Monográfico

Drugs and society in Spain in the 2020s: Outlining alternatives to the biomedical-punitive model

Drogas y sociedad en la España de la década de 2020: retos y propuestas político-legislativas

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Abstract

This article aims to outline the basis of an alternative proposal to the traditional approach to drug policy and drug dependence in Spain. It is based on a critical analysis of the currently predominant hegemonic model, which is considered to be limited for two fundamental reasons. The first is its excessively biomedical and individualised approach to the treatment of mental health problems (and, therefore, drug dependence). The second is its emphasis on repressive and punitive measures to manage the social challenges related to adult recreational drug use and, especially, the problems arising from the existence of illicit drug markets. Both limitations have made it necessary for public policy to manage not only the consequences of substance use but also the consequences of drug policies themselves. As an alternative, we outline a model that combines a non-stigmatising approach to psychoactive substances with the centrality of human rights as the fundamental axis that should guide drug policies. We will focus on the specific cases of psychotropic substances (psilocybin, LSD and MDMA) and psychoactive plants of traditional origin, such as ayahuasca or coca leaf. With a more reflexive than academic intention, but as a result of the authors' experience in research and advocacy in this field, this article outlines some elements that could be taken into consideration when designing a drug policy that is more focused on community health and care, based on human rights, the participation of civil society and the objective evaluation of public policies.

Keywords

Human rights, Psychotropic drugs, Narcotic drugs, Psychoactive plants, Drug policy, Regulation.

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Resumen

Este artículo pretende esbozar las bases de una propuesta alternativa al tradicional abordaje de la política de drogas y de las drogodependencias en España. Se parte de un análisis crítico del modelo hegemónico predominante en la actualidad, al que se considera limitado por dos motivos fundamentales. El primero, por su enfoque excesivamente biomédico e individualizado para el tratamiento de los problemas de salud mental (y, por ende, de drogodependencias). El segundo, por su énfasis en las medidas represivas y punitivas para la gestión de los desafíos sociales relacionados con el uso adulto recreativo de drogas y, especialmente, de los problemas derivados de la existencia de los mercados ilícitos de drogas. Ambas limitaciones han hecho que, desde el ámbito de la política pública, se haga necesario gestionar no únicamente las consecuencias del uso de sustancias sino, además, las consecuencias de las propias políticas de drogas. Como alternativa, esbozamos un modelo que combina una aproximación no estigmatizante hacia las sustancias psicoactivas, con la centralidad de los derechos humanos como eje fundamental que debe guiar las políticas de drogas. Nos centraremos en los casos específicos de los psicótropos (psilocibina, LSD y MDMA) y de plantas psicoactivas de origen tradicional, como la ayahuasca o la hoja de coca. Con una intención más reflexiva que académica, pero fruto de la trayectoria de los autores en la investigación y en la incidencia política en este ámbito, este artículo perfila algunos elementos que podrían tomarse en consideración a la hora de diseñar una política de drogas más centrada en la salud comunitaria y en los cuidados, que esté fundamentada en los derechos humanos, en la participación de la sociedad civil y en la evaluación objetiva de las políticas públicas.

Palabras clave

Derechos humanos, Psicótropos, Estupefacientes, Plantas psicoactivas, Política de drogas, Regulación.

1. SOME INITIAL CONSIDERATIONS ON THE RELATIONSHIP BETWEEN DRUG POLICY AND HUMAN RIGHTS

We take as our starting point Babor et al.'s (2010) notion of drug policy, which they define as government activity that includes laws and programmes aimed at influencing people's decisions to use psychoactive substances, as well as those aimed at modulating the consequences of this use on individuals and communities. Similarly, in the area of human rights, our reference will naturally be to the fundamental international human rights standards: the 1948 Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (both adopted in 1966). Although for many decades the two spheres have been more parallel than coinciding, in recent years there have been many voices in research, politics and civil society that have worked to incorporate human rights into the design and implementation of drug policy. For example, the International Guidelines on Human Rights and Drug Policy, published in 2019[1], have provided a comprehensive diagnosis of how drug control connects to human rights, and what States can do to meet their internation-

