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PERSPECTIVE

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For a renewed harm reduction model

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Abstract

In the early 1990s, the spread of HIV among heroin injectors prompted a shift in drug policy internationally, including in France. This led to the emergence of a new policy known as Harm Reduction (HR) and related tools, including needle exchange programmes, opioid substitution therapy programmes to manage illicit opiate consumption, as well as reception facilities and support systems for the most precarious People Who Use Drugs (PWUDs). This new policy is based on the assertion that drugs have always been there and will always be a part of society, and that we have to live with them and not try to eradicate them. Promising PWUD emancipation, the advent of HR was accompanied by the birth of peer-support groups for unrepentant PWUDs, who decided to speak out in the public arena for the first time. Thirty years on, the authors assert that this promise has not lived up to expectations. More specifically, the cohabitation of an institutionalized, bureaucratized HR with the criminalization and stigmatization of drug use has worked against PWUD emancipation. As PWUDs, users of the addiction care system, peer workers and managers of addiction and HR facilities, the authors discuss the tensions between HR and the continued criminalisation and stigmatisation of drug use in France. Using the PWUD internet platform Psychoactif and the related peer-support group, both of which they created, the authors share their experiences and reflect on their practices to propose a renewed model of HR which reconnects with the civic and emancipatory roots of HR: a rights-based model that enables PWUDs to regain their power to act and escape the alienation caused by the stigma of drug use.

Keywords Harm reduction, Peer-support, Experiential knowledge, Benefits of drug use, Stigmatization, Emancipation, Drug policy and prohibition

Introduction: Are we alone?

In the early 2000s, the two authors of this article were introduced to harm reduction (HR) through community-based associations and discovered that the principles of HR echoed their values. It would be fair to say that it was a revelation. Finally, they could be accepted as they were: people who use (illicit) drugs (PWUD[1]s). Their passion for HR led them to work in the professional (i.e., institutionalised) HR sector. It was when they encountered this milieu that their enthusiasm waned. Although HR actors accepted some drug use, opiate addiction remained taboo. They saw it as something to fight against, something to be ashamed of. Specific practices, such as injecting, were highly stigmatised, despite the supposed non-judgemental nature of HR practices and HR actors. HR actors tacitly accepted the discrimination within the care and addictology system, and did not question drug prohibition.

Faced with these facts, at the end of 2006, the authors set up an internet platform called Psychoactif which contained forums, blogs and a wiki. Its aim was, and still is, to enable all PWUDs, irrespective of the drugs they use, their mode of consumption, and their relationship with drugs, to talk anonymously about their experiences. The aim of the platform is to share experiences in order to create individual and collective HR strategies. Internet users soon began to flock to Psychoactif. The possibility of remaining anonymous online provided unrepentant PWUDs the opportunity to share their opinions and experiences publicly. A team of volunteers was soon

[1] PWUD : Person who use (illicit) drugs

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co-opted from among the platform's users to moderate. Their job was to ensure that the platform's values were respected and to guarantee the safety of internet users by censoring and banning those who did not comply with the platform's rules.

Almost 20 years later, in 2024, Psychoactif's moderation team comprise approximately fifteen volunteers who are also PWUDs. This team also acts also a peer-support association in its own right. Members of the team have daily online discussions and meet physically several times a year to reflect on HR, addiction, the French care system (i.e., both general care and care for addiction), and the prohibition of drug use.

There are nearly a hundred different forums on Psychoactif, covering different substances, prohibition, the healthcare system, the intersectional stigmatisation of women, and chemsex... There are also forums to help users maintain their anonymity on the internet and the deep web. Psychoactif is a community, and what makes it a community is not so much the fact that its members are PWUDs, but that they belong to the same digital platform and share its values.

Alongside this voluntary peer work with Psychoactif, the two authors are now managers of addictology and HR structures. Not only do they have personal experience of drug use, they also have personal experience of police arrests for drug use, OST, and of the difficulties of accessing the care system linked to their drug use. This 'ubiquitous' experience enabled them to develop what Medina [1] calls a 'double conscience': belonging to two groups with asymmetrical power relations, specifically PWUDs and managers in the addictology system. This double conscience has given them the opportunity to deconstruct the dominant discourse for drugs and addiction in order to better understand it and critique it.

In this context, their experience and distinctive position give them a unique view of HR, its mechanisms and its philosophy. They are also aware that the continued stigmatisation of PWUDs may lead to their discourse in this article being discredited. Revealing oneself in a prohibitionist system is taking a risk. However, they feel compelled to share their perceptions given a context where HR and addictology professionals and researchers have for too long said nothing about their own use of drugs in order to protect their own interests and not to jeopardise their credibility and professional careers.

As PWUDs, users of the addiction care system, peer workers and managers of addiction and HR facilities, the authors propose discussing the tension between, and the silence surrounding HR that coexist with criminalisation and stigmatisation. By sharing their experience and reflecting on their practice, they propose to explore a new model of emancipatory HR: a rights-based HR model that enables PWUD to regain their power to act and escape the alienation caused by the stigma of drug use.

Conceptualizing harm reduction (in the French context)

The first HR measures linked to HIV infection among injecting drug users were introduced in France in the late 1980s and early 1990s. These included over-the-counter sale of syringes, needle-exchange programs, the first methadone programmes, and the creation of 19 PWUD associations as part of the PWUD network ASUD [2] throughout the country. For the first time, unrepentant PWUDs who injected heroin were able to speak out in the public arena. They produced brochures and newspapers and set up needle exchange programs for their peers.

In 2004, HR was finally written into French law as follows: "The policy of harm reduction for drug users aims to prevent the transmission of infections, mortality from overdose by intravenous drug injection, and the social and psychological harm linked to drug addiction by substances classified as narcotics." [3]. Existing needle exchange and Drop In Center programs became institutionalized medico-social centres which would be financed by the State for the following 15 years called CAARUD (Reception and HR Centers for Drug Users). Five years later, CSAPA (Addiction care, support and prevention centers) were also officially mandated to implement HR [4].

