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Substances considered addictive: prohibition, harm reduction and risk reduction

Sustancias consideradas adictivas: prohibición, reducción de daños y reducción de riesgos

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ABSTRACT Latin America is currently the region with the highest rate of homicides worldwide, and a large part of the killings are linked to so-called organized crime, especially drug trafficking. The trafficking of drugs is a consequence of the illegality of certain substances which – at least presently – is based in and legitimated by biomedical criteria that turns the production, commercialization and often the consumption of certain substances considered addictive into "offenses against health." This text briefly analyzes the two policies formulated and implemented thus far in terms of prohibition and harm reduction, considering the failure of prohibitionism as well as the limitations of harm reduction proposals. The constant and multiple inconsistencies and contradictions of prohibitionism are noted, indicating the necessity of regarding cautiously repeated comments about its "failure." The text proposes the implementation of a policy of risk reduction that includes not only the behavior of individuals and groups, but also the structural dimension, both in economic-political and cultural terms.
KEY WORDS Substances Considered Addictive; Prohibitionist Policies; Harm Reduction; Risk Reduction; Homicide.

RESUMEN América Latina es actualmente la región con mayor tasa de homicidios a nivel mundial, y gran parte de los asesinatos están vinculados al denominado crimen organizado, especialmente al narcotráfico. El narcotráfico es producto de la ilegalización de ciertas sustancias, la cual –por lo menos en la actualidad– está basada y legitimada en criterios biomédicos que convierten la producción, comercialización y frecuentemente el consumo de ciertas sustancias consideradas adictivas en "delitos contra la salud". En este texto se analizan en forma sucinta las dos políticas formuladas y aplicadas hasta ahora en términos prohibicionistas y de reducción de daños, considerando el fracaso del prohibicionismo, así como las limitaciones de las propuestas de reducción de daños. Respecto del prohibicionismo se señalan sus múltiples y constantes incongruencias y contradicciones, lo cual implica que tomemos con cautela los reiterados señalamientos sobre su "fracaso". El texto propone la aplicación de una política de reducción de riesgos que incluya no solo los comportamientos de sujetos y grupos, sino también la dimensión estructural tanto en términos económico-políticos como culturales.
PALABRAS CLAVE Sustancias Consideradas Adictivas; Políticas Prohibicionistas; Reducción del Daño; Reducción del Riesgo; Homicidio.

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INTRODUCTION

One of the most serious social problems increasing in almost all Latin America is the expansion of so-called organized crime and, especially, of drug trafficking. Organized crime operates like a capitalist company, not only fulfilling the desires, needs and demands of different types of users, but also the rules of a consumerist society. Thus, it provides drugs considered addictive to those who demand them, male and female prostitution to satisfy the sexual desires of buyers, and a variety of organs for transplants that are performed by medical staff. Moreover, organized crime is constantly creating jobs – including the position of hired assassin – in societies characterized by high rates of unemployment and by the low wages earned by the majority of population.

While the actions of organized crime have different types of consequences, I would like to highlight only one in this work, and that is that drug trafficking has not only generated and formed part of different types of violences, but has also become one of the main causes of homicide, making it so that some Latin American countries now have the highest homicide rates in the world. Moreover, along with other processes, it has led certain regions of America to become among the most homicidal on the planet (a).

We must remember that drug trafficking is currently sustained by one basic fact: the illegality, and therefore the prohibition, of many of the substances considered addictive. This prohibition is what drives the increasing development of drug trafficking and enables – and I stress the word *enables* – the increase in homicides (b).

While illegality is a necessary condition for drug trafficking to exist, it does not mean that all illegal production and commercialization of drugs considered addictive is responsible for the high rates of homicides we are currently witnessing, especially in countries like Brazil, Colombia, El Salvador, Guatemala or Mexico. However, although this aspect is relevant I will not explore it in further detail here, as it is not part of the main objectives of this work.

Now, what is the basis of the illegality of substances considered addictive? Illegality is based on moral, political, racist considerations, but – at least at present – it is also based on biomedical criteria. Biomedicine professionally establishes that these substances have harmful effects on health, that is, they can cause both individual and collective illnesses. Furthermore, biomedicine considers addiction itself to be an illness, "scientifically" justifying the prohibition of these drugs and demanding their exclusive use for therapeutic reasons through the health sector, thereby allowing illegal uses to become "offenses against health" (c).

Nevertheless, economic, political or social processes have repeatedly encouraged prohibitionist policies (3,4), attempting to articulate them with biomedical criteria while at the same time subordinating these criteria. Often biomedical criteria are used to justify actions against drugs, even when in practice criminal and police actions are the actions actually imposed. At least throughout the last three decades, the medical-public health apparatus at the national level has not been the institution to design and much less to carry out policies regarding "drugs"; the core of these policies lies within the government agencies and especially the security agencies. The same happens at the international level. The World Health Organization (WHO) and the Pan American Health Organization (PAHO), in the case of Latin America, are not responsible for establishing the policies that are actually applied regarding the use and consumption of drugs, despite them being considered serious health problems. The bodies that actually propose and decide these policies are agencies of the United Nations such as the Commission on Narcotic Drugs, the International Narcotics Control Board and the United Nations Office on Drugs and Crime (d).