1 International guidelines on human rights and drug policy https://www.humanrights-drugpolicy.org/site/assets/files/1640/hrdp_guidelines_2020_english.pdf

al obligations when designing and implementing drug policy. Also the Global Drug Policy Index, composed of 75 indicators covering broad dimensions of drug policy, such as the absence of extreme responses, proportionality of criminal response, health and harm reduction, or development.[2] Key to these novel tools is that they suggest that policies aimed at alleviating the consequences of both problematic drug use and illicit drug markets (violence, exploitation, corruption, or obstacles to sustainable development), having been overly focused on supply reduction from a security and punitive perspective, have done more harm than good in contexts where this phenomenon takes on a significant dimension (Gillies et al., 2019). Recent research suggests that communities, especially the most vulnerable sectors, have not only had to face the social and economic costs of illicit economies but also the consequences of public policies aimed at managing them (Bewley-Taylor et al, 2020; Buxton et al, 2020).

The relationship between drug policy and human rights is twofold. Firstly, we must emphasise that people who use drugs do not lose their human rights. This is most evident, for example, in the case of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. It is also the right to enjoy the benefits of scientific progress and its applications, including research on controlled substances. Secondly, States, in designing and implementing their drug control policies, must take into account not only the dimensions of public security and social control, but also human rights considerations. International human rights obligations, as outlined in the Guidelines, should guide the design, implementation and interpretation of drug control norms. In other words, human rights obligations do not lose any effectiveness and must be equally guaranteed, for all persons, in the context of drug control. Also for people who use drugs, also for people involved in illicit drug markets.

2. FRAMEWORKS FOR ADDRESSING THE DRUG PHENOMENON AND THE TREATMENT OF DRUG DEPENDENCE: THE LIMITS OF THE BIOMEDICAL-PUNITIVE MODEL

Due to social, historical and political reasons that go beyond the scope of this article, many of the social phenomena in Spain have been approached from criminological and biomedical frameworks, ignoring the multiple structural causes of these processes in their management. In many cases, the so-called "drug-related problems" are not so much related to the use of substances per se, but rather to the structural starting conditions in the different contexts in which this use takes place. The harms to people who use drugs and to communities and, why not say it, also the benefits, will be closely linked to the socio-economic conditions of the contexts in which they operate. These include inequalities, precariousness, access to basic services such as health or education, stigmatisation of certain groups or the ability to exercise and enjoy fundamental rights. Frequently, the perspective adopted by Spanish political decision-makers (and here we could include the different levels of administration, and successive stages of governments of different political colours) has been that of punishment, criminalisation

2 Elaborated by the Global Drug Policy Observatory of Swansea University (UK) and other organisations- See https://globaldrugpolicyindex.net

of social exclusion in order to manage the problems of illicit markets, and the pathologicalisation and medicalisation of drug users. The approach to the drug phenomenon in Spain, since the creation of the National Plan on Drugs (PNSD) in 1985, is paradigmatic. At the time of its creation, it was administratively located in the organisational chart of the Ministry of Health, before passing to the Ministry of the Interior in 1993, returning to the Ministry of Health in 2004, where it is still located.

Taking these parameters into account, the model for tackling the drug phenomenon and the treatment of drug dependence in Spain could be described as mixed, as it involves, on the one hand, the adoption of a biomedical approach to the approach to what has to do with the individual (such as the treatment of drug dependence) and a punitive prohibitionist approach that is applied to the social side of the drug phenomenon (such as recreational or non-problematic adult use, or the impacts of illicit markets). Hence our name: biomedical-punitive model.

This is an approach with a clear international origin. Since the adoption of the 1961 Single Convention on Narcotic Drugs, the United Nations has based its drug policies on a toxicological model (Sánchez-Avilés, 2017). The different narcotic substances - including the cannabis plant, the coca bush and the opium poppy, as well as their derivatives in the form of both active ingredients extracted from these plants and synthetic compounds - were classified into four schedules according to their potential toxicity and therapeutic potential. In reality, the toxicological criterion was only an alibi for including the three plants mentioned in the most restrictive list, i.e. the list of the most toxic substances. In the case of cannabis, this inclusion was not motivated by any technical report (Bewley-Taylor et al., 2014a). In the case of coca leaf, the inclusion was based on a report of dubious objectivity that would hardly pass any current scientific or ethical standard (United Nations, 1950).