In 2016, following a debate on introducing drug consumption rooms [5], a new public health law provided a virtually identical definition of HR. Both legal and illegal drugs were included, and HR became written into the Public Health Code under the heading 'the fight against addictions', rather than the fight against HIV [6]. However, neither this law nor that of 2004 takes into account the place and funding of PWUD associations in the HR system.

While the first HR measures may have led to believe in the emancipation for PWUDs, HR professionalization and institutionalization in public health policy—in a context where drug consumption in France is still illegal—has shown its limitations. Of the 19 ASUD associations, only one—ASUD Paris—remained as a peer-support group producing a newspaper for PWUDs. Sixteen others disappeared and two became CAARUD (see above), which have nothing to do with peer-support. The only way for these groups to obtain long-term funding is by obtaining CAARUD status. In this and other ways, the institutionalization of HR has worked against PWUDs' emancipation.

Institutional HR is not a model that evolves based on the needs of PWUDs; it is a vertical public health model

where 'populations that manifest high risk or are composed of individuals deemed at risk become the target of programmes to transform their status, to make them active citizens capable, as individuals and communities, of managing their own risk' [7, 8]. HR is therefore an agentive technique that requires the targeted PWUD population to adopt measures recommended by epidemiological studies to combat risks (e.g., HIV, HCV, overdoses). The players involved never stop to ask themselves if the risks they are tackling are themselves the consequence of the ideological system the players work in. In other words, institutional HR focuses on the individual and health risks of drug use but does not take into account the psychosocial or legal risks and damage associated with prohibition and stigmatisation, or indeed the social inequalities and oppressive systems (patriarchy, racism, etc.) that increase this damage [9]. This is reflected by the fact that intervention strategies for PWUDs in 2024 are still limited to assessing health risks (e.g., HIV, HCV, overdoses) and distributing tools to reduce them. This focus only on health risks has consequences for the knowledge required of those involved in institutional HR: Professionals need medical knowledge; experiential knowledge is not considered.

Institutional HR is part of the public health system; this system asks addicts to become autonomous, responsible and healthy citizens, and ultimately free from addiction [10]. This leads to what Shira Hassan calls 'recovery readiness' [11] (p. 118) where institutional HR 'encourages' PWUDs towards what is seen as the ultimate goal, abstinence, to the detriment of PWUD self-determination and autonomy. It is by trying to be benevolent and by 'encouraging' PWUDs to stop that professionals create violence and undermine PWUDs' autonomy. Here are a few real-life examples of this:

- An HR association offers a homeless person who injects high doses of morphine a trip to Africa. But the condition for going on the trip is to stop injecting and to switch to methadone, by spending a week in hospital just before the trip. This proposal is part of an incentive programme that prepares PWUDs to consider stopping injecting. The person, who has never travelled, is ready to accept any condition imposed on him to go to Africa. Unable to cope with the impact of stopping injections and the effects of switching from morphine to methadone, he stays in hospital for three days and leaves early with a severe sense of failure, incapacity and guilt. What was seen by the professionals to be a "therapeutic" trip to stop injecting, was counter-productive.
- Health professionals refuse to interview a PWUD who appears to be high, because in their opinion, he would not have the minimum mental capability needed for clear exchanges. By doing so, the professionals refuse access to care and access to rights, inciting the PWUD to come sober the next time, without knowing whether he will be able to or not.

This vision of institutional HR refers to what Hunt [12] calls 'weak rights' HR for PWUDs. This HR model coexists with the criminalisation of drug use and focuses on the individual risks associated with drug use. It is a model where prevention of use is considered as one legitimate aim. It differs from 'strong rights' HR, which considers that drug use is a human rights [13].

In this context, the two authors argue that it is possible to develop a renewed HR model, one that is rooted in human rights, that is emancipatory for PWUDs, and that not confined to health risks. Psychoactif is one example of an emancipatory HR space, providing something similar to what Shira Hassan calls Liberatory Harm Reduction [11](p. 30)[2]

Psychoactif is a peer support group. As Dean Spade explains in his book Mutual Aid, peer support groups are born out of feelings of anger and rage at the shortcomings of institutional system in general [14] (p. 28). The authors were angry at the offer of existing HR services, which did not correspond to the way they experienced their drug use and how they perceived HR. They wanted to set up a peer support group where PWUDs could discuss their drug use, the benefits of drug use, their modes of use, and their dependence without shame or guilt. Initially, they wanted to set up a physical group, but that did not work. The idea of creating an internet-based platform only came to them because one of the authors had internet programming skills. In 2006 the 2.0 peer-support group Psychoactif came into being.

Barrat [15] showed that internet forums such as Psychoactif are spaces in which individuals pool their experiential knowledge and produce a lay pharmacology. Psychoactif is based on the self-determination, autonomy, and PWUDs' experiential knowledge related to their use. PWUDs on the platform ask questions and people in the community respond by sharing their experiences. These

[2] "Liberatory Harm Reduction is a philosophy and set of empowerment-based practices that teach us to accompany each other as we transform the root causes of harm in our lives. We put our values into action using real-life strategies to reduce the negative health, legal, and social consequences that result from criminalised and stigmatized life experiences such as drug use, sex, the sex trade, […] and any other survival strategies deemed morally or socially unacceptable. Liberatory Harm Reductionists support each other and our communities without judgement, stigma, or coercion, and we do not force others to change. We envision a world without racism, capitalism, patriarchy, misogyny, ableism, transphobia, policing, surveillance and other systems of violence. Liberatory Harm Reduction is true self-determination and total body autonomy»

testimonies provide multiple tried and tested strategies to provide an answer to the question asked. Those who read them can draw inspiration from them and define their own strategy to resolve the problem they are encountering. This production of knowledge is therefore collective in nature. This process of producing knowledge is governed by a charter that sets out the values and rules of the platform's community. Moderators, who are members of the community, ensure that the charter is respected, with the help of the community itself; specifically, members who are not moderators can report messages that do not comply with the charter. The platform's moderation team takes care to ensure that positive testimonials, that is to say testimonials which go against the pattern of repentance of drug consumption issues, are highlighted on the platform's home page. It is the members of the community who decide which risks are important to them and how to reduce them. Psychoactif's forums talk about all types of drugs and their associated risks; new forums have been added over the years in response to requests from the community. For example, forums on new synthetic drugs, on growing psilocybe, and on extracting DMT have been opened. As new topics emerge, knowledge on HR is produced and summarised in 'Psychowiki' sheets that combine experiential and medical knowledge.

