the various "risk environments"[4] there are more people who use cocaine and heroin, among other drugs, through parenteral and pulmonary routes. In these places, characterized by unhealthy and unsafe conditions as well as material environmental limitations, users carry out activities that entail social and health risks. When using the various classes of opioids (heroin, fentanyl, etc.) and cocaine (crack, coca paste, etc.), by resorting to different methods through pulmonary routes (pipes, metal cans, etc.), and injection (intravenous, subcutaneous, etc.), users develop physical health problems, related to weight loss; precarious personal care; dermatological problems; bloodborne infectious diseases (HIV and Hepatitis B and Hepatitis C) because they share hand-made pipes to smoke or they share needles and other equipment for the preparation of the injection; opioid overdose or adverse reactions to cocaine; cardiovascular and pulmonary diseases – more

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acute when using drugs through pulmonary routes –; as well as mental health conditions such as depression, psychotic symptoms, and suicidal ideation.[5,7,10,11,12,13,14]

Hidden drug practices take place in outer city boundaries, in "psychotropic territories,"[15] urban areas characterized by poverty and segregation, attended by drug users to buy and ritualize drug use in extreme conditions with low police control, which prove failure of social intervention and drug policies. In said environments, drug users suffer symbolic, everyday, and structural violence.[5,16,17,18] Symbolic violence is characterized by self-guilt and stigma among drugs users, by assimilating drug-related suffering and harm as a "punishment" that can be justified. Everyday violence refers to the normalization of violence and suffering among users and other agents involved, triggering relations of power and gender, represented by physical violence in everyday drug use scenes. Structural violence is related to social norms imposed on drug users related with the criminalization of drugs, which involves police force brutality and barriers preventing access to social and medical services.

For so many reasons, and from our experience as professionals in health care services focused on drug addictions and as researchers of public policies on drugs and their impact on this population, our aim in this work is to provide theoretical and applied concepts to reflect on possible strategies to fight stigma and to promote the development of human rights among people who use drugs. To achieve this purpose, the first part of this paper offers theoretical alternatives to surpass a biologically-oriented scientific conception, by relying on models based on social sciences that advocate for the relevance of context and social learning in managing and approaching the different uses of psychoactive substances. The second part of this paper presents an array of selected experiences and research studies to implement sustainable policies and programs to mitigate stigmatization and to promote the participation of drug users in public policies with a human right approach.

ADDICTION DEFINED AS A BRAIN DISEASE: A PROHIBITIONIST ENTELECHY

Both biomedicine (as a scientific paradigm) and the contemporary cultural idea regard the use of illegal psychoactive substances as a disease or deviant behavior. Both the brain disease model and the social deviation model are the dominant schemes toward the socio-cultural representation of this phenomenon, which also legitimate the continuity of public policies that perpetuate and enable the stigmatization of the people who use these types of substances. Questioning the concept of addiction as a biological disease admits the possibility that this concept is just a "culturally constructed syndrome," influenced by social and historical characteristics of our societies.[19] The different approaches, definitions, and classifications adequate for what we know as addiction have not reached enough consensus. Addiction, as a disease, was not created from the natural accumulation of scientific discoveries,[20] but it was a historical and cultural invention under specific conditions, endorsed by specific actors and institutions, and it was reproduced by means of certain discursive practices. According to Peele,[21] the idea that addiction results from a specific biological mechanism that blocks the body into an invariable behavioral pattern is being globally discussed through unequivocal evidence. Nevertheless, public policies dealing with the use of psychoactive substances – though based on the premise that the population must be protected –, from a complex perspective, can prove more harmful than beneficial.

From another point of view, Puerta and Pedrero[22] argue that, at present, "addicts" should not be called "ill persons" because they use drugs, or they should not be associated with a mental or brain condition under the yoke of "dual pathology," as promoted by psychiatrists with strong conflicts of interest with the pharmaceutical industry, thus generating greater stigmatization with an endless number of diagnostic labels related

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to the use of drugs. Taking these reflections into account, we will consider that scientific research should be focused, to a greater extent, on its efforts into the promotion of personal autonomy of users, the observation of self-regulation and harm and risk reduction strategies, and in their interaction with the social context, but not so much on the search of the origin and a biological treatment for the problem.