The 1971 Convention on Psychotropic Substances also placed a number of substances under control through a scheduling system. This time it dealt with active ingredients, which were called psychotropic substances, including LSD (lysergic acid diethylamide) and all the hallucinogens that are controlled today, as well as other phenylethylamines that were later included, such as MDMA (3,4-methylenedioxymethamphetamine), once again on the most restrictive list.

The third international convention on which the international drug control system is based is the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, which obliges signatory states to criminalise, in their domestic legislation, activities related to the substances controlled in the two previous conventions. From that moment on, users from the most vulnerable sectors of society began to be criminalised with special emphasis, and punishment was introduced as a fundamental tool for managing the drug phenomenon in national policies (to the point of tolerating the death penalty for small-scale traffickers). Spain was no exception to this trend. We consider that, from the origins of the drug control system, there was a toxicological view that understood the drug problem as a problem of the dangerousness of the substances, and not as a problem resulting from structural situations or, directly, as no problem at all beyond that derived from the social control

of certain groups and populations. The prohibition of drugs was never motivated by medical reasons, even if such reasons had to be used to justify their persecution.

Prohibitionism, in its most punitive version, shaped drug policies in virtually every country in the world. Even today, societies continue to be inspired by this model, which has been in place mainly since 1961. Although, in its beginnings, placing the phenomenon within the toxicological framework was an "alibi" to justify certain political decisions based on scientific-medical grounds, this alibi, with the passage of time, was very profitable for the biomedical establishment, which began to set itself up as the guardian and manager of problems that had a social, rather than a bio-health origin. The "medicalisation of social problems", on the one hand, has turned the biomedical establishment into the hegemonic body when it comes to considering its evidence as the highest quality and, on the other, has generated an immense industry based on biomedical technologies and treatments that absorbs most of the public and private resources in research, with the budget they receive being disproportionate to the limited clinical achievements they achieve (NESTA, 2018). To give an example applied to the field of drug addiction, the investment in the development of drugs to cure addictions is multi-million, and has been repeated for decades. However, to date, not a single effective drug has been found to cure any drug dependence, and the evidence shows rather that people simply end dishabituating themselves off substances on their own, with their own tools, over and above the success of any pharmacological or psychosocial treatment (for a comprehensive review of the evidence on addiction see Pedrero-Pérez, 2015).

It is necessary, in order to implement efficient public policies, to carry out an in-depth analysis of the determinants of problematic drug use, and to see to what extent these determinants are being addressed and taken into account in the policy design, and to what extent the relationship between the eventual results of this diagnosis and the allocation of public resources is coherent. If we look at the National Strategy on Addictions 2014-2024, it talks about "the drug problem", again, as the problem of the consequences of drug use, and not the social, political, economic and cultural determinants that may be contributing to increasing the most harmful consequences of drug use. There is talk of risk reduction, of a gender perspective and of the different consequences, both psychological and social, of drug use. But not how the constraints should be addressed, nor how they should be resourced. The Strategy, with specific objectives in the control of supply and demand, continues to have this biomedical postulate that looks at drugs as if they were a problem of the individual, an isolated individual in an impermeable environment, with no contact with the social exterior. But the truth is that this is not the case. By way of illustration, in the 2019 Annual Report of the National Health System, we find shocking figures for Spanish society: the dependency rate is 54.2%, the percentage of the population with low education is 61.4%, the percentage of the population in the lower class is 47%, the poverty risk rate is 26%, 28% of the population lives in conditions of environmental noise and 26% with a shortage of green areas. Moreover, the prevalence of mental health problems among low-income people is twice as high as among middle- and high-income people. [3] It seems ironic to contin-

3 See https://www.sanidad.gob.es/estadEstudios/estadisticas/sisInfSanSNS/tablasEstadisticas/InfAnualSNS2019/Informe_SNS_2019.pdf

ue to argue that the solutions to the problems arising from these social determinants must be biomedical. Biomedicine does a disservice to community health if, instead of making a scientific contribution, it continues to set itself up as the hegemonic model for addressing social problems. Problems which, on the other hand, become medical problems when they are no longer addressed from a social policy perspective. Furthermore, it is important to focus on the fact that it is not only people who use drugs who suffer from the effects of ineffective drug policies, but society as a whole.