Psychoactif is a community that not only seeks to reduce the harms associated with drugs, but also the social, legal and health consequences of the continued criminalisation and stigmatisation of drug use in France. From the outset, the platform was set up as a means of documenting and reducing the damage caused by addictology (e.g., stigmatisation, abstinence-based strategy), which PWUDs saw as a form of violence against them. In 2008, the moderation team decided to open a forum called 'Repression: Victims of the war on drugs' to identify the risks and legal damage associated with prohibition. This forum talks about the consequences of arrests for drug use, house searches, the hunt for PWUDs on the road as a consequence of the advent of saliva tests for drugs (unlike blood alcohol tests, which assess the level of alcohol in the blood, saliva tests for drugs assess the mere presence of drugs in the saliva. They do not assess the influence of the drug on the person. A person may therefore test positive and no longer be under the influence of drugs), losing one's driving licence, and the best defence lawyers for drug convictions. To avoid police violence, the community also talk about rights in police custody and during roadside tests. In 2012, Psychoactif opened another forum where people can learn how to use the deep web, which can be used to buy drugs to avoid police violence.

HR on the Psychoactif platform is non-normative and non-prescriptive. It leaves people free to choose their HR strategy, even for so-called 'at-risk' practices such as injection. Shira Hassan points out that these practices are also survival and coping strategies [11] (p. 123) and that wanting to change them against the PWUD's will is taking away their ability to act. Worse still, labelling 'risky practices' reinforces the stigmatisation of PWUDs, and traps them in their shame and guilt. Furthermore, these practices are labelled as risky in terms of their risk to health; labelling does not take into account the risk generated by the context of prohibition. For example, the term 'at-risk' practice for injecting does not take into account injecting an altered product, injecting under stressful and unsanitary conditions, stigmatisation linked to injecting, of refusal to provide care because a person injects. One way to avoid labelling is to talk about areas for vigilance linked to specific practices. These areas for vigilance make it possible to talk about the risks associated with practices without classifying them in terms of level of risk, and without stigmatizing some practices more than others. For example, in flyers on safer injection, there is always a diagram of the human body classifying injection points as green, orange or red, depending on the supposed level of risk. These zones stigmatize certain injection points in red (jugular, femoral, penis, etc.), and trivialize others in green (arm, hand, etc.). At Psychoactif, we limit ourselves to a description of practices and risks, which we call 'areas of vigilance'.

The platform's moderators are careful not to say what is 'good' or 'bad' for PWUDs. For example, The Psychoactive community debated over injecting methadone in capsule form. For a long time in France, oral methadone (i.e. liquid or capsule) was seen as a treatment against the injection of opioids. When PUDs started to inject the contents of capsules, this representation was broken. The aim of the debate on Psychoactif was to hear what PWUDs had to say about the issue, but also to share information about their recipes for preparing capsules for injection. Some members argued that methadone injectors should not be able to post their recipes on Psychoactif, so as not to encourage others to inject capsules. The issue which emerged was: 'Should this practice of posting recipes be banned on Psychoactif ?' HR means starting from where the person is at, from his/her needs. Apart from the fact that little is currently known about the real risks of injecting methadone capsules, categorising it as a risk practice, under the guise of a discourse based on health, is another way of passing moral judgement on the practice. In the end, the platform's team of moderators decided to allow members to talk about this practice and to share their recipes for injection capsules. The important point in this decision was not to exclude people who have 'at risk' practices, but to build a relationship with them in order to develop HR strategies.

Experiential knowledge

In various areas of health, such as mental health and disability, the concept of the participation of healthcare service users has become central; representing users of the health system, aiding in public policy development and involvement in peer support are three examples of this. Similarly, the involvement of PWUDs in decisions on public policy should be promoted as a valid approach for the development of drug policies and programmes. PWUD involvement would ensure that decisions are relevant, appropriate and effective for the specific PWUD community affected. Greer [16] shows that the PWUDs most affected by prohibition have specific opinions and knowledge about drug policy. In her study, she proposed three hypothetical ways around prohibition to PWUDs attending Sydney's social services: decriminalization, legalization, and medicalization/prescription of drugs. Although opinions were divided, a majority of the PWUDs favored drug regulation via medicalization/prescription, despite the fact that "the medical model has been largely ignored in drug law deliberations by experts" [16] (p. 45).

For all that, the narrative of a PWUD's experience is shaped by an intense social opprobrium that simultaneously produces and constrains this narrative; the only public speeches by PWUDs that are tolerated and solicited by society are speeches of repentance, where PWUDs apologize for their use and the mistakes they have made. Defending experience as evidence in public policy, Valentine & al. [17] warn against an approach that relies unreservedly on narratives 'which follow an arc of decline and redemption and a trajectory from "addict" to "clean". To challenge the dominant discourse based on PWUD's redemption, Engel & al. [18] argues that positive PWUD narratives can counteract and help to reshape it. These positive narratives show that there is not just one truth about drug use, and highlight that other points of view should be taken into account when developing public policy on drugs.

In terms of HR practices, Dertadian &Yate [19] argue that HR which is based solely on medical knowledge is rigid. It does not adapt to the needs of PWUDs and excludes those who are most stigmatised. It minimises the importance of PWUDs' quality of life, opting instead to focus on health issues defined by medical knowledge. Experiential knowledge[3] can prevent medical knowledge from doing harm. Farrugia & al. [21] describe the practices of Dylan, a PWUD and volunteer in a peer-run drug consumer organisation which teaches volunteers how to deliver naloxone[4] in such a way as to gently wake up a PWUD from an overdose. This ensures that the PWUD can interact better with the emergency services once he/she wakes up. Farrugia & al. [21] show that this practice is more effective than that performed by paramedics who inject the full dose of naloxone, which puts the PWUD into a state of advanced withdrawal. Moreover, the 'gentle wake-up' approach is superior in terms of public health, since previous negative experiences with naloxone may discourage people from both administering and receiving it.

