

YOUNG VISION

MEXICO'S ALCOHOL POLICY

LISA SÁNCHEZ



The *Young Vision* series offers a space for analysis and discussion of issues on the public agenda from a youth perspective. We assume that there are young experts, professionalised and with much to contribute to public agenda items related to drug policy, prevention of HIV and promoting gender equality and equity.

Through this series we seek to recover policy recommendations, best practices, benchmarking and social experiences of young people, helping decision makers and public policy makers achieve a better understanding of the realities of young people.

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INTRODUCTION

In recent years, Mexico has witnessed an unprecedented increase in the use of legal and illegal drugs. Several studies show the country went from a transit country to one of production, distribution and final destination for a range of narcotics that, in public health terms, made a once resilient population more prone to drug use. Increased drug availability, more drug use opportunities; a lower legal age and the emergence of similar drug use patterns between men and women are only a few of the trends observed by health authorities since 1988.

But are churros (joints), metas (methamphetamine), ecstasy, inhalants and speed truly the most harmful drugs?

Is illegality the only factor that determines the dangerousness of drugs and the level of priority assigned to address the drug phenomenon? Is it true that illegal substances are always more harmful than legal ones? The response is simple, binary and unique: no. In Mexico, illegal drug use and abuse has never exceeded or replaced alcohol consumption.

According to data from the National Survey on Addictions (ENA), alcohol is the most consumed substance among the Mexican population, with rates ranging from 72 to 77% among men and 36 to 43% among women between 1988 and 2002. According to the 2011-2012 update of the Program Against Alcoholism and Alcoholic Beverage Abuse, the annual per

capita consumption of alcohol in Mexico is 7.7 liters, while the most common form of consumption among the population consists of drinking large amounts on a single occasion. In other words, while most Mexicans do not drink alcohol everyday, 8 in 1,000 Mexicans have daily consumption patterns, with a ratio of 7.5 men for every woman. This figure, without a doubt, is a lot higher than that of “problematic” illegal drug users.

Why isn’t anyone talking about alcohol consumption if it is a health problem bigger than other forms of drug use? How is it possible such an important phenomenon is overlooked or minimized every time we speak about drug policies? How does this bias affect our risk perceptions and influence the decisions we make regarding consumption? These questions will be addressed in the following pages with the aim of encouraging reflection and analyzing young people’s needs in terms of alcohol consumption information, prevention and treatment.

To guide the discussion, we suggest two main reasons why, in our opinion, alcoholic beverage consumption must be considered a priority and addressed in a serious and coherent fashion in the process of developing a comprehensive drug policy with a public health perspective:

First, the harmful effects of alcohol consumption exceed, both in terms of

number and seriousness, the harm caused by the use of other drugs;

Second, as a legal drug subject to national and international production and trade rules, alcohol is a great example to analyze the limits of the discussion around legalization, regulation and prohibition, and reveal the selective nature of existing prohibitionist policies.

The purpose of this document is not to explain in detail the impact of alcohol consumption on all the social and economic dynamics where it intervenes, or to conduct an exhaustive analysis of national policies, programs and strategies in the areas of regulation, consumption and addiction control.

On the contrary, the opinions expressed here are simply a young perspective of the subject with the sole purpose of raising awareness among our peers and decision makers of the need for an honest drug policy. Our objective is to encourage an informed discussion of the effects and consequences of alcohol use, abuse and dependence, which, in our opinion, have remained hidden behind a discourse that magnifies the potential dangers of illegal drugs and promotes harassment of drug users.

FROM PULQUE TO “I DON’T REMEMBER”

Alcohol consumption in Mexico is linked to the cultural roots of Mesoamerican peoples. In Pre-hispanic cultures, alcohol consumption was generally limited to *pulque*,¹ and it was strictly controlled by a cultural structure of senses, practices, rules, codes and myths that not only were consistent with their religious cosmovision, but actually represented a full system of prescriptions aimed at regulating everyday behavior and extraordinary situations.²

For centuries, the distribution of time defined by their calendar included a series of holidays where it was perfectly legal to drink *pulque*, while a spatial planning structure linked to the social class divide defined who, how and where it was possible to drink alcohol.³ There were clear and precise rules for each group that determined the authorized amount of *pulque*, the frequency with which it could be drunk and the physical spaces available for it.