3. THE CASE OF PSYCHOTROPIC SUBSTANCES: MDMA, LSD AND PSILOCYBIN

a. Social, political-legal and public health context

As noted above, psychotropic substances are controlled under the 1971 Convention on Psychotropic Substances. Many of them are active ingredients contained in plants, such as psilocybin from psilocybin mushrooms, or mescaline from peyote and San Pedro cacti (note that only their active ingredients are controlled, not the plants that contain them, which is discussed below). In addition, the Convention controls substances of synthetic origin, including the most widely used psychotropic substances in the Western world, such as LSD (tripping, acid) or MDMA (ecstasy). These substances are included in Schedule I of the Convention, which is the most restrictive and includes substances considered a particularly serious threat to public health and with little or no therapeutic value. In the Spanish legal system, this group of substances is classified as "drugs that cause serious damage to health", placing them in the family of hallucinogens.

Before these synthetic compounds were brought under control, they enjoyed widespread medical use, mainly psychiatric, during the 1950s. Growing concerns about the recreational use of these substances, closely linked to the counter-cultural movements of the 1970s, led to their medical applications being abandoned because of increasing barriers to research, finally coming under international control in 1971 (Hofmann, 2018). The international drug conventions only recognise the licit use of scheduled substances for medical and scientific purposes. Thus, during the 1990s, a number of research groups, mainly European -including some Spanish groups- and some North American, resumed scientific research with these substances. Thanks to this pioneering work, the interest of the scientific community grew to the point that, at present, they have emerged as the new promise of biological psychiatry. Faced with the crisis of psychopharmacology, derived from the lack of efficacy and adverse effects of psychiatric drugs, the pharmaceutical industry is betting on the development of these drugs as medicines, mainly MDMA and psilocybin (Ona and Bouso, 2020). Both substances have been classified as breakthrough therapy by the US Food and Drug Administration (FDA): MDMA for the treatment of post-traumatic stress disorder (PTSD) and psilocybin for the treatment of major depression. MDMA for PTSD has been named by Science magazine as one of the 9 most important scientific milestones of 2021. By the end of 2020, there were more than 70 clinical trials with LSD, MDMA and psilocybin registered on clinicaltrails.gov (Siegel et al., 2021) and a website that lists clinical trials with psychedelics and the pharmaceutical

companies that fund them refers to some 18 of these.[4] Without having completed the clinical trial phases, the Canadian government has already authorised the use of these substances within its compassionate use programme. The FDA in the US, and Israel, have done the same for MDMA for compassionate use. The Australian government has earmarked three million dollars for clinical research into the use of psychedelics in mental health. In Spain, the only clinical research being carried out is that promoted by a private company, for phase 2 and 3 trials of psilocybin for people with treatment-resistant depression.

In addition to these ongoing clinical trials, there is already an example of a recreational drug that has been transformed into a psychiatric medicine: ketamine. Ketamine is used as an anaesthetic and analgesic in human clinical practice, as well as being a widely used recreational drug. Since the 2000s it has been used in research as a treatment for depression and suicidal ideation, and in recent years numerous clinics have opened in the US and Europe where it is used for this purpose. Recently, the FDA, the EMEA (European Medicines Agency) and the AEMPS (Spanish Agency for Medicines and Health Products) have authorised a ketamine-based drug (Spravato) as a treatment for depression. A vial of Spravato costs about 5,000 euros, while a vial of ketamine (Ketolar) with the same dosage costs only 2 euros. However, only the former is specifically authorised for depression, which leads many clinicians to use Ketolar in violation of administrative regulations. These paradoxes are also likely to occur when MDMA and psilocybin start to be authorised for medical use: At what price they will be sold, and whether they will be competitive with prices on the illicit market.