At present, the idea that addiction is a brain disease transcends classical psychiatry and psychology, being mainly based on the postulates of human neurosciences and, especially, in neuroimaging techniques. Basically, neurosciences propose that all cultural representations may come down to and be explained as an activity of the brain or neurobiological activities.[23] However, this field is not capable of specifying the significance of those findings or correlating causality with the function of detected brain activation events, since the complexity of human reality excessively transcends clinical tests, which can indeed be regarded as an interesting new line of research, but never as conclusive evidence.

Plurality against biomedical singularity: different ways of understanding the concepts of health and disease

The different types of medical services to treat a disease, which are many and varied (medical pluralism), use several techniques for diagnosis, detection, and treatment that, in turn, are related to different religious, ethnic, economic, political, technical, and scientific characteristics, thus configuring different health care systems that often are not independent but overlapping categories. It is well known that biomedicine and other professional medicines consider that most of these differential ways are secondary, mainly and particularly those activities known as self-care, creating an antagonistic and exclusive vision among these types of medical services.[24] It is therefore understood that the use of any substance – in any of its multiple facets – beyond their legality or their medical, pharmaceutical control will be considered a devious, pathological use or, as we will see below, a knowledge or practice to be changed.

Self-care or health lay care is seen as a structural dimension that occurs in all societies, also known as folk medicine, which exists as an answer to how the population or society understands or grasps the concept of health, and what type of answer can or should be obtained and how it should be used. A good example on the theorization of a self-regulation process through social rituals of the use of illegal substances is that they are oriented to the control and regulation of drug use experiences, and that such control occurs in the following ways: 1) maximizing the drug effect sought; 2) controlling the levels of drug use; 3) balancing adverse and positive effects of the drugs used; 4) preventing secondary problems.[25]

The richness of the different health care systems, understood in a broader sense, and their different conceptions by the population will be taken into account and elaborated within medical anthropology using the theory of explanatory models. This subdiscipline in anthropology will be adapted to analyze the discourse and meanings concerning health, disease, medical attention, and prevention in relation to different health care itineraries and, to a larger extent, drug use itineraries. At the same time, these itineraries, discourses, and meanings will be analyzed accordingly as historical and sociopolitical byproducts, and in relation to personal events experienced through the body, as a device used for the production of elements necessary for the creation of social identity and as a vehicle to adapt oneself to different life situations.

Medical systems describe disease as a cultural language, linking beliefs in the causes of the disease, symptom experiences, specific patterns of illness behaviors, decisions regarding alternative treatments, therapeutic practices, assessments of therapeutic results, establishing systematic relationships among these behaviors.[26] In this sense, the concepts of disease and illness that Fabrega[27]

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presented as observable and static objects or entities will be conceptually re-signified not as entities resulting from empirical observation, but as different ways of explaining disease, different social constructions of reality. The idea of explanatory models or discursive ways to explain a single phenomenon emerges from those developments. In each social area or sector of a medical system, different explanatory models may stem from doctors, patients, or family to explain each particular disease episode or health-related phenomena. Explanatory models contain arguments and descriptions of any or all of the following topics: etiology of a disease, onset of symptoms, physical pathology, course of disease and treatment. In addition, they are related to different systems of knowledge and specific values centered on different values or actors within the system, thus becoming historical and sociopolitical byproducts. Hence, we can recognize the paradox put forward by the influence of culture over the disease as a psychosocial experience, under the influence of cultural standards that govern perception, assessment, and manifestation of symptoms, and that determine individual characteristics of the role played by the disease that are a part of the medical systems themselves.[26]

If from a hypothetic, theoretical sphere our work is based on the perspective of the use of substances as a brain and social disease, we can consider that the representations of these substances are constructed through the patients' beliefs and expectations regarding a disease or somatic disease (symptom). Representations of diseases are fundamental to the different self-regulation theories.[28,29] The theory of self-regulation postulates that disease and representations determining the assessment of the disease establish that the behaviors related to health processes can be triggered as a result of cognitive and emotional processes.[30]

Moreover, generalization and translation of social problems into medical and psychiatric categories legitimate the vertical models of public health that, far from being based on local knowledge and potentialities for proper management, they give priority to vertical, unilinear, monologic way of communication. The main feature of this model is launching basic informative initiatives in health education and prevention (the most commonly used model worldwide when it comes to drugs) taking as a model "the prototype of a rational subject in the decision making process, limiting knowledge to local reality and, as a consequence, the provision of a dialogic relationship."[31]

ENVIRONMENTS TO FIGHT CRIMINALIZATION AND VIOLENCE: DIFFERENT ANSWERS TO A SINGLE PHENOMENON

During the first years, responses to the social alarm generated by the phenomenon of problematic use of psychoactive substances was framed within the so-called drug-free programs. Simultaneously, incipient criticism of these programs began: therapeutic approaches were proposed that did not give priority to withdrawal but suggested approaching the individual as a person, their relations and the environment from a position of greater respect toward individuals and an understanding of their reality.