With the arrival of the Spanish conquistadores, the control of alcohol consumption and use of other drugs was linked to the conquest violent processes, which led to a prohibition regime that, while restricting the sale of “poisons, herbs or other deadly things”,⁴ contributed to the process of alcoholization of local communities. The conquest and

colonial periods brought new distilled beverages and turned grapevines into a flourishing industry in the New Spain.

Class restrictions still existed under this new structure, but they were now associated with the type of beverage, rather than the possibility -or not- of drinking it. Religion, on the other hand, became more flexible, to the extent of no longer being a limitation to consumption. This led to a more permissive culture with major social consequences. Indigenous, native and peninsular residents soon developed “vicious” behaviors that had to be addressed through, laws, hospitalization, *mandas* (religious vows) and other social and religious atonement mechanisms.

In Independent Mexico, the proliferation of *pulque* and other alcoholic beverages, such as beer and tequila, became particularly important. Huge fortunes were amassed during this period thanks to the boom of alcohol trade and the “democratization” of its consumption. Religious, cultural, class and time limitations disappeared almost completely to give way to new regulation mechanisms, this time determined by the market dynamics with its supply and demand laws.

The above, however, does not mean that alcohol production, distribution and consumption have escaped all forms of state and/or social control in the past.

1. Pulque is a traditional alcoholic beverage made from the fermented sap of the maguey plant, whose alcohol content ranges from 6 to 20% depending on the degree of fermentation. Its use is concentrated especially in rural communities in the central part of the country, and its history can be traced back to 200 AD according to prehispanic Meso-American records.

2. Cf. Machín, Juan and del Bosque, Joaquín. “Situación actual del tratamiento en México”, in Modelo Eco2. Hogar Integral de Juventud, Mexico, 2005.

3. *Ibidem*.

4. Martínez, Mónica. “Fármacos que los mexicanos han tenido a su alcance”. *Recorrido Histórico. Nuestra Historia* No. 44. Centro de Estudios Históricos del Porfiriato, Mexico, 2001.

In fact, the alcoholic beverage industry was always a major source of public and private financial resources, whether through legal trade, smuggling, exploitation of peasants and day laborers⁵ or taxation.

Alcohol abuse, on the other hand, was also used for the refinement of different social control strategies. Thus, the development of dependences and the adoption of socially “reprehensible” behaviors such as drunkenness and indecency allowed for the sanctioning of what soon would be considered a deviant behavior: drunks and *teporochos* (homeless alcoholics) were soon identified as human beings unfit for life in communities and, therefore, locked up.

At the same time, and as a process in synergy with the one mentioned above, we find the emergence of a stigmatized image of consumers labeled as bums, thieves, assailants and vicious individuals.⁶ Similarly to the US, where the prohibitionist policy was built on racial grounds,⁷ in Mexico the foundations of prohibitionism were laid on classist and xenophobic biases. Consequently, alcohol consumption was socially “regulated” through a continuous and ambiguous oscillation between everyday permissiveness and moral persecution by the public opinion and authorities.

Modern Mexico would only witness major changes until the early 20th century. In fact, except for a few health actions, laws passed

to control the use of alcoholic beverages passed from the *Porfiriato* period to the Miguel de la Madrid administration included an endless number of rules and regulations with the sole purpose of regulating supply.⁸ In other words, our country spent decades issuing permits for alcohol beverage production, sale and consumption while neglecting efforts to reduce demand.

The consumption control policy was limited to the medical-health sphere and was not assigned a high priority until the 1960s, when a series of studies conducted worldwide showed alcohol abuse and dependence were not only psychological diseases, but sociocultural disorders that transcended the individual and caused major social harm.