The above can be verified by identifying the social actors that plan and carry out the "war on drugs" and that receive and use the largest amount of all types of resources, especially financial recourses: these are, as we know, the security agencies.

The medical-public health apparatuses did not even take responsibility for attending to the addictive aspects of these drugs until relatively recently; the care centered on some of the consequences of these addictive properties and, above all, on the physical aspects of these consequences. Addictions were not seen as a medical problem, which in the case of "alcoholism" can be clearly

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seen not so much within the discourse as within the specific medical practices (2).

POLICIES AND DRUGS: PRIMARY CHARACTERISTICS AND CRITICISMS

In simplified terms, there are two proposals for global action with respect to substances considered addictive: prohibition and harm reduction. The actions from the late nineteenth century to the present have been predominantly prohibitionist, implemented through specific policies of each Nation-State. The so-called harm reduction policy has been developed since the mid-1980s through specific activities in Germany, Australia, Spain, the Netherlands, United Kingdom, Switzerland, and is only applied more comprehensively in Portugal, where the use of these substances has been legalized. However, we must highlight that, in the last decade, the application of these activities was notably expanded:

> Currently, about eighty countries have needle exchange programs, and about a million people receive methadone or buprenorphine substitution therapy for heroin addiction [...] In 2003, the European Union (EU) adopted the harm reduction approach as a common position, including this approach in the EU Drug Strategy for the period 2005-2012. (5 p.335) [Own translation]

However, as we shall see later on, in most countries harm reduction activities refer to certain specific aspects centered on individuals.

As I mentioned earlier, prohibitionist policies have dominated global strategies regarding drugs considered addictive, but we must acknowledge that there have been periods of greater and of lesser intensity in the application of prohibitive measures, and that there are marked differences in the implementation of such measures among different countries. Since the 1970s, the US has generated and promoted the so-called "war on drugs," implementing prohibitive measures that they have attempted to impose worldwide through political and economic sanctions. Nevertheless, this "war" is being lost in all the countries where it was undertaken. Precisely, the development of "harm reduction" activities is one of the most visible expressions of the failure of prohibitionism.

The main characteristics and criticisms of these two policies are presented below in a general and schematic way, as both within prohibitionism and the harm reduction approach specific and, in some cases, fundamental differences can be found. This is true even within a single country, as in the case of the US, where despite federal prohibitionism several states have adopted harm reduction policies.

The main features of prohibitionist policies are the following:

a) At least since the 1960s, prohibitive actions regarding drugs considered addictive have been based on addiction criteria that would become "substance dependence" criteria during the 1970s (e).
b) Explicitly or implicitly, these policies consider an addict to be an individual who is "dependent" on a substance that determines his or her behavior and, therefore, needs to be controlled.
c) Many of these substances are not only considered illegal but are also banned, so that their production, commercialization and often consumption constitute a crime.
d) The main objective of these policies is to reduce consumption to the point of elimination; that is, to contribute to producing abstemious individuals. In Mexico, the predominant message of the health sector, of the institutions in charge of the treatment of addicts, of the Ministry of Education, is abstinence.
e) Legislation on these drugs involves punishment, including imprisonment and, in some countries, capital punishment.
f) These policies generate criminalization, persecution and stigmatization of the drugs considered addictive and of the different actors involved in the production, commercialization and consumption of substances considered addictive, thus increasing drug-related offences and incarceration. Therefore, we can see that 25% of the nine million people incarcerated in the world are imprisoned for this type of crime (7). Moreover, a study that analyzes the situation in Latin America concludes that "the number of people in prison for simple possession of drugs,

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including marijuana, even in countries where carrying small amounts of drugs for personal use is not a crime, is astonishing" (8 p.96).

g) Prohibition policies mainly affect the poorest social sectors in terms of both drug users and dealers; they are the most criminalized, imprisoned and persecuted groups. It is among these sectors, mainly male adolescents and young adults, that we find the largest number of homicide victims and perpetrators related to drug trafficking. Moreover, these are the sectors in which the most serious health consequences are observed, and at the same are those that have the least access to medical and psychotherapeutic services.

h) The increase in the consequences in terms of mortality and morbidity not only affects those involved in production, commercialization, consumption, and also repression, but it also generates growing "collateral damage." Punitive policies have favored the spread of HIV/AIDS in certain contexts, as prohibition turns the consumer into a criminal who does not demand medical care. It also leads, especially in the poorest and most excluded sectors, to the use of addictive substances that are not only of low quality but also more harmful, as happens with the so-called "paco" (cocaine base paste) in Argentina or glues in Mexico. This means that this type of policies leads individuals and groups to develop behaviors increasingly dangerous to their health, and to demand very little or no therapeutic care for several reasons, including the criminalization of consumption. It is important to note that recent studies indicate that, at least in Latin American countries, many more deaths are caused by the application of punitive policies than from the effects of using cocaine, heroin and other substances considered addictive.