The core intention consisted in minimizing harm from a more active and participatory role of the addressees of medical services.[32,33] A combination of an ecosystemic and epidemiological framework with the pragmatic findings of the theory of harm and risk reduction was suggested.[33,34] As a result, what is most appropriate, when it comes to giving a response to medical demands, is to conceive them in a complex map of multiple contact areas and itineraries. These will help design unique journeys for each person and address their needs based on the definition of objectives, depending on predominant aspects of the demands of each subject and their possibilities of obtaining the answers sought. In order to approach or embrace this way of discussing relationships based on basic rights, it is important for the medical system to accept that people who use drugs have the

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final say in the change proposed. To this end, we can make interventions from different levels. Nevertheless, in order to achieve coherence and articulation, it is essential to draft, in coparticipation, communal action plans to tackle drug issues.

Stigmatization and criminalization toward the people who use drugs implies insisting on strategies of harm reduction to continue defending human rights and access to social and medical assistance of this population.[7,17] Even if prohibitionist policies were set aside and actions for decriminalization and regulation of the use of drugs were adopted, it would be necessary to promote specific interventions to mitigate social and structural inequalities among drug users.[17] At present, various settings and organizations have been set up to fight against adverse consequences of prohibitionism as well as social and structural forces that violate rights and generate violence among drug users immersed in "risk environments."[4] Among these spaces, we would like to highlight associations of drug users and social and medical centers that are included in harm reduction programs.

These spaces have had a positive impact by improving the quality of life and promoting a commitment to fight for one's interests among people who use psychoactive substances, promoting normalization of the use of drugs with the aim of consolidating elimination of stigma processes, and advising and managing interventions, establishing a dialogue with professionals and technicians to undertake actions that better suit the needs of people who use drugs.[35,36] In this way, people who use drugs participate as experts and as qualified agents to promote the attendance of other users at social and medical services, providing aid in health-disease-attention processes, and mobilizing within the community educational, cultural, and preventive actions for normalized management regarding drug use.[37] In this sense, collaborative forces among people targeted by services and professionals have promoted the creation of harm reduction services, whether self-managed or with a mixed management model, aimed at empowering people who use drugs and creating spaces to fight social and negative consequences for health arising in open drug scenes.

Following Van Dam[38] – who elaborated a great compendium of the proliferation of drug user movements organized in Europe, where he had an active participation –, in 1977, in Holland, the first activist groups of heroin users – also called stakeholders – were created such as the *Rotterdam Junkie Union* (RJU), made up of active users and led by Nico Adriaans, and the *Medical-Social Service for Heroin Users* (MDHG), composed of users, relatives, social workers, and people who were just interested. They were against the political and social policies that were being adopted in relation to heroin use. This phenomenon increasingly became a serious social problem, mainly in terms of the spread of diseases among people who injected drugs.

In 1980 there were already fifteen associations focused on the defense of drug users in the Netherlands and, at a later time, groups of drug users began to organize themselves across Europe until the creation in 2005 of the *International Network of People Who Use Drugs* (INPUD), an organization that globally centralizes the fight for the rights of poeple who use illegal drugs.