Finally, ibogaine is an alkaloid from the African plant Tabernanthe Iboga and has a long history of paramedical use in the treatment of dependence, mainly to heroin and cocaine (Dos Santos et al., 2017). Although it is not controlled and therefore not a psychotropic, it is not considered a medicine. Our team, in collaboration with the Hospital Sant Joan de Reus, is conducting the world's first clinical study with ibogaine for the detoxification of methadone dependence.

b. Proposed new approach

The pathway for access to these drugs is very clear: once they have passed the clinical trial phases, they will be available for psychiatrists who wish to use them to treat their patients. As in the case of ketamine, only use under medical supervision will be permitted. In this respect, we identify a fundamental problem, related to the framework for approaching drug dependence treatment referred to above: Whether mental health problems are considered to be a disease of the brain, or even the result of intrapsychic conflicts that must be corrected with medication and/or psychotherapy, or whether these eventual neurobiological alterations and intrapsychic conflicts are considered to be a manifestation of the social, economic, political and cultural obstacles that prevent a person from reaching his or her maximum possible level of mental health. Consequently, it is necessary to carry out an in-depth analysis of the social conditioning factors that prevent a person from achieving adequate emotional well-being, and to manage the resources aimed at improving it accordingly. Although recovering the use

4 See https://psilocybinalpha.com/data/psychedelic-drug-development-tracker

of hallucinogenic drugs is probably the most innovative aspect of psychiatry in its history, if such use is incorporated by reproducing the biomedical model applied until now, these substances will not have a very different impact on mental health from that of other psychotropic drugs already authorised. Their effectiveness will be limited, as this depends not only on the tools used, but also on the medical system in which they fit and which determines the effectiveness of mental health treatments.

In view of this, we believe that these drugs should not follow the same processes that are normally required for medicines to be authorised as such. Their safety has already been proven through decades of recreational use, and the risks are well established. An advance in the medical treatment of mental health problems would simply be to allow medical professionals, under their responsibility as clinicians, to have access to psychoactive drugs that they believe may be of use to their patients. These drugs are no more dangerous than prescription psychotropic drugs and can be very beneficial. This is the path being charted in Canada, Australia, Switzerland, the United States and Israel. By combining the different strategies of these countries, an ideal strategy could be arrived at, firstly, by allocating public money for studies by independent research groups. Secondly, to allow use on a compassionate use basis, generating a register of cases that could be worked on statistically as experience accumulates. Thirdly, as medicines from pharmaceutical industry research are authorised, logically allow their use.

Finally, it is important to highlight that some of these substances are also proving useful in the treatment of substance abuse problems, such as psilocybin (Yaden et al., 2021), ayahuasca (Silva Rodrigues et al., 2021) and, above all, as mentioned above, ibogaine (Dos Santos et al., 2017). Therefore, facilitating the development and knowledge of these medicines could, for the first time, lead to safe and effective medicines to treat drug dependence problems, within, of course, broader psychosocial programmes.

4. THE CASE OF PSYCHOACTIVE PLANTS FOR TRADITIONAL USE: AYAHUASCA, IBOGA AND COCA LEAF

a. Social, political-legal and public health context

One of the phenomena associated with globalisation, in the field that concerns us, has undoubtedly been the expansion of the use of a series of psychoactive plants that, until a few years ago, only existed in their places of origin and are now available practically all over the planet. This is the case with some hallucinogens such as peyote, the San Pedro cactus or the iboga plant, but especially ayahuasca (Sánchez, & Bouso, 2015). As well as another plant, which is not hallucinogenic but is also of ancestral use: the coca leaf.

Although there is not enough space in this article to analyse this phenomenon in depth, it is very striking that such exotic plants with so little recreational potential, such as ayahuasca or iboga, have become so popular in the West. Iboga is in the minority. Ayahuasca, which has reached almost every corner of the world in the last decade, is not. There are already academic articles where both psychiatrists (Stiffler, 2018) and priests (Prue, & Voss, 2014) advise their colleagues