i) Most countries adhere to a lesser or greater extent to prohibitionism, regardless of their political-ideological orientation, economic and political characteristics, degree of democratic development, or dominant religious forms. This does not mean that such aspects do not reduce or intensify the application of prohibitions and punishments and their severity. However, what I want to emphasize here is the predominance of these policies in virtually all countries, which means adhering to the basic principles of prohibitionism, even if harm reduction activities are also being promoted.

j) The implementation of these policies has made possible enormous profits in economic terms both illegally and legally, especially through "money laundering," and has also favored and promoted impunity and corruption processes at every socioeconomic level. Corruption and impunity are processes that predate the present development of organized crime, but they are implemented and enhanced by the current development of drug trafficking.

k) It has also fostered and legitimized the development of legal, police, and in some cases, military apparatuses, that act against so-called organized crime, including "drug addicts." These apparatuses can operate as a force for social and political control at the national level and in terms of foreign policy. The remarkable development of persecution and control systems, especially in certain Latin American countries, contrasts with certain epidemiological data, since according to a recent report by the United Nations Organization (UN) there are 208 million illegal drug users worldwide, that is to say, 4.8% of the world population consumes these drugs (9). However, only 0.1% of the world population consumes what are considered "hard drugs" such as cocaine or cocaine derivatives (10). Therefore, we need to reflect on the real role not only of prohibitionism but especially of the "war" on drugs, without denying that certain types of consumption can directly or indirectly generate serious social and health problems.

l) In turn, prohibitionist policies favor the development of social self-control mechanisms through fear and insecurity; thus, security has become one of the main demands of the population in countries such as Colombia, Guatemala and Mexico.

m) All indicators highlight the failure of prohibitionist policies in many different aspects of reality, since production and consumption has not decreased but actually has increased, especially in countries where the consumption of some of these addictive substances was historically low or even very low. Moreover, the increased military and police presence implied in the "war" on

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drugs has also failed, as there was no reduction in consumption or in the activities and power of organized crime, especially when analyzed globally. Although in the US during the last ten years the consumption of certain substances such as cocaine and heroin was reduced, the consumption of drugs considered addictive but that are medically prescribed has increased significantly, indicating that in real terms drug consumption has continued to increase.

Several authors have proposed not to restrict the analysis – and much less the actions – of policies applied to drugs considered addictive to the opposition prohibition/legalization. I agree with them in part, but consider that this proposal should be contextualized, that is to say, it should refer to the characteristics that prohibitionism has acquired in specific situations. In the case of several Latin American countries, the promotion of legalization should be a priority, given the consequences of the criminalization of substances considered addictive. Moreover, without overlooking the pragmatic goals of harm reduction, we must consider legalization as an ideological or even imaginary objective that would operate in the transactions taking place between the different social actors involved in the different uses of legal and illegal addictive substances.

Criticisms of prohibitionism can be traced back to the implementation of the first prohibitionist policies in the late nineteenth and early twentieth centuries, especially prohibitionist policies regarding alcoholic beverages, which were applied during the 1920s in a number of countries like the US that included a ban on the production and commercialization of all types of alcoholic beverages. I highlight this period in particular because it received very similar criticisms to those made in recent decades regarding current prohibitionist policies. These criticisms emphasized not only the rise in organized crime and homicide mortality but also the failure of the policy to achieve its main objective, the elimination of consumption, which finally led to the abolishment of the prohibition on production and commercialization of alcoholic beverages in most "Western" countries.

In the mid-1930s, one of the earliest and most effective harm reduction mechanisms was developed, the Alcoholics Anonymous groups. These groups are not usually included within the harm reduction conception by the majority of those who adhere to this proposal, despite being a relatively effective mechanism which was created and used by former consumers themselves, and even though the goal is abstinence.

I stress that the prohibition was lifted for the primary substance considered addictive – at that time alcohol – which was the "drug" that identified and continues to identify Western countries culturally, but whose production and especially consumption had expanded significantly worldwide, including of course Latin America and the Caribbean.

This anti-prohibitionist precedent is constantly but timidly revisited by those who currently question prohibitionism. Such timidity is perhaps due to the fear that instead of empirically substantiating the legalization of other "drugs," this process could create a rebound effect in which if not the prohibition then at least an increase in the punitive activities of control over alcoholic beverages might again be proposed, as indeed we have repeatedly observed.

HARM REDUCTION POLICIES: CHARACTERISTICS AND PROPOSALS

As we know, these proposals originated in four complementary ways. First, through the experience of drug users on how to control some of the most negative consequences of drugs while at the same time recovering some of the individual and social functions of consumption. Second, by verifying the failure of prohibitionist policies and criticizing the different consequences generated by these policies, as they not only increase negative health consequences but also violate the human rights of the users of these prohibited substances. Thirdly, by recognizing that drugs will not be legalized and therefore, the "realistic" approach is to focus on harm reduction. And fourth, due to the need to confront the HIV/AIDS epidemic using all possible processes, including taking action on the use of injectable heroin (f).