In terms of drug use, experiential knowledge concerns the various areas of social participation of PWUD, and their social consequences. It consists of knowing how to identify and understand the effects of drugs, of adapting consumption according to the desired effects and the motivations for consuming, and of managing the undesirable effects of use. However, experiential knowledge also consists of knowing how to use HR and the care system, knowing what to say to one's doctor about one's drug use, and knowing how to participate in the decision-making process regarding which Opioid Substitution Treatment (OST) and other treatments to take. The authors point out that the institutionalisation of HR brought about an end to the participation of PWUDs in HR and consequently, an end to the use of their experiential knowledge of drug use in developing HR [22].

At the start of HR in France in 1994-95, PWUDs participated as peer workers in existing needle-exchange programs and even created their own such programs [23] (p. 165). The professionalization and institutionalization of HR in 2004 meant that only qualified people could be hired in CAARUD (see above). Consequently, a large proportion of PWUD could no longer continue their role as peer workers. This led to many peer-workers disappearing from these centres. The same change occurred in CSAPA (see above), which had hired 'ex-junkies' in the early 1970s to provide a welcome service in their centres and to give advice to PWUDs on their care pathway. To reintegrate experiential knowledge into institutional HR, we need to involve players who recognise its value and cultivate it. These players can only be (ex-) PWUDs, specifically peer helpers or professionals (educators, nurses, manager, etc.) who disclose that they are (or were) PWUDs themselves.

However, there are many obstacles to overcome before this knowledge can be reintegrated. One of these obstacles is linked to what Fricker calls the epistemic injustice.

[3] Experiential knowledge is not only based on experience. It is characterized by the simultaneous mobilization of personal experience, reflection on testimony and the opinion of peers, the observation of similar or related situations, the results of analytical reasoning, and the appropriation of other content (possibly scientific) [20]

[4] Naloxone is an opioid antagonist, a medication used to reverse or reduce the effects of opioids. For example, it is used to restore breathing after an opioid overdose.

The term comes from feminist and postcolonial authors. It is used to analyse the hierarchy of knowledge within systems of domination. Fricker [24] characterizes epistemic injustice as a wrong that affects someone specifically in their capacity as a 'knower'. Rajeev Bhargava defines it as follows: "I define *epistemic* injustice as a form of cultural injustice that occurs when the concepts and categories by which a people understand themselves and their world is replaced or adversely affected by the concepts and categories of the colonizers" [25]. Marie Dos Santos extends this term of epistemic injustice to PWUD (especially peer-helper) in contact with addiction and HR professionals. She asserts that "the re-conceptualization of psychotropic experience through the prism of medical and addictological epistemology alone is a form of epistemological violence experienced by PWUDs, who will reinterpret their own social world and experience using the concepts of the professionals around them, rather than using their own framework of thought" [26, 27]. Epistemic injustice in the HR context is the impossibility for peer helpers to impose their point of view and framework of thought on professionals. Put another way, it is the ability of healthcare professionals to impose their medical knowledge over the experiential knowledge of peer helpers. As a result, in many facilities, peer helpers have stopped using their experiential knowledge and instead have adopted the medical knowledge of carers. All they do is pass on medical information.

In a system dominated by a medically-based discourse, individual experiential knowledge is not enough. Collective knowledge that builds other norms and strengthens individuals is also essential. Monica Jane Barrat's work shows that PWUD platform such as Psychoactif produce social interactions that contribute to the production of knowledge, identity and culture [15]. Through the internet, PWUDs produce their own identity discourse, and by doing so, resist the deviant, pathological identity which the medicalised model of addiction labels them. Barrat shows how groups self-manage and take responsibility for themselves by redefining normality on the basis of their own experiences. Psychoactif is a space of epistemic resistance that allows people to think differently about themselves in a wider context than simply that of the therapeutic field, and to experiment with other ways of living with drugs. Experiential knowledge, when constructed collectively, can be used to challenge the epistemic injustice PWUDs suffer in the face of the dominant medically-based discourse.

It is thanks to the use of the experiential knowledge gained at Psychoactif in their work as managers of CSAPA (see above) that the authors of this article have been able to (i) create services that are adapted to different PWUD profiles, (ii) lower accessibility thresholds, and (iii) change institutional norms. Moreover, it is thanks to their status as institutional managers that has enabled them to counter the dominant medical and pathology-based discourse surrounding drug use, and to redistribute the balance of power. Having experiential knowledge of drugs makes it easier to be less afraid of them, to talk about them, and to design appropriate HR strategies. For example, the authors have made HR tools (e.g., injection kits, syringes, filters) available on self-service shelves in the CSAPAs where they are managers; many CSAPA have no such tools available, or only provide them after an interview with a health professional. Another example is the authors' decision to abolish urine testing (after a legally mandatory initial test) as a condition for receiving methadone. Indeed, methadone is distributed without monitoring people's drug use, and without monitoring abstinence from drugs. More generally, the fact that the authors talk about their own drug use in the facilities they manage helps to lift the taboo around the use of drugs, and encourages professionals and users to talk more freely about their own use. Shira Hassan points out that seeing peers take a leading role, encourages other people from the drug community to regain their self-confidence, and to tell themselves that they are the solution and not the problem [11] (p. 122).

Language and stigma

The authors want an HR model that combats the stigmatization of PWUD. This stigmatization is not just the imposition of prejudice towards a specific group of people. According to Link & Phelan [28] the term stigma applies when there is the simultaneous presence of the following criteria: labelling (i.e., the identification and naming of differences between PWUD and others, for example terms like "drug addicts" and "addicts"), stereotyping (i.e., associating negative characteristics with PWUD, for example "irresponsible", "animal", etc.), separation (i.e., the process of distinguishing between those who are PWUD and those who are not, between "us" and "them"), loss of status (i.e., a decrease in the social status of PWUDs and in the perceived truth of what they may say), and discrimination (i.e., unfair treatment of PWUDs and a loss of their rights). These different components of stigmatization coexist in a power relationship between a dominant group (i.e., the police, the justice system, addiction specialists, researchers, political leaders, etc.) and a dominated group (i.e., PWUDs).