to inform themselves about ayahuasca, given the number of people who come to their respective practices mentioning that they are taking it: either to improve their mental health or for spiritual purposes (and usually for both reasons). In the case of Spain, ceremonies are organised almost every day around the main cities. There are several options. Generally, such ceremonies are officiated by people who have been spending varying lengths of time in the Amazon, learning how to use ayahuasca, and then perform the ceremonies here. But also shamans and Amazonian healers come to our country, bringing their knowledge with them. A third option would be to travel to places where the use of this decoction is native, especially Peru, where there is an extensive offer of centres and places to take ayahuasca with local healers. The interesting thing about the globalisation of ayahuasca ceremonies, which differentiates it from other drugs "imported" from America, is that the ceremonies outside the Amazon try to be organised in the Amazonian way: in a place in nature, in a group taking, respecting a series of rituals, where those who officiate generally have a special care and concern for the safety of the attendees (although there are always exceptions), which somehow favours the protection of the initiates. The people who attend these ceremonies are usually mature people (mid-thirties onwards), with a good level of education. Far from seeking escapist experiences, they attend these ceremonies as another expression of their self-care behaviours (Ona et al., 2019).

The case of coca leaf is different. Although it is true that more and more "westerners" bring coca leaf with them when they come from Andean countries, or buy it from here because they have experienced its benefits in those countries, the highest prevalence of consumption is among native Andean people who, when they travel from their countries of origin, bring coca leaf with them for personal or family use, in accordance with the customs of their countries of origin. There are even shops run by Andean people who import coca leaf or coca leaf-based products, mainly herbal teas, to sell to their compatriots. Again, there is no evidence of problematic use.

We have already mentioned that no plant containing psychotropic substances is controlled internationally or in Spain. However, the fact that their active ingredients are (in the case of ayahuasca, DMT, and in the case of peyote and San Pedro, mescaline; in Spain neither the iboga plant -Tabernanthe iboga- nor any of its alkaloids, including the psychoactive one, ibogaine, are controlled) means that arrests are made when someone travels from South America with ayahuasca or buys it by mail order. The case of the coca leaf is similar, but more serious, as the coca leaf is controlled as a narcotic drug and in its case there is no doubt that a crime against public health may be being committed. In Spain, every year there are dozens of legal incidents related to these psychoactive plants, either because some people bring them from their native contexts, or they buy them over the Internet and receive them by post. In the case of ayahuasca, most of these proceedings end up being shelved before reaching a trial, but despite this predictable outcome, these arrests and confiscations continue to take place. And in the case of coca leaf, many end up with administrative fines and even prison sentences for possession of quantities hardly destined for trafficking, between 3 and 4 kilos of leaf. This generates a series of costs for both the administration and the people involved, which could easily be avoided if a series of

pre-established channels were designed for the importation of substances of plant origin that are not prohibited in our legal system, and for those that are prohibited, simply modify it because it is out of date with the scientific evidence, thus violating the most elementary rights to a fair trial.

b. Proposal for a new approach

With regard to the globalised phenomenon of ceremonies with ayahuasca and other plants for traditional use, it would be desirable that international and national legislation simply be respected, and that the people who bring or buy them are no longer persecuted, since, as has been said, only their active ingredients are controlled, not the plants themselves or their decoctions (Sánchez and Bouso, 2015). Going further in the analysis of this phenomenon, it is possible that its popularity has to do with the way in which many people relate to their health and seek wellbeing and self-care in non-hegemonic practices. For scientistic medicine, all of these practices are considered pseudo-therapies and pseudo-sciences. There are even groups calling for their criminal prosecution. Once again, we see how a social phenomenon is managed by proposing punitive solutions, instead of appealing to social dialogue and encouraging scientific discussion. In a report published by our group on the health of ayahuasca users in Spain (Bouso et al., 2020), we already proposed that, from the community bases of the municipalities, meetings should be established between the people who organise ayahuasca ceremonies and the public social and health services, so that everyone is informed of the type of activities that are being carried out in the municipality in question, and everything is done in a transparent manner. The ultimate aim, above all, is to protect the people who attend such ceremonies as much as possible. But for this to happen, there must be a structural change in the logic of public management: public management must stop thinking in therapeutic-penalistic terms, and move on to formulating responses and solutions in terms of dialogue and care with civil society.