I emphasize that, in my perspective, harm reduction is and has been carried out by other civil society groups that are often not included

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in harm reduction proposals, such as Alcoholics Anonymous, and is also generated and promoted by State agencies, among them the healthcare system. I refer to the use of measures such as seat belts or the breathalyzer which try to reduce the damage and risks caused mainly by alcohol consumption. Therefore, I include within harm reduction the total set of actions aimed at reducing and preventing damage (g).

As I have already mentioned, some countries, especially in Europe, acknowledged these proposals and implemented some activities, mostly promoted by non-governmental organizations (NGOs). In most Latin American countries, these policies are not applied, are applied differentially, or the application is incipient and limited, even if it is incrementing.

Considering what has been mentioned thus far, the main proposals and characteristics of harm reduction policies can be described as follows (11,12):

a) To propose and promote changes in legislation and policies on drugs which include legalization and depenalization of all or at least some drugs. In this regard, there are substantial differences among harm reduction trends, as almost all propose legalizing marijuana and, of course, maintaining the legalization of alcohol and tobacco, however some oppose the legalization of drugs considered to be harder, such as cocaine or heroin.
b) To avoid, reduce and, if possible, eliminate the criminalization of these drugs and especially of consumers. To reduce to the point of elimination the criminalization and persecution of consumers.
c) To prevent and reduce to the point of elimination the discrimination and stigmatization of these substances and their users. This includes acting upon the self-stigmatization of some consumers.
d) To evidence the failure of prohibitionist policies and of the majority of prohibitionist activities by carrying out studies and disseminating study results at different levels of decision-making.
e) To disseminate the success attained as a result of the depenalization of these substances and/or of the general or specific application of harm reduction activities, such as the more or less paradigmatic cases of depenalization in Portugal, or the positive consequences of needle exchanges or the legalization of small amounts of substances considered addictive for personal use.
f) To question the medical treatments and harm reduction actions that tout abstinence as the sole explicit objective.
g) To question – without denying the importance that biomedical and psychological care and prevention may have – the medicalization and psychiatrization of the consumption and the consequences of these substances, which tend to exclude what is known as the "actor's point of view," in this case, the drug user. To depenalize the use of these substances and to recognize that some users can be treated biomedically, or through other forms of care, without turning any type of care into a penalized obligation.
h) To foster the notion that consumption is a right of users, a "normal" behavior and not a pathological one, while recognizing that it may have negative consequences. Therefore, to eliminate the image of the consumer as the object of legal and police intervention in favor of that of a normal consumer, as in the case of alcohol; or at least, to promote an image that treats the condition as such and thereby eliminates the criminal image. This perspective promotes, on the one hand, the development of specific medical and "social assistance" institutions with professional (medical, psychological, etc.) care; and on the other hand, the creation of institutions such as the "Drug Courts" to give a different criminal status to users of addictive substances considered illegal, while recognizing that these can have a negative use.
i) To encourage user awareness, through various educational, promotional, preventive and experiential means, of the positive aspects and negative consequences of the different substances considered addictive – especially those they consume – in individual and group terms. To foster user knowledge and the user's ability to manage the negative effects so as to reduce their consequences.
j) To monitor, through the conduct of the users themselves, those behaviors, tools or concepts that promote harm reduction both individually and in groups. This task must be systematic, so as to search for all types of possibilities generated

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by the users, since it is assumed that these actions would be the most acceptable to other users who belong at least to the same social context.

k) To encourage the existence of groups of users who organize themselves to fight against illegality and criminalization, for the right to consume, and for the knowledge and recognition of harm reduction policies.

l) To promote the forming and/or reconstruction of social networks for protection, support, and mutual aid among users of the substances considered addictive.

m) To recognize that some consumers do not seek or want medical treatment, even when they are suffering from severe physical or mental consequences; indeed, they may even reject such treatment. They therefore do not seek any kind of healthcare services. Consequently, it is necessary to consider and develop other action strategies. While NGOs and health institutions in some countries have promoted health care and prevention for homeless people, we must assume that some users, for different reasons, also reject this type of care. These reasons may be related to their need to "hide" their drug dealing activities, or because they consider that health services are not effective, or simply because they want to continue living as they do.

n) The harm reduction approach means recognizing that a "drug" user has the right to consume and to decide whether or not to seek treatment or help. However, this recognition has to be articulated with the damage that the subject can inflict not only onto him or herself, but also onto others. And this is one of the topics that most needs to be analyzed and resolved at least provisionally, in terms of the creation of specific regulations that above all take into account the consequences of the drug user's behavior towards "others."

o) The groups of users of drugs considered addictive and other sectors of civil society should be involved – if so interested – in the planning, design and implementation of policies and activities generated around the uses and effects of drugs considered addictive.

I believe that one of the fundamental roles of these proposals and particularly of harm reduction activities has been to help moderate the implementation of prohibitionist policies, including in a direct or articulated way the conceptions and actions of the users themselves, in order to limit damages to health. The changes introduced to prohibitionism in countries in Europe and the Americas cannot be understood without looking at the active role of the organizations that have promoted harm reduction policies (h).