At present, among associations led by drug users, we should highlight the actions accomplished by *Vancouver Area Network Drug Users* (VANDU), an organization formed in 1998 that is completely run by people who use drugs in the Downtown Eastside of the city of Vancouver (Canada). VANDU has about 1,000 members and since its formation they have undertaken actions to provide coverage to users administering drugs through parenteral and pulmonary routes, and advocacy to promote and extend harm reduction programs in local policies. Their initiatives included outreach interventions to contact users in public spaces; the installation of an unsanctioned supervised drug consumption room for users who inject drugs, run by peers who are trained to provide assistance to drug users in hygienic and

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safe conditions; and the arrangement of a little space for the use of crack cocaine in their facilities, as an alternative to avoid street violence and surpass the barriers that limit access to official drug consumption rooms where drug injection is the only method allowed and aid for drug injection is not authorized by law, among other actions.[18,39] A special comment should be made about recent feminist approaches, which seek to break down any logic beyond prohibitionism. A good example is the Metzineres project, which is designed exclusively for women and people of dissident genders in multiple situations of vulnerability, created in 2017 in Barcelona, composed of an interdisciplinary team, which includes people who use substances with no distinction, offering therapeutic, cultural, and leisure activities and that promotes actions for a reform of drug policies from a non-heteronormative, feminist perspective.[40] The *International Network of People Who Use Drugs* already included this non-patriarchal approach, creating parallel networks like the *International Network of Women Who Use Drugs* (INWUD). European experiences also come from women and people of dissident genders as a strategy that, for the first time, helps to weaken the prohibitionist system, but mainly the patriarchal and heteronormative system that supports it (*see* also the case of the Network of Antiprohibitionist Women (REMA) [*Red de Mujeres Antiprohibicionistas*] or Cannabis Women [*Mujeres cannábicas*] in Spain).

In terms of social and medical services, harm reduction programs have been developed and safer environments have been promoted.[17] By the end of the 1980s, in Europe and the USA various programs have been implemented with an impact on the reduction of social and health harms among drug users in vulnerable conditions.[33,41,42,43,44] Among the programs and interventions that were spread and more positively assessed globally speaking, we can mention needle exchange programs, aimed at distributing material for a hygienic and safe administration of drugs through parenteral and pulmonary routes; opioid substitution therapy programs, which consist in the controlled provision of opioids (methadone, buprenorphine, morphine, etc.) for regulating this type of substance use and preventing the risk of transmission of infectious diseases (HIV and Hepatitis B and Hepatitis C), and overdose crisis, improving the quality of life and decreasing correlated criminal activities; drug consumption rooms, which are facilities for drug use under supervision of trained professionals that provide aid after an overdose or other complications and medical attention and social services; as well as drop-in centers, which work as facilities for rest, eating, and personal hygiene, among other activities of social and medical attention, including games for users in vulnerable and homeless conditions. In several European and North American cities, there is an increasing number of social and medical centers that offer harm reduction programs and treatments for a holistic health care of people who use drugs.[11,17,45]

Various ethnographic and qualitative studies explored the impact of harm reduction services to reduce vulnerability, social and medical deficiencies, and violence among drug users. In studies conducted in harm reduction centers with drug consumption rooms, the conclusion is that users are given preventive messages and receive medical attention to minimize the risk of bloodborne disease transmission and overdose crisis, as well as reducing risk practices and discarding material used when taking drugs in public spaces and other risk environments.[11,45,46] In a study carried out in one women-only drug consumption room in the city of Vancouver, participants responded positively to safety and hygiene offered in these facilities.[47] Furthermore, on these sites, users feel that they can receive help and be connected with other social and medical services.[48,49,50] Harm reduction centers that have resting areas and drug consumption rooms are perceived as safe environments to escape violence and other social risks associated with drug use in public spaces.[17] In research studies conducted in drug consumption rooms across Vancouver and several cities in Europe, participants report that attending these

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facilities is a way to avoid everyday violence among users, stigma, and structural violence from police intervention.[11,17,49,51] In studies focused on women,[16,17,47] it is concluded that drug consumption rooms amounted to a site for shelter and an alternative rest to mediate the relations of power and abuse from peers in public spaces, strengthening management to accomplish drug-use practices.

Accessibility and participation of people who use illegal psychoactive substances in harm reduction strategies

Although the objectives sought by harm reduction programs are often well defined, people who use drugs continue to find barriers limiting access to these mechanisms, which have to do with social and structural forces, as well as scarce services to cover their basic needs. Within the framework of prohibitionist policies, access barriers affect differently depending on the application of harm reduction policies in the various political and geographical contexts. Depending on the degree of endurance, prosecution and criminalization provides drug users with a greater or lesser access to social and medical services. Nevertheless, in most geographical contexts the main access barrier is related to fear and police force intervention near drug services that impede or hinder social and medical attention among drug users.[10,11,12,52]