The coca leaf is a different matter. As we have already pointed out, the prohibition of the coca leaf was based on a 1950 report that would hardly surpass today's scientific and ethical standards. It is surprising that, on the basis of an openly neo-colonial and racist document, with strong contempt for the Andean populations and their customs, a punitive policy continues to be modulated towards people who use a plant of ancestral use and which has shown benefits in so many areas of health and quality of life of the communities (TNI, 2014).

In this regard, the content of paragraph 68 of General Comment No. 25 (2020) on science and economic, social and cultural rights is highly relevant, which states:[5]

> "[…] *Scientific research is impaired for some substances under the international conventions on drug control, which classify these substances as harmful for health and with no scientific or medical value. However, some of these classifications were made with insufficient scientific support to substantiate those classifications, as credible evidence exists regarding the medical uses of a number of them, such as cannabis for the treatment of certain epilepsies. Thus, States parties should harmonize the fulfilment of their obligations under the international drug control regime*

5 General Comment No. 25 (2020) on science and economic, social and cultural rights https://undocs.org/en/E/C.12/GC/25

with their obligations to respect, protect and fulfil the right to participate in and to enjoy the benefits of scientific progress and its applications, through regular revision of their policies in relation to controlled substances".

The implications of this conclusion are, in our view, as obvious as they are relevant. An urgent review of policies in relation to controlled substances is needed. As a starting point, a review of the available scientific evidence is needed (if there is any, as in many cases it is scarce or non-existent, as is the case for those substances that have been placed under control without any technical report). A first step in this direction, although we fear it is an exceptional one, has been the review of the scientific literature on cannabis, finally recognising its therapeutic properties and thus removing it from Schedule IV of the 1961 Convention. However, the review of drug policies cannot only be of a toxicological nature, but must also have as its backbone the international commitments acquired by Spain in the human rights treaties, which do not lose their validity in the context of drug control. Our approach, therefore, is rather the opposite. A drug policy that aspires to comply with international standards must begin by respecting human rights norms, and set as its objective their full enjoyment and guarantee by and for all citizens. In this sense, a good starting point is found in the International Covenant on Economic, Social and Cultural Rights[6], especially in the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Article 12) and in the right of everyone to enjoy the benefits of scientific progress and its applications (Article 15).

5. FINAL REFLECTIONS

Our proposal has been illustrated with the cases of psychotropic drugs and plants for traditional use; however, the recommendations for regulation could be extended to cannabis and other illegal substances. In our opinion, the key is the participation of civil society in the formulation of public policies, especially of the groups affected, as well as the centrality of care, moving away from simplistic biomedical dogmas and sensationalist but inefficient penal solutions. The former United Nations rapporteur on the right to the highest attainable standard of physical and mental health, Dr. Dainius Pūras, has been repeating in his various reports the need to understand mental health beyond the biomedical model. That is, not so much from the disease model but rather as the result of a series of social, political, cultural and economic obstacles that prevent people from achieving the highest possible level of physical and mental health. Public health policies in general, and drug policies in particular, should therefore be designed on the basis of a proper diagnosis of what these obstacles are. These obstacles are not only of an economic and social nature, but also of a political nature. Specifically, of the epistemic policy that considers the biomedical-punitive paradigm as the most appropriate to address social problems that are the cause, and not the consequence, of many of the health problems derived from drug use. There is an urgent need, therefore, for an in-depth study of the different burdens that the different social, economic, political and cultural conditioning factors have on the health of communities, as well as on the ob-

6 International Covenant on Economic, Social and Cultural Rights. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 3 January 1976, in accordance with article 27. https://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

stacles that prevent them from reaching their maximum levels of enjoyment. Our radical proposal emphasises the need to open up these debates with rigour. For the allocation of financial resources for research, prevention, intervention and education to be consistent with the different burden of each of these barriers and determinants. Therefore, there is a need for inter- and trans-disciplinary dialogue, the development of policies that can be periodically evaluated and, if they do not work, can be modified (something that, in terms of drug policies in Spain, is far from having happened in the more than 30 years that they have been implemented), as well as a rational allocation of resources, according to the results of these analyses. Otherwise, we will continue to make public policies on drugs based on convictions, not on evidence.

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