Unfortunately, conceptual evolution and achievements made in the field of alcoholism research were not enough to turn alcohol consumption into the object of serious programmatic efforts and public policies. Once again, endeavors focused on hardening control mechanisms to prevent the illegal trade of other drugs that, classified as “substances hazardous to health” by the UN, shifted public attention from *teporochos* (homeless alcoholics) to *marihuanos* (potheads), *cocos* (cocaine users) and *tecatos* (hardcore drug users).

In short, the history of alcohol consumption in our country is marked by the constant

5. Induced to alcohol consumption and in debt to “*tiendas de raya*” (company stores) for life.

6. Astorga, Luis. *El siglo de las drogas*. Espasa Calpe, Mexico, 1996.

7. The first American antidrug law was the San Francisco 1875 ordinance, which banned the smoking of opium, and was passed for fear the Chinese would pervert white women. The same happened with cocaine, which was banned to prevent white women from being raped by “Cocainized Niggers”. Cf. Schaffer, Clifford.

8. Berruecos Villalobos, L. *Panorámica actual de la investigación social y cultural sobre el consumo del alcohol y el alcoholismo en México*. Universidad Autónoma Metropolitana. Mexico, 2002.

opposition between the increasing permissiveness that enabled it and the limited efforts made by society and authorities to address the challenges it posed from a public health perspective.

This contradiction was followed by restrictions on, and penalties for, the use of other psychoactive substances. This policy led to particularly harmful social, economic and health consequences, considering that, as explained below, the limited and inefficient efforts made to implement a coherent alcohol policy turned Mexico into a country of drinkers.

THE EPIDEMIOLOGY OF ALCOHOL IN MEXICO: TWO IN DISTRESS MAKES SORROW LESS

Alcohol abuse and alcoholism are major public health issues due to their social and health consequences. Alcohol consumption is the cause of 2.5 million deaths a year worldwide, and it is associated with the death of 320,000 young people ages 15 to 20, thus accounting for 9% of deaths in this age group.⁹ Alcohol consumption is also the third main risk factor for global morbidity, as well as the top risk factor in Latin America, where it is related to serious social problems such as violence, accidents and workplace absenteeism.

From a regional perspective, Latin Americans drink approximately 40% more

alcohol than the global average. Despite significant subregional variations, the annual average consumption per capita in the Americas, weighted by population, is 8.7 liters, a figure well above the 6.2 liter global average.¹⁰ This indicator is as high as 7.7 liters a year in Mexico, even if we consider differences by type of beverage and age group.

According to the latest data of the 2008 National Survey on Addictions, adults in Mexico drink larger amounts of *aguardiente*, 96° alcohol, and *pulque* compared to other age groups. Young people and adolescents, on the other hand, consume larger amounts of beer, distilled beverages, wine and prepared beverages. But something even more revealing than preferences is the issue of consumption patterns. In fact, in Mexico it is common to drink large amounts on a single occasion. In 2008 alone, almost 27 million Mexicans (26,828,893) ages 12 to 65 showed this drinking pattern, with consumption frequencies ranging from less than once a month to everyday.¹¹

This phenomenon is more serious than it appears. 5 years ago, around 4 million Mexicans (3,986,461) drank large amounts of alcohol at least once a week or more often.¹² While most of them were men, the tendency towards abuse patterns is growing quickly among women, especially adolescent women. According to data from the National Council Against Addictions (CONADIC), the difference between

9. Comisión Nacional contra las Adicciones. *Programa contra el alcoholismo y el abuso de bebidas alcohólicas: actualización 2011-2012*. Secretaría de Salud, Mexico, 2011, p. 15

10. *Idem*, p. 16

11. *Ibidem*.

12. Instituto Nacional de Psiquiatría Ramón de la Fuente. *Encuesta Nacional de Adicciones 2008*. SSA/CONADIC, Mexico, 2008, p. 62.

adult and adolescent women (one woman between the ages of 12 and 17 per 1.9 adult women above 18) is smaller than that observed among men (one adolescent man between the ages of 12 and 17 per 5 adult men above 18). In practical terms, this means an increasing number of women are adopting this type of patterns, and the proportion is higher compared to men.