Harm reduction proposals have received criticisms from different perspectives. It is argued that total or partial legalization would increase the production and consumption of addictive substances with negative social and health consequences. These could mean specific repercussions in the healthcare system due to rising costs of care and prevention. Legalization could also favor the development of other crimes, especially those perpetuated against people, to compensate for the reduction in profits generated by drug trafficking. Other perspectives note that harm reduction work focuses on individuals or to a lesser extent on microgroups and, while the role of economic and cultural processes may be considered, they tend not to be included: the goal is to help individual subjects. Consequently, limiting harm reduction measures to the implementation of specific activities, rather than promoting a global policy of harm reduction which includes structural aspects, has been questioned.

RISK REDUCTION PROPOSALS

Risk reduction proposals seek to highlight and expand upon certain aspects which, although analyzed and actuated within harm reduction proposals, may have received less study, use and attention, or have been largely neglected in terms of action (i).

These proposals are based in the trajectories of harm reduction proposals generated and implemented both by civil society organizations and by state institutions and, especially, the pragmatic goals of reducing as much as possible certain damages and social and institutional aspects which negatively affect the users of substances considered addictive. From this pragmatic point of view, these proposals seek to foster the articulation among social actors who organize themselves in

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order to question prohibitionist policies, defend the rights of consumers and, in particular, implement actions for harm and risk reduction.

A key part of harm reduction involves effective activities such as needle exchanges or the creation of social spaces for the therapeutic consumption of marijuana. Although these activities are highly important due to their efficacy, I believe that harm reduction should not be limited to such actions. Therefore, although some characteristics I list below are recognized and promoted by some sectors that work at harm reduction, they are not used by others; in fact, they may even be questioned, which is why I am including them here. It is also worth mentioning that many activities enumerated in the section on harm reduction are also included in the proposal of risk reduction, but they are articulated with the activities detailed here.

A great number of experiences and studies support the risk reduction proposal. I will only mention some of them, such as the research studies carried out by Antonovsky (15,16) on the role of coping, considered at the group level and not just in terms of individual subjects; or the existence of social and cultural capital which make it possible to confront risks; or the empowerment proposals observed not only among the female gender or in certain groups with HIV/AIDS, but also at the level of what we call the well-informed patient. From these perspectives it is important to rediscover works that since the late 1940s have highlighted the role that both political and ideological activism and affiliation played in ensuring the survival of subjects in extreme situations such as the German Nazi concentration camps.

I consider there to be a number of important works, partly resulting from the consequences of what is called World War II, which in different ways show the existence of individual and collective resources for harm and risk reduction. These include the work of Bowlby (17), or those stemming from the Italian school regarding "health in the factory" (18). That is, risk reduction policy should recover the different studies and varied experiences which place the possibilities for greater control of harm and risk in social, economic, ideological and cultural dimensions, in addition to subjects and microgroups. Moreover, I consider that the central role of self-care should be recovered as one of the main processes that can articulate the individual and the collective in the development of a policy on substances considered addictive (19).

From this perspective, the following are some of the characteristics of risk reduction:

a) Drugs considered addictive should be analyzed not only as addictive in and of themselves, but also as part of processes through which different drugs are individually and socially constructed, defined and used. Although I understand that drugs – and not only the addictive ones – may have negative consequences of very different types, I recognize that they may also have positive purposes, and that both negative and positive aspects may operate simultaneously. For years I have studied "alcoholism" from this perspective, and have thus developed the concept "alcoholization process," which includes both the positive functions and negative consequences arising from the uses of alcohol. This implies neither reducing alcohol consumption to its pathological aspects nor denying the existence of those aspects. I believe that the same could apply to other drugs considered addictive (1,20,21).
b) Considering this characteristic and others, it is difficult to imagine a "world without drugs" given the variety of very different functions they fulfill. It may be that certain drugs are no longer used, have been eliminated or perhaps even forgotten. However, even though we need to contemplate each individually, when thinking about addictive drugs we must keep in mind the function they perform as a whole, beyond the specificity of each.

If anything characterizes so-called Western society, it is that it is likely the society simultaneously using the greatest number and the greatest variety of drugs considered addictive. Moreover, in my consideration it is a society that has not only "appropriated" substances used by other societies, but has also created most of the addictive drugs currently consumed both legally and illegally. And it has created them with the aid of scientists and technicians who work in the chemical and pharmaceutical industry generating drugs that are medically prescribed; as well as through reprocessing procedures carried out by the civil society, as in the case of "paco" or "tachas," mixtures such as "teporocho"

or mixtures combining energizer drinks, alcohol and other addictive substances. Subjects and groups, due to various and often contradictory reasons, must consume these types of substances as part of the society and/or the social groups to which they belong and, of course, in response to their own individual needs and problems.

c) Harm reduction includes, at least partially, the reduction of risks operating in different health-disease processes. These proposals have worked to reduce the risk of becoming infected with HIV/AIDS or other contagious diseases in the case of injecting drug users. Needle distribution and exchange programs are one of the activities largely associated with harm reduction. As previously mentioned, in various countries social security institutions have fostered harm reduction regarding drugs allegedly addictive but legal, such as alcohol, through the mandatory use of safety belts or the use of breathalyzer tests. However, risk and harm reduction should not only act upon these types of aspects, but also intervene in – and eliminate if possible – some structural aspects of the risks, such as the fact that young people in various countries in Latin America become increasingly involved in criminal activities not only to get drugs for their own consumption, but also as part of their work in drug trafficking.