Although all users of illicit psychoactive substances are affected by stigma, those addicted to illicit drugs are the most stigmatised. In her book 'What's wrong with addiction?' Helen Kean argues that extending the concept of addiction to a disease that also encompasses sex and food has not destigmatised people addicted to illicit drugs

[29]. The social situation of the illicit drug user still falls within a framework of criminality and moral bankruptcy. Illicit drug addicts are considered slaves to an all-powerful substance that can only damage them and others.

The effects of stigma are harmful; it can lead to delays/barriers in accessing addiction treatment and other health services. It can also mean being treated in a discriminatory manner in terms of the justice system, housing, employment and in other aspects of daily life [30]. For example, on the Psychoactif website forum, one member, Littleboy[5] talked about the delay in receiving treatment for cystic fibrosis because he is a former morphine addict[6] :

I was supposed to receive Trikafta for my cystic fibrosis but because of my problems I got nothing. Despite my health being really bad (FEV1 score 35) they didn't want to give me anything because for them I had to [first] completely fix all my problems... But what problem?! I only used [drugs] rarely, and for them it was impossible because [in their mind] a PWUD is a person who never leaves drugs, not even for a day, and who [continuously] suffers harm; whereas today with good harm reduction it's [i.e., drug-related harm] minimal or even completely absent, at least for me... Anyway, I experienced severe stigmatization and my health was getting worse day by day.

Littleboy's words also show that addiction to illicit drugs continues to stigmatise people, even when they are no longer addicted.

Another example is Mro-fret who talked about the poor care he received to manage his pain [7]:

As far as I'm concerned, I had a bad experience regarding this subject... to make a long story short, I happened to talk about my problems [with drug consumption] to my GP. The latter reacted and made some comments that weren't very professional... anyway.

Two years ago I had a serious accident at work (construction); around 25 or 30 sheets of BA13 plasterboard - for those who know [what that is] - fell on my left leg. My femur and tibia were fractured in several places and several ligaments and tendons were torn - sorry I'm telling you my life story - but all that to say that after my past confessions [i.e., revealing he used drugs to his GP], I got a prescription for painkillers the same [strength] as for a simple migraine...

So if I had to do it [i.e., talk again about drug consumption problems] again, I'd think twice.

Mro-fret's words highlight how a healthcare professional did not prescribe appropriate opiate-based pain treatment to a person addicted to illicit opiates, even for severe pain. The doctor's relationship with his patient was based on suspicion and stigmatisation.

In order to propagate, stigmatization depends on language and communication [28]. Words can have enduring social, political and health effects particularly in substance use-related contexts [31].

John Kelly and Richard Saitz show that people may be treated differently (i.e., more punitively) by clinicians if they are labelled as substance 'abusers' instead of being described as having a substance use disorder [32]. Referring to people as substance abusers defines them by their problem; it strengthens stigma, increases blame and their sense of guilt, and diminishes help-seeking behaviours.

Drug consumer movements led the charge to remove dehumanising language from drug policies and advocated the use of person-first language [33]. Traxler & al. [34] and Hartwel & al [35] show that scientific studies also use stigmatizing and dehumanizing language. Consequently, editors of peer-based journals have adopted guidelines to ensure that studies contain as little stigmatizing language as possible 31 . They now recommend (i) using People-First Language (ii) using empowering and strength-based language, (iii) avoiding jargon, slang and emotion-based language, (iv) avoiding generalisation, and (iv) using inclusive language. For their part, the authors of this article noted the negative and stigmatising impact of certain terms used in HR and addictology. This is why they have worked on using non-stigmatising language in Psychoactif. For example, they adopted the term 'person who uses illicit drugs' (PWUD) instead of 'drug user' for all communications, in order to (i) recognize our collective humanity, (ii) not reduce a person to their use, and (iii) be inclusive (using gender neutral terminology) [36]. Moreover, to define the term PWUD, they explicitly use the word 'drugs' and not substance psychoactive to (i) challenge stigmatizing language, (ii) turn stigma on its head, and (iii) highlight the trivialisation of the use of illicit psychoactive substances in society. The authors use the same person-first logic for the terms 'heroin addict' or 'crack head', which they replace with 'person who uses heroin or crack'. Similarly, they no longer use the term 'relapse' but 'reconsumption of drugs' as the term relapse implies 'a fall from grace', with the dominant discourse of abstinence reflecting 'grace'. Moreover, for people who inject or sniff their opioid antagonist treatment (i.e., buprenorphine or methadone), the authors have replaced

[5] To chat anonymously on the Psychoactif platform, people need to register and choose an identifying nickname (pseudo), in this case Littleboy".

[6] Psychoactif.org - Litlleboy's testimony - Pourquoi parlez-vous ou pas à votre médecin de vos consommations ? - https://www.psychoactif.org/forum/2024/02/15/Pourquoi-parlez-vous-ou-pas-votre-medecin-traitant-vos-consommations_75226_2.html#p655164

[7] Psychoactif.org - Mro-fret 's testimony - Pourquoi parlez-vous ou pas à votre médecin de vos consommations ? - https://www.psychoactif.org/forum/2024/02/15/Pourquoi-parlez-vous-ou-pas-votre-medecin-traitant-vos-consommations_75226_1.html#p653925

the medical term “OAT misuse" with "alternative use of OAT[8] " [22]; the term "misuse" denigrates the practice of injecting or sniffing OAT and thus prevents PWUD from talking about it. Likewise, the term ‘misuse’ can affect care providers’ attitudes and stigmatize treatments and the use of treatments [34]. However, these alternative uses of OAT offer many benefits to PWUD; for example, they no longer spend time or money on illegal drugs, they no longer use the black market, they use a quality pharmaceutical product, and they are closer to the HR and care system. Paradoxically, using the term ‘alternative use’ enables PWUD to recognize and appropriate these benefits.