These data are particularly relevant considering that, both among men and women, the age group with the highest consumption level is that between the ages of 18 and 29, and the proportion of consumers that meet the abuse or dependence criteria is a lot higher among alcohol users compared to other drugs. By 2008, more than 4 million Mexicans (4,168,063) already met the abuse and dependence criteria (3,497,946 men, 670,117 women).¹³

As is well known, harmful alcohol consumption is associated with more than 60 different diseases, including cirrhosis, diabetes, and several heart, liver, stomach and nervous system disorders. If this were not enough, abuse of this legal drug is associated with acts of violence that have an impact on the family, personal and social spheres. A clear example of it is the percentage of persons with alcohol abuse problems who have been involved in some type of household violence (10.8%), participated in brawls or fights under the effects of this substance (6%), had problems

with police (3.7%) or were arrested while intoxicated (41.3%).

Finally, work-related problems, although less frequent, also lead to significant financial losses for families as a result of firings, chronic unemployment and the high cost of rehabilitation. In short, and based on the data presented herein, Mexico has a public health problem related to alcohol consumption that must be considered a priority and addressed as such.

PREVENTION AND TREATMENT INTERVENTIONS

Regarding intervention needs, harmful alcohol consumption puts pressure on health and education systems.¹⁵ In the case of prevention alone, there are major challenges to overcome in terms of resource allocation, cost-effectiveness of efforts, and the truthfulness and relevance of all alcohol-related information.

Taking in consideration and thinking outside the traditional paradigm of abstinence, it is important to address the issues of use, abuse and dependence from a perspective based on reality that recognizes the former and reduces the harm associated with the latter. Thus, mitigating the harmful consequences of alcohol abuse and dependence requires real efforts that take into account the multiplicity of factors that encourage consumption and the contexts in which it takes place.

13. *Ibidem*.

14. *Ibidem*.

15. The chemical most commonly used by members of the scientific research community is $C_8H_{10}N_4O_2$, followed by C_2H_5OH , with impacts on both the above mentioned systems.

The efforts required to increase the quality and availability of treatment are even bigger. More political will on all levels is still required to recognize the problem and undertake specific actions to get the commitment of all sectors of society to reduce harm and guarantee effective and quality treatment for individuals at risk of becoming dependent.

In the case of treatment alone, there is an estimated 60 million persons who need to prevent and reduce the harm associated with occasional alcohol abuse. On the other hand, more than 10 million persons require selective and targeted interventions, and almost 4 million will require early detection and timely interventions. Finally, it has been estimated that 0.60% of the population meets the criteria for illegal drug abuse and dependence, which means more than 428,000 persons will require addiction treatment specialist services.¹⁶

In the case of alcohol, a 2011 study revealed this was the drug with the biggest impact on populations under treatment, exceeding by far other drugs such as cocaine, methamphetamines and over-the-counter drugs.¹⁷ According to treatment providers, between 51 and 59% of individuals receiving residential care reported they sought treatment to overcome alcohol addiction, even though this was not the only drug they used.¹⁸

Additional data from 2011 show alcohol was the main gateway drug among population in rehabilitation, in a proportion twice as large as that for marijuana and three times that for tobacco. In addition, alcohol as a gateway drug is 8 times more common than inhalants, 16 times more important than smoked methamphetamine, and 24 times more frequent than snorted cocaine.¹⁹ Considering most people start using substances before age 17, it can be affirmed alcohol is the drug of choice among adolescents and young people.

But something even more important than these figures is the urgency to effectively reach and provide care for a hidden universe of individuals who continue to reproduce harmful cultural patterns of alcohol consumption and use of other drugs in their communities without access to appropriate prevention, harm reduction or treatment services. Thus, any addiction intervention strategy that seeks to be effective must be aimed at reversing the sociocultural factors that cause and reinforce consumption in the same place where they occur. We should not forget that, while drug addiction is a multifaceted phenomenon, it does not begin or end within the individual.