We may assume that the involvement of youth in criminal activities and the criminalization of young people's behavior, as well as their important involvement in automobile accidents, have contributed to the fact that, for the first time, mortality rates of young people (15 to 24 years of age) have surpassed those of children (less than 10 years of age) at the international level (22).

Furthermore, most young people and children who suffer violent deaths or who are arrested, blackmailed and/or imprisoned are poor and live within a circle of poverty which is developed and transmitted across generations. Although poverty, extreme poverty and chronic unemployment are not the only factors inducing the consumption of addictive drugs, these factors characteristically generate greater deterioration within consumers. For this reason, health and social policies should keep in mind both poverty and the "circle of poverty," of which the consumption of legal and illegal drugs is a part, as an almost permanent reference for their proposals and actions. We must try to break this "circle of poverty" in order to create conditions for harm and risk reduction that go beyond the individual conditions of each subject (23,24). They should include the possibility of establishing – as various authors have proposed since the 1930s – a minimum standard of living that guarantees not only income but housing, education, security, and free time. In this way, based in a certain standard of living, we may observe the consequences of the use of addictive and non-addictive drugs, taking into account that the legalization of drugs does not change the fact that above all certain poor groups are still the most vulnerable, as has been observed historically with alcohol consumption.

Therefore, risk reduction implies including economic, social and cultural conditions as an essential part of a true harm reduction policy, for if certain aspects of social reality are not radically modified, at the very least certain damages and risks will increase. Only legalization will enable effective harm and risk reduction: "unless we repeal drug prohibition and all the baggage of public attitude it carries with it, things will continue to deteriorate" (25 p.118) (j).

d) We must work with structural processes, including especially what is known as structural violence – by others called systemic violence – in the analysis, proposals and interventions, which implies taking into account causality both at the individual and social levels. Although part of harm reduction takes into account causality, it becomes secondary, because the goals are basically pragmatic, that is, to reduce specific damages; however, in the case of risk reduction, causality constitutes a strong theoretical and empirical core.
e) Hence, we must work not only with vulnerability in physical and psychical terms, but also with the social and economic vulnerability of subjects, including specific vulnerabilities resulting from belonging to a certain social class, gender, age or ethnic group. This does not mean, however, restricting our actions to social determinants; we must also include risk factors, even those understood in terms of lifestyles, but

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as they apply to social groups and intentional and unintentional behaviors.

f) We should include the perspectives of public health, social medicine, human rights, but also that of medical anthropology, rethinking policies and activities related to the uses of illegal substances considered addictive that go beyond the substances themselves. That is, the situation of these substances should put on the same level not only as alcohol and tobacco, but also considered similarly to the social uses and state actions regarding salt, sugar, flours and starches, red meat and "junk" food, which have been implicated in the primary causes of mortality given their decisive role in diabetes mellitus or cardiovascular diseases. In terms of public health, and due to their increasing effects on mortality, salt, sugar and "junk" food should be prohibited just as or more strictly than drugs considered addictive. However, despite the harm and risks they imply, such substances have not been prohibited; rather, programs and activities are created which assume the free consumption of these substances, providing recommendations and establishing certain conditions to help limit the damages. The same should hold for each of the substances considered addictive (26).

g) The existence and expansion of certain processes are not only due to the desires and needs of subjects, or because they are imposed by the mass media, but also because economic, political and/or symbolic processes are operating which promote their emergence and development. The great expansion of drug consumption cannot be understood without considering certain contradictory consequences of neoliberalism developed during the 1980s and 90s. Drug-trafficking, based in the illegality of certain substances, could not develop and grow if it did not have a social basis of support, with a "reserve army" to perform the different "criminal" and non-criminal activities, and the establishment of direct and indirect relationships both with the government and with sectors of civil society, favored of course by the conditions generated by neoliberalism. We should not forget that the majority of the profits illegally obtained by organized crime are "laundered" through the legal, productive, commercial and financial apparatus.

h) We should promote and support the effort of organized groups in defense of the rights of the consumers of drugs considered addictive and, if possible, promote the articulation among fights lead by women, people with HIV-AIDS, gay groups, ethnic groups and other groups that organize around their specificity and difference. Although I recognize that the characteristics of these groups imply different struggles with different goals, and that their struggles gain efficacy mainly by fighting for their specificity, we must look at the political scenarios and processes which enable convergences, as has happened with the defense of coca by the current Bolivian government, or between gay sectors and consumers of injectable drugs, at least in certain contexts.

i) Although this proposal includes the actor's point of view as central, as I have repeatedly stated (14), it does not reduce comprehension and interventions solely to that point of view. We need to include the testimonies, experiences and practices of the consumer as well as those of other actors, of whom I highlight as especially important the following three: those who question consumers, those who are harmed by consumers and those who accompany consumers trying to improve their situation, including not only NGOs but also government sectors in biomedicine or other fields.