In the fight against stigma, the battle against self-stigma has a special place. Self-stigma is the consequence of PWUDs’ assimilation of and belief in the dominant discourse on drugs, and the prejudices that go with it (i.e., irresponsibility, compulsivity, animality) [37]. PWUDs with self-stigma consider themselves to be bad people because they use drugs. Self-stigma fuels shame and guilt; it is also responsible for a drop in self-esteem, which in turn reduces the power to act, causing immense psychosocial harm (depression, stress, overconsumption, craving, etc.) [38]. The fight to deconstruct self-stigma, which we might also call ‘psychosocial HR’, is all the more complex in the French context where drug consumption is prohibited and where the PWUD is consequently seen as a repulsive figure. The fight against stigma (including self-stigma) is essential to develop adapted and effective HR interventions and to fight against addiction [39]. Accordingly, it should be one of the objectives of French addiction structures (i.e., CSAPA and CAARUD). Unfortunately, as the Psychoactif peer-support group has observed, if specific strategies to combat stigma are not implemented, healthcare professionals reproduce the existing dominant, stigmatizing discourse where drug use is perceived as a scourge [18]. The French addiction care system is almost completely based on abstinence and professionals with stereotypical beliefs who do not comprehend the value of experiential knowledge acquired by PWUD, or the benefits linked to their drug use, and who therefore do not talk about emancipation or the power to act outside of the rigid context of abstinence.

Self-stigma in PWUD combined with the healthcare professionals’ prejudices is an explosive mix because it leads PWUDs to consider that mistreatment is normal. In turn, this leads to PWUDs not seeking care, and to accepting discrimination and violence. Psychoactif’s team of moderators sees this constant and massive institutional violence at first hand, because people share their experiences with healthcare on the Psychoactif platform. One example concerns urine tests for methadone users being used as punishment by a CSAPA. Fastofle[9] said:

The practices [at a CSAPA] continue; punitive peeing. Actually, they test for all the products in a “surprise, you have to pee” way. The result is that if there are traces of products, then there’s punishment. For example, if there are traces of coke, the methadone [dose] is lowered... A stupid and ruthless logic. In this same CSAPA, if a PWUD - playing straight - announces that she’s taking stuff [HR equipment (syringes etc.)] from a CAARUD, she’s also punished by a reduction in [methadone] treatment and a one-week suspension... Well yes, you can’t be on methadone and be a consumer [at the same time]... Otherwise punishment!!!

That’s why you see these people who are suffering turn again to heroine and the joys of the ‘ovens’ [i.e., point of sale for drugs] to compensate for their one-week red card and the reduction in their medical treatment... And yes, in 2023, "care providers" are still acting like this using punitive medicine... [This is a] situation of abuse of power, [it’s] revolting, mistreating, inhumane and disgusting....

While methadone should an HR tool that helps manage illicit opiate use, professionals in the CSAPA Fastofle talked about used access to methadone as a means of social control [40] of illicit opiate use. This choice is about re-educating the person addicted to opiates, even against their will. Helen Kean explains that “the flaw in the addict’s being is not so much dishonesty as inauthenticity, an inability to be true to oneself” [29] (p. 74) which makes them the object of therapeutic interventions. By considering that the addicted person is “deafened by the clamoring of the craving for the drug” and has lost all free will, coercive practices are justified as efforts to help the true self to respect its authentic desire for abstinence.

In the following example, Elgourou talks about poor practices, a lack of trust, and months-long waiting lists in his CSAPA[10]:

[I] fell into heroin in July 2022; it was around October of the same year that I went to the CSAPA in my city to start substitution [treatment] and to gradually wean myself off; at that time, they put me on Subutex which worked really badly for me; the desire to consume 24 hours a day, sometimes withdrawal symptoms despite everything, so very tired and weak, but above all forcing myself to come

[8] Term proposed by Fabienne Pourchon & Pierre Chappard [22]

[9] Fastofle’s testimony - Les tests urinaires pour la méthadone - Des abus de pouvoir du milieu médical - https://www.psychoactif.org/forum/2023/11/29/Les-tests-urinaires-pour-methadone-des-abus-pouvoir-milieu-medical_73688_1.html#divx

[10] Elgourou’s testimony - Les tests urinaires pour la méthadone - Abus de pouvoir du milieu médical - https://www.psychoactif.org/forum/2023/11/29/Les-tests-urinaires-pour-methadone-des-abus-pouvoir-milieu-medical_73688_2.html#p647839

to the CSAPA every two days at 9 a.m. to get my "dose" of Subutex; except that I was so weakened, I couldn't always go diligently; almost every morning I ended up relapsing. When I returned to the CSAPA hoping to find a better solution, ideally starting treatment with methadone which would probably be more suited to my situation, I was told that there was a long waiting list, and that as I wasn't able to come every morning to get my dose of Subutex they no longer trusted me.. I was therefore advised to go for detox treatment if I wanted to have access to methadone; I really didn't want to be locked up in treatment, but if I wanted this treatment, [there was] no choice; so, I waited several months until a space would open up so that I could enter, several months during which the CSAPA made it clear to me that I had to get by on my own, and therefore spend all my money on heroin just to avoid suffering withdrawal.

Elgourou's words show once again how OAT is used to re-educate a person against their will through coercive practices: professionals required him to come every two days to get Subutex®, which is not normal for a treatment that can be prescribed by any general practitioner for 28 days. They required him to go through opiate withdrawal before starting methadone treatment, which is a dangerous strategy and could lead to an overdose. Moreover, they made him wait several months so as to prove his willingness to get back on the 'right' track.

Benefits of drug use

A limitation of current HR is that it is impossible to conceive of the benefits associated with drug use. Indeed, very few studies exist on the benefits of drugs. Walker and Netherland [41] argues "that we have little research about why people use drugs, the net benefit of drug use, and the outcomes sought by people who use drugs**"**. In the authors' literature search, the closest thing they saw to an exploration of the benefits of drug use was a classification of motivations for use by Biolcati & Passini [42] who created five categories: Hedonism (stimulation, pleasure, euphoria), Socialisation and conformity, physical, intellectual and social doping, relief (physical or psychological) and personal development. It is very complicated for researchers to talk about the benefits of drugs. They are funded by prohibitionist states where the very notion of benefits of illicit drug use does not exist, and where any such talk amounts to heresy. Researchers themselves have integrated this prohibitionist framework into their work [41]. HR itself has made very little use of the benefits of drugs. It has hidden behind a mechanism of 'non-judgement' and amorality, where neither PWUDs nor drug use is judged [9]. Institutional HR is only interested in the health risks and damage associated with drug use; the benefits are forgotten despite the fact that they lie at the heart of drug taking.