But also harm reduction services have been applied in order to reduce drug-related morbidity and mortality, disregarding social, structural, and environmental dimensions that persevere vulnerability among people who use drugs. Addressees often report that they do not resort to social and medical services because they do not trust in the professionals or because they consider that the services offered do not fit the particular reality of these populations: for instance, these specific centers do not distribute material or do not have areas for using of crack cocaine,[10,11,18,53] or in cities with harm reduction centers which have drug consumption rooms, they place restrictions on opening hours, adherence to standards prevailing in these facilities is strict, and interaction with other users and professionals is problematic.[11,49,54] In the case of women who use drugs, absorbed in a double stigma, as a result of breaking off traditional gender roles and of using illegal drugs,[16,55] several studies show that drug services do not take specific features into consideration regarding discrimination, stigma, and structural and gender violence that restrict women's access to these services.[16,47]

In view of the foregoing, we propose actions to increase adherence to these types of services and to cover social and health care needs of people who use drugs, and we highlight the importance of the participation of people who use illegal psychoactive substances (whether in a problematical way or not) when it comes to formulating public policies toward drugs. A very interesting experience in this sense is the proposal by the draft bill Regulated Coca, Guaranteed Peace [*Coca Regulada, Paz Garantizada*] brought forward in Colombia.[56]

Strategies aimed at improving accessibility, effectiveness, and coverage of basic needs

In order to improve accessibility to and effectiveness of these services, it is essential to surmount situational and structural obstacles in order to maximize the impact of harm reduction programs.[4] In this sense, huge changes in prohibitionist policies are needed; meanwhile it is necessary to amend local statutes in geographical contexts lacking harm reduction policies and to establish positive relationships among harm reduction services, the police force, and people who use drugs, with the aim of fostering a social environment to minimize criminalization and violation of drug users' rights.[4,52] As regards communal contexts, outreach interventions are necessary, in which professionals and expert users (health care agents) connect users with harm reduction programs and services within the community.

For an optimization of harm reduction services, it is necessary for these services to inspire public confidence and offer services

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covering actual basic needs. Research studies conducted in harm reduction centers with drug consumption rooms show that users' adherence to these facilities increased whenever it is possible to establish favorable relationships with professionals, which include understanding and non-stigmatizing bonds, and good interaction with other users, as well as finding a wide range of cares, beyond sterilization techniques in harm reduction schemes, which involve being in a hostility-free environment, where support is provided and negative experiences related to addiction processes and street-based lifestyles are mitigated.[11,48,49,51,57,58] However, we consider that significant changes are necessary to offer essential coverage that enables the mitigation of violence and criminalization among people who use illegal substances.

In the case of the users of opioids in vulnerable conditions, a more precise regularization and extension of heroin-prescription programs are necessary. In clinical trials offering injectable diacetylmorphine conducted in several cities across Canada and Granada (Spain), participants responded positively to the treatment aimed at improving stability in their lives, establishing a discontinuity in open drug scenes, improving social aspects such as job search and family relations, and mitigating social exclusion processes, as well as improving eating habits, personal hygiene, and follow-up of drug-related diseases.[59,60]

Regarding homeless populations, the suggestion is to apply housing first assistance approach to harm reduction policies. This practice is based on regularly assisting homeless people, with serious mental illnesses and conditions related to the use of substances. Research studies conducted across the USA suggest the need of access to these types of programs, applying inclusive criteria – without withdrawal being a necessary requirement – and adapting the type of house and the necessary support services that have evidenced the recovery of social and medical conditions, and family and cultural re-connection of their beneficiaries.[61,62]

In conclusion, we consider it crucial to apply basic principles of harm reduction to global drug policies, and widely apply these principles to other spheres of medical and social conditions of people that suffer from exclusion.