j) These proposals should question and expose the consequences of prohibitionist policies in the quality of life of consumers, in the propagation of stigmatization, discrimination and criminalization, and also in the development of processes of corruption and impunity.

k) A key aspect is the recognition that prohibitionist policies operate on various levels with respect to the production, commercialization and use of different legal and illegal drugs considered addictive. A first level refers to the differential policies for drugs considered addictive, as we saw previously with alcoholic beverages and tobacco in comparison with the rest of the drugs considered addictive. A second level refers to the global analysis of the consequences in the health of the population generated by the consumption of addictive and non-addictive substances, as we also stated earlier. And a third level refers to

the comparative analysis of the production, commercialization, use and consequences of illegal drugs considered addictive, and those "legal" drugs produced by the chemical and pharmaceutical industry, which can only be acquired with medical prescriptions.

l) Based on what has been developed thus far, one of the key strategies in risk reduction should be to focus on scientific, professional and technical aspects in order to address the different factors that legitimate the actions of States to illegalize, prohibit, imprison, discriminate and also legalize the different substances considered addictive. The real addictive quality of these drugs, as well as what dependency on these drugs means, should be analyzed in scientific terms. The consequences in morbidity and mortality should also be compared epidemiologically with other social aspects generated by addictive and non-addictive drugs. The existent information should be analyzed in order to put into evidence in scientific terms the incongruities and contradictions of the current prohibitionist policies (k). Recent reports by the institutions in charge of supervising the production and consumption of addictive drugs in the USA conclude that, in the last decade, the consumption of the majority of illegal drugs has diminished, but that the production and consumption of "prescription drugs" may have increased; they have become the most consumed addictive substances after marijuana, considering that "abuse of prescription drugs is the fastest growing drug problem in the country" (28). However, medical prescription is growing not only in the USA, but also in European countries for depression, stress, to "feel good," or to improve performance. I would like to emphasize that this growth has generated an increase in the number of deaths caused by overdose of these drugs. According to a report by the Center for Disease Control and Prevention in the USA, the number of deaths caused by overdose is greater for prescription drugs than for illegal drugs. Prescription drugs cause 15,000 deaths annually whereas all other drugs together cause 12,000 deaths; of these, 4,000 are caused by heroin and cocaine overdose (29,30).

As part of a risk reduction policy, we should focus on the fact – and not hide from or deny it – that alcohol, although legalized, is the substance considered addictive which brings about the greatest number of negative consequences in terms of morbidity and mortality through liver cirrhosis, alcohol dependence syndrome (1), and fetal alcohol syndrome; and is also the substance most related to violence in terms of homicide and deaths due to automobile accidents. This fact has long been known by "alcoholism" experts and medical professionals in general (1,2), and has also been repeatedly documented through epidemiological information and/or specific research studies.

Recently, Nutt, King and Phillips (31) published the results of a research study in which they compared the negative effects of 20 drugs considered addictive, concluding that alcohol is by far the most harmful of these drugs at the international level (m). Such conclusions should lead us to question the social representations, the discourses and especially the prevailing practices about illegalized addictive drugs being a serious problem, in order to show that the problem is above all a constructed one.

m) The goals of risk reduction should not be reduced to abstinence. Nevertheless, abstinence should not be questioned if subjects and groups decide intentionally to move in this direction with respect to their own consumption.

n) We should observe the achievements and efficacy of prohibitionist and harm reduction policies, including their negative and positive consequences, using as a point of reference the conditions of consumers and of society in general. It must be clarified that, even though legalization eliminates or reduces some harms and risks, it does not reduce and in some cases may even increase others.

o) Based in the perspective I am presenting here, prohibitionist policies constitute a sort of inconsistency in capitalist societies characterized especially in the neoliberal stage by fostering consumption, because prohibitionist policies try to eliminate or at least reduce the consumption of some substances considered addictive. In this regard, this policy not only questions and opposes the laws of the market,

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but also cannot explain why the production and consumption of all types of addictive substances has most increased during the neoliberal stage.

There is one last element I would like to address and which I mentioned previously in this text. This is to analyze whether prohibitionist policies and in particular the "war on drugs" have really failed. Although such failure has been observed and highlighted since the 1990s, the question is whether the "real" goals of this war were and/or are the elimination – or at least the reduction – of drug consumption, or if the objectives are related to developing justifications for permanent or periodic control and intervention when deemed necessary, especially over certain groups and countries.