It was during a meeting of Psychoactif's team members, pained by the negative view of drugs in society, that they rediscovered the benefits of drug use. The two authors of this article began to note down on a board all the benefits which the members present listed. Around the table, different members shared different ways of experiencing drug use (dependence on medication, morphine, speed, cannabis, 3MMC, and recreational use) and different modes of consumption (injection, inhalation, sniffing, plugging). Here are the results of the exchange during that meeting [11]:

improving self-esteem, overcoming blocks, sociability, spending a night without waking up, sensory experience, creativity, reducing symptoms of psychological illness, managing physiological needs (hunger, sleep), passing a milestone, going beyond one's limits and experiencing things one would not otherwise experience, gaining confidence, concentration, work performance, managing anxiety, acquiring skills, reducing physical pain, well-being, perfecting spirituality, euphoria, pleasure, identity building, pharmacological knowledge, discovery of disciplines, self-knowledge, finding one's way, relativizing, questioning the norm, taking a step back from choices that don't suit me, developing a better version of oneself, allowing oneself to do things, open-mindedness and tolerance, emancipation, more power to act, improving the experience of art, facing fears, being a resource/crutch, facing unbearable situations, getting to know one's body, having new experiences with one's sexuality, restoring balance, disinhibition, being able to express feelings.

As we can see, the benefits reported were very varied. Importantly, they are all benefits experienced after the fact, and which were not necessarily sought at the time of consumption. They are both long-term and short-term. They run counter to the idea that PWUDs are irresponsible and do not have any power to act, and more generally, run counter to society's negative view of PWUDs. These benefits concern all drug use, not just so-called 'recreational' use, reflecting Shira Hassan's description that the benefits of her drug use enabled her to combat her traumas and rethink her drug use: "Being able to view drug use as an act that creates safety, as secure attachment, is profound and transformational. Thinking about drug use and addiction on an elastic continuum from pleasure to chaos and everything between create an opportunity to reconsider addiction. It gives us permission to think of our presumed 'high risk' behavior as brave" [11] (p. 127). It was this intense collective sharing of the benefits of drug use that helped to strengthen the Psychoactif team

[11] Psychoactif.org - Vos bénéfices liés à l'usage de drogues - https://www.psychoactif.org/blogs/Vos-benefices-lies-a-l-usage-des-drogues_7088_1.html

as a group and to combat self-stigma. It enabled the team to see that there are benefits to drug use even for addiction, and so-called 'most-at-risk' practices such as injecting. With this meeting where community resilience came to the fore, the team moved from simply being witnesses to the benefits of drug use to a group demanding that these benefits be recognized in HR policy.

Engel & al. 18 argue that focusing on narratives that highlight the positive aspects of drug use for PWUD helps to break the grip of the negative representations made by the dominant medical discourse of abstinence, where drugs are considered to be a scourge, something harmful, and to foster beliefs that differ from self-destructive prophecies (such as the catastrophe that would automatically follow the honeymoon phase). For those involved in HR, the benefits of drug use for PWUDs should be essential to understanding drug use practices and patterns. One cannot co-construct an HR intervention without assessing the benefit/risk ratio of drug use with PWUDs themselves. The danger of not involving them would not only be the failure to provide adequate responses, but also to ignore the PWUD experience and to produce violence. One example of taking into account the benefit/risk ratio the authors came across in terms of drug use is the injection of Skenan®, a morphine-based drug, by people living in precarious conditions in Paris. There are different methods for preparing Skenan®[12]. The cold method involves crushing the contents of the capsules in the cup, adding cold water and filtering; the hot method involves heating the water first. The cold method uses a membrane filter and gets rid of excipients (e.g., talc). The hot method creates a gelatinous mixture that cannot be filtered by the membrane filter. It does not remove the excipients from the capsules, which are therefore injected with the morphine. For a long time, HR professionals encouraged PWUDs to use the cold method, not understanding why PWUDs chose to use the hot method despite the increased risk to health. This lack of understanding sometimes took the form of injunctions like 'Why don't you take care of your health?'. Then two researchers came up with the idea of testing Skenan® preparations using both methods to measure morphine levels. They found that the level using the hot method could reach double that of the cold method, because morphine sulphate is more soluble in hot water [43]. The PWUDs therefore experienced a greater effect using the hot method. Subsequently, PWUDs and HR actors developed a third method, called the lukewarm method, which gets rid of the excipients while still ensuring the solution contains as much morphine as possible.

Prohibition, decriminalisation and regulation

The authors want HR to be anti-prohibitionist. Drug prohibition generates a parallel economy run by criminal networks. It leads to violence and insecurity in communities affected by the transit and sale of drugs [44]. It has also contributed to the spread of HIV and viral hepatitis through the injection of drugs with contaminated equipment. Excessive incarceration for minor drug offences has led to overcrowding in prisons. Prohibition has also had a discriminatory impact, disproportionately affecting racial and ethnic minorities, as well as women [45]. In short, it has led to violence, disease, discrimination and human rights violations [46], while failing to significantly reduce drug use and trafficking.