From a repressive model to a model based on self-regulation management

With this commitment in mind, it is important to change intervention models based on drug withdrawal toward models that include "control" or "positive self-management" of drug use as a possibility afforded by law. This involves mitigating professional vocabulary conceptions such as "addict," "relapse," "chronic," or other discursive ways that stigmatize people who use drugs.[53,63] In fact, various research studies deny that the use of supervised drugs is impossible to control, being more common for vulnerable populations to switch from intense consumption periods to low-frequency consumption, even maintaining a self-regulated consumption, depending on social, structural, and environmental conditions.[7,11,64] Most people that use supervised drugs adopt control mechanisms with the aim of getting positive experiences from drug use, establishing a control of the use of substances, within the group of consumption and in the setting where this occurs.[51,53,63,65]

Therefore, a model based on self-regulation acknowledges the abilities of drug users, with a positive impact to mitigate stigmatization and promote preventive inclusive programs with goals other than withdrawal.[53] For instance, several research studies focused on users of crack cocaine in Brazil[13,14,66] observe the ability of participants to regulate their consumption by using crack cocaine in combination with marijuana, with the aim of reducing anxiety, excitability, and other negative psycho-stimulant effects; minimizing their craving for crack cocaine and enduring withdrawal periods; as well as for improving hygiene, rest, and eating patterns, while improving the quality of life. Other methods mentioned by crack cocaine users include looking for recreational, occupational, or physical activities to avoid drug-related

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anxiety and maintain periods of control or withdrawal.[13]

Finally, it is necessary to highlight that most postulates and interventions are based on research studies conducted in clinical environments, running the risk of making generalizations centered only on users having intensive or problematical consumption patterns. Unfortunately, qualitative research studies, carried out in natural environments and from a user perspective, often have little impact on the formulation of drug policies.[53,67,68] In general, quantitative science investigators undervalue that research studies that consider the perspective of people who use illegal psychoactive substances can be objectified, replied, and generalized, despite following strict procedures for the study of drug use.[10,67,69] However, qualitative science provides a greater and more complex understanding of micro and macro dimensions of drug use, of the significances and representations among drug users, and on the characteristics of drug use in vulnerable environments where they suffer social and health harm, and different types of violence,[69,70,71] that can be more useful to introduce health problems and variables into epidemiologic studies.[67,69,70] That is why our emphasis is put on the importance of resorting to these types of studies for a better adaptability and credibility in specific interventions.

CONCLUSION

Our aim was to challenge the idea that the use of illegal psychoactive substances can be unilaterally considered through legal and medical discourse as a socially deviated activity or as a mental condition or illness originated in the brain, a situation that has inevitably pierced the collective imaginary in a progressive and very successful way. Despite partial and not global implementation of harm and risk reduction policies at an international level, people who use illegal drugs are – explicit or implied – victims of exclusion and repression processes, carrying out secret drug use practices in hazardous environments, characterized by social, structural, and environmental conditions leading to social and health harms (stigma, marginalization, and different types of violence) among the most vulnerable collective groups or against standard drug use forms. Facing the disregarded biomedicalization threat of harm and risk reduction proposals – which progressively focus their efforts on health care spheres only – they should widen their proposals by having a more powerful influence on politics, in order to fight criminalization and promote stronger policies in favor of the rights of individuals and collective groups with respect to drug use. This would help promote statutes that better reflect different social and cultural realities. In order to achieve this goal, what is crucial is an articulation of social movements led by representatives of people who use illegal substances, relatives and other affected individuals, researchers and professionals in alliance with other disciplines, to be able to put pressure on different levels of administration agencies responsible for maintaining – without any self-criticism at all – prohibitionist policies overtly discredited by poor results regarding their objectives: a decrease in both demand and supply.

Eliminating barriers that limit access to the right of health, increasing the coverage of medical attention services, optimizing political participation – broadly speaking – of the people who use illegal and legal psychoactive substances, taking into account specificity and diversity of each individual and collective groups made up of people who use substances and to whom services are offered, and decriminalization of drug use by amending international supervision agreements are some of the essential and indispensable premises, albeit not all, in furtherance of said objectives. In short, guiding a regulatory process regarding illegal substances different to the present-day rules. All these premises should have as a starting point a deep and complex knowledge of the multiple realities and local or regional contexts with their own cultural characteristics together with biomedical

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advances dedicated to the research of health issues. Only that way will the advancement in small contexts and spheres (see the case of cannabis regulation), small victories, against the prohibitionism that has been erected globally as a repressive, implacable monster be the only solution to expand a social and political movement to protect and defend people who use illegal substances. To sum up, it is necessary to approach the issue discussed here more in tune with human rights within the health sphere and the right to free will. After all, the use of psychoactive substances is part of the unquestionable freedom to deal with the vicissitudes of our health and, consequently, the attention to discomforts or incidents presented by biological, social, or cultural diseases.

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