Even though the US has fought against drugs considered addictive more strongly than any other country since 1914, this fight was characterized by its low profile, largely expressed by the limited resources applied to it. However, since the Nixon administration, and owing to different factors, this fight has received a new impulse, turning it into a "war on drugs":

> The US government had never before implemented measures of political and economic pressure of such magnitude regarding drugs [...] Nixon had found in a strategy that had had a relatively low profile for decades a compelling reason for a more direct and decisive intervention in the internal affairs of other nations. (32 p.359) [Own translation]

In short, I question the prohibitionist policies applied to drugs considered addictive and propose fostering harm reduction and above all risk reduction through a plausible articulation among processes that operate both at macro and at micro-social levels. A basic starting point would be to identify the social actors that oppose these policies and activities and those that endorse them, because I consider that drugs are basically what social groups and subjects in their social relationships, and, especially, in relationships of hegemony/subordination, do with drugs, and not only what drugs do to subjects and groups. Indeed, the USA and of course other countries have utilized drugs considered ad dictive according to certain goals, thereby turning drugs into a mechanism of political and social control.

ENDNOTES

a. Latin America, in particular certain countries and regions, has been historically characterized by high homicide rates due to numerous processes and economic, political and cultural factors. It is therefore upon this trend that organized crime mounts its homicidal violence.

b. Even though this text frequently refers to other contexts, it specifically refers to Latin American situations, and especially to Mexico. My analyses and proposals are based, above all, on my work regarding the alcoholization process in Mexico (1,2)

c. We must recognize that the consumption of certain substances considered addictive is "legalized" when the consumption becomes therapeutic, such as the cases of marijuana and methadone; and, above all, through the endless list of substances considered addictive, but which are prescribed by doctors.

d. Two facts must be stressed. First, turning drugs into a health problem instead of a crime problem, although tending towards medicalization, also makes it possible to modify some of the most negative aspects of prohibitionism. Second, it is necessary to make a distinction between the health sector and biomedical and sociomedical research; while the former adheres to one of the various forms of prohibition, a part of medical and social research analyzes and denounces the inconsistencies and fallacies of prohibitionist policies. I believe that the prohibitionist policies will increasingly be justified using biomedical criteria.

e. The concepts of addiction and dependency do not withstand theoretical or empirical criticism (1,6).

f. While the first three ways are proposed and advocated by users, NGOs and intellectuals, the fourth is what really led governments to support harm reduction, especially certain activities such as needle exchanges.

g. Although it is important to acknowledge the origins of harm reduction, in terms of actions and ideas about drug users held by those sectors of the civil society who created and promoted such policies, I believe that it is necessary to include the harm reduction actions promoted by other sectors regardless of whether they are social or state

initiatives. This does not imply that such actions and institutions be joined, but rather that they function in an articulated manner utilizing their particular motivations and ways of organization. However, we must recognize, with all its implications, that government funding of activities has in fact articulated the state and social sectors, except in the case of some self-help groups.

h. A large proportion of harm reduction activities are performed in European countries by NGOs or similar organizations which obtain their funding through international institutions and/or national governments. In countries such as Spain, where there are about 250 social institutions oriented toward people who are drug dependent that are funded by Spain's autonomous governments, the present financial crisis could cause NGOs to lose their financial support. As the current director of the Fundación de Ayuda contra la Drogadicción explains, "NGOs depend on public funds. If they do not get them, and that network of coverage disappears, the problem could get out of control and drug addicts might have to return to the streets" (13). This is a problem which needs to be thoroughly explored.

i. The concept of risk reduction has been questioned, even by me, to the extent that the dominant proposals consider both the risk itself as well as its reduction in terms of individual and intentional responsibility, ignoring structural conditions operating not only at the context level but also at the subject level. However, the fact that the concept was used in this way, especially by the health sector, does not prevent us from using it from a perspective that centrally includes structural aspects and social actors, without of course eliminating their responsibilities in the consequences generated (14).

j. It is evident that not only poor people consume, nor are they the main consumers of substances considered addictive. They are also not always those most involved in road accidents. However, it is they who experience the most negative and frequently irreversible consequences.

k. We certainly understand that knowledge itself, even when evidenced by "objective" criteria and data, is not what decides the truth about the type of process we are discussing; rather, and to put it in terms currently en vogue, it is "power" that decides. This idea was early on proposed by Dilthey, who held that "facticity" is what actually decides the truth or falsehood of a fact (14,27). This does not imply that we stop highlighting, arguing and demonstrating which are the "objective" criteria in terms of knowledge and, if possible, intervention.

l. The five national surveys carried out in Mexico since 1986 regarding the consumption of drugs considered addictive have concluded that alcohol "produces" more "dependent" subjects than any other drug. Moreover, during a number of years in the 1980s and 1990s, alcohol dependence syndrome was one of the first twenty causes of death in males, something that has not occurred with any other drug.

m. The 20 substances were rated from 0 to 100 – 100 being the maximum level of harm – yielding the following results: alcohol 72, heroin 55, crack 54, crystal methamphetamine 33, cocaine 27, tobacco 26, amphetamines 23, cannabis 20, gamma-hydroxybutyric acid 18, benzodiazepines 15, ketamine 15, methadone 14, mephedrone 13, butane 10, khat 9, ecstasy 9, anabolic steroids 9, LSD 7, buprenorphine 6, and mushrooms 5. Sixteen criteria were applied for this assessment. It should be noted that data establishing scientifically that certain drugs are considered harmful is repeated constantly, even though these drugs may be much less detrimental to health than other drugs that have been legalized (4).

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