These social harms specifically created by a prohibitionist drug policy [47] are not taken into account in institutional HR which only targets health risks and focuses on individual behaviour. Naloxone—an antidote for opiate overdoses—is an excellent example. Although its distribution by HR structures saves lives, institutional HR players are not interested in changing the system that causes overdoses; a system of adulterated, uncontrolled products, and of "illegal drug markets driven by economic processes that encourage the production and supply of more potent and profitable drugs and preparations" [48]. Rhodes [49] writes that the risks associated with PWUDs' use of psychoactive substances cannot be explained without taking into account the prohibitionist context in which these people live. Dertadian and Askew [47] describe an approach to drug policy that integrates social harm. By moving away from the concept of drug-related crime, such an approach would make it possible to conceptualise the social harm of prohibition. They argue that a social harm approach to drug policy would be more compatible with a peer-led activist HR based on human rights and the denunciation of state violence, and less compatible with bureaucratised and medicalised HR models which often end up reinforcing and justifying prohibition. Current HR practices are extremely limited by prohibition: Psychoactif's creation of a remote quantitative drug-checking service, which allows PWUDs to send a sample of their drugs by post and receive the results on a public website[13], is an example of a system that pushes the limits of the legal and institutional framework. This initiative makes quantitative analysis available to everyone, without restrictions, and helps to combat

[12] Psychoactif.org - Skenan Chauffer ou pas - https://www.psychoactif.org/forum/t11222-p1-Skenan-chauffer-pas.html

[13] Psychoactif.org - Analyse à distance - https://www.psychoactif.org/forum/analyse-a-distance.php

risks which the prohibition of drug use in France continues to generate (e.g., adulteration of drugs, unknown levels of purity).

More generally, in order to implement HR effectively over the years, the authors have had to find loopholes in legislation in order to 'push' HR a little further: the creation of the Psychoactif association, the creation of a remote drug-checking service, discussions on the benefits of drug use, on the use of experiential knowledge to create epistemic resistance to medical knowledge, and on the place of experiential knowledge in the institutional structures which they manage are all examples of this. However, all this is very fragile and could be crushed by stricter implementation of current legislation overnight. PWUD associations could be considered as criminal associations as PWUDs are considered delinquents; if the authors were to be convicted of drug use, they could no longer work in HR or in care. Furthermore, discussions about the benefits of drug use could become criminalised unless they are led by HR actors recognized by the State. Finally, remote drug-checking is legally 'fragile'. In summary, prohibition is a constant threat to HR.

To reduce the risks associated with prohibition, one possible option is to decriminalise drugs. Greer [50] assessed the situation in countries that have decriminalised drugs and proposed a framework for building a system to decriminalise possession for personal use. Various authors, including Stevens & al. 51 show the benefits of decriminalisation. It provides better access to care for PWUDs, with a substantial reduction in drug-related deaths, HIV infections and viral hepatitis. Decriminalisation can mitigate the role which stigma plays in keeping people away from healthcare services and hindering their social integration. By reducing criminal penalties and no longer dealing with drug use through the justice system, decriminalisation can help to reduce social harms against PWUDs. Decriminalisation is also economically responsible, since it tends to reduce the overall costs associated with drug policy by cutting criminal justice expenditure and promoting more effective public health approaches. Nevertheless, decriminalization would not reduce the risks associated with the illegal drug market or the violence linked to drug dealing caused by prohibition. To limit these aspects, Csete & al. [44] and the Global Commission on Drugs [48] go further and propose regulating the drugs market. In order to effectively reduce the harms associated with the use of psychoactive substances, HR approaches must take into account the risks associated with practices, products and the specific context; this is why HR must be anti-prohibitionist.

Conclusion

There have been three waves of PWUD peer-support in France. The first was the creation of the ASUD network in the early 1990s. The second brought together peer-support groups practicing HR in free-party contexts in the second half of the 1990s[14]. The advent of web 2.0 in the early 2000s led to the third wave of French PWUD peer-support groups, with platforms focusing on psychonautics being set up such as Lucid State (now defunct) and Psychonaut. These groups are closely related to the peer-support groups of the techno free-party setting. In 2006, the authors created Psychoactif, an internet-based platform rooted from the outset in HR. Psychoactif is more closely related to the French PWUD network ASUD, and to Junky Bond in the Netherlands, which was created in 1981.

Each new wave of peer-support has brought new visions and tools to HR, and the advent of internet platforms made HR widely accessible. The relative anonymity of the internet enabled PWUDs to testify publicly, avoiding stigma and repression by society. For the first time, PWUDs' testimonies and experiential knowledge became widely available in the public arena. Web 2.0 tools (forum, wiki) have enabled PWUDs to participate in HR for other PWUDs, promoting autonomy and self-determination. By speaking out publicly, some PWUDs enable others to draw on their experience to help them reduce risks. By sharing their stories, PWUDs have helped other persons in their community with similar experiences to feel less alone. Moreover, by telling their stories, PWUDs increase their own and others' power to act.

Building the Psychoactif community, which is based on the needs of PWUDs, has made it possible to document the various risks that concern PWUDs (i.e., health-related, legal, cultural, judicial, and police-related risks, as well as risks linked to stigmatisation, and to the current addiction treatment system which is based on abstinence). The consequence of this is the reappropriation of HR, where the focus is no longer solely on health issues, but on the risks associated with prohibition and stigmatisation, and where the right to use drugs is legitimised. The many testimonies of self-stigma on Psychoactif have raised awareness of the processes of domination which PWUDs experience. The damage caused by prohibition is reinforced by other systems of domination (capitalism, racism, patriarchy, etc.). However, testimonies of the positive aspects of drug use have also emerged, bringing the question of the benefits of drug use, and enabling a breakaway—to

[14] History of Technoplus - https://technoplus.org/historique/

a certain extent–from the dominant discourse based on abstinence and PWUD repentance.

The emancipatory nature on HR promoted by Psychoactif is also the result of a somewhat conscious decision to create a political mission, by the platform's founders; a mission which lies at the heart of Psychoactif's charter of values: to challenge the dominant discourse on abstinence, to move away from considering drug use and addiction as diseases, to move away from an HR model that emphasizes only medical knowledge and that crushes experiential knowledge, to move away from an HR model that is supposedly morally non-judgmental, but which does not take into account the benefits of drug use or the damage caused by prohibition and stigmatization. This political project was made possible by Psychoactif's team of moderators, a peer-support association in its own right, who initiated an experiment in collective transformation and community resilience, before proposing it to the other members of the platform. For the authors of this article, this is what a renewed HR model is all about: a PWUD community-led political project to change the way in which individuals and society relate to drugs, to challenge the dominant discourse of abstinence and the repression associated with drug use, and enable PWUD to regain their power to act.

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Publisher's Note

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