In short, the phenomenon of drug addiction requires recognizing that individuals in substance abuse and dependence situations have unresolved health problems and social conflicts that demand a sustained

16. We are taking into account the number of persons who require treatment to overcome their drug addiction, because a large percentage of them has, or has had, problem alcohol consumption patterns. Instituto Nacional de Psiquiatría Ramón de la Fuente, *Op. Cit.* p. 52

17. CENADIC-CICAD. *Diagnóstico Nacional de Servicios Residenciales en el Tratamiento de las Adicciones*. Secretaría de Salud. México, 2011, p. 61 y 114.

18. *Ibidem*.

19. Los datos de la encuesta revelan que 48% de lxs usuarixs tiene....

TRADUCIR CITA CENADIC-CICAD, *Op. Cit.* p. 130

effort to increase and improve the supply of prevention and treatment services.

The first step towards consolidating a comprehensive alcohol policy consists of accepting the big failure of strategies already implemented in schools, sports centers and the media. Despite all media efforts, strategies based on abstinence and deterrence have been, and will be, unable to reduce or delay consumption. In fact, the premise underlying these Utopian public efforts is a fallacy, because a 100% alcohol-free world has never existed, and will never exist.

Health authorities and the different personalities participating in the fight on addictions may argue that, while there are still gaps, this government administration allocated an unprecedented amount of resources to addiction treatment and prevention. They will insist on the fact that, since 2006, more than 330 addiction treatment centers were built and, thanks to training and a series of information campaigns, the State has built the capacity to tackle the problem of addictions. They will also affirm that these campaigns work, but the impact “will only be tangible in the mid or long-term”. We truly hope so, but for now the only thing for sure is that:

- Existing treatment centers are not enough, and they do not provide quality care, considering most of them are not subject to supervision and do not comply with existing regulations;

- Addiction treatment centers only provide short-term outpatient services to experimental users, who do not represent the majority of addicts.

In addition to the lack of transparency in the operation of treatment centers (which, by the way, are not run by the State), we must consider the complete lack of respect for human rights in those facilities. The lack of financial resources, the limited availability of training options and poor infrastructure are also factors that have a negative impact on the possibility of rehabilitation for users all over the country.

It is also necessary to recognize that, in the case of young people, the potential harm of alcohol abuse increases in the presence of other risk behaviors such as driving, unprotected sex, use of other psychoactive substances and violent behavior. While we are not in favor of any form abuse or demonization of any particular substance, we must emphasize that, in the case of alcohol, young people are the group most prone to adopting risk behaviors that, in turn, expose us to other problems such as sexually transmitted infections (STIs/HIV), unintended pregnancies, traffic accidents and alcohol poisoning.

However, if we look beyond the negative consequences of occasional drug use, we can conclude the biggest concern today is the number of individuals who transition from use to abuse, and the even larger number

of them who transition from abuse to addiction, sometimes without even realizing it. And it is just that, again, the prevalence of alcohol consumption among populations under treatment is almost 70%, which is hardly the case with other drugs. Bearing in mind that accumulated prevalence is not necessarily the best indicator to trigger an alarm signal, we can also add that alcohol and tobacco consumption are usually not interrupted among populations under treatment.

In short, there are many reasons to affirm that alcohol consumption is a key issue that must be considered in the design and implementation of drug policies and drug addiction prevention and treatment policies and programs. This has been historically been dealt with, but not in a comprehensive fashion.

A NEW GENERATION OF ALCOHOL POLICIES

The development of alcohol policies with a public health perspective requires the design and implementation of a range of appropriate interventions that, from a population perspective, should benefit the largest number of individuals possible. According to the Pan American Health Organization (PAHO), developing a comprehensive alcohol policy requires recognizing that populations consume alcoholic beverages

as a result of an interaction between the substance (alcohol as a psychoactive and toxic substance), the individual (gender, biological traits, personal history) and environmental factors (availability, price and alcohol advertising).²⁰

Therefore, any alcohol policy intended to address the issue from a public health perspective must rely on epidemiological principles. This will allow for a better evaluation and understanding of alcohol beverage consumption in a given population, monitoring trends, designing better interventions and evaluating programs and services.²¹

For PAHO/WHO, alcohol policies are defined as authoritative decisions made by governments through laws, rules and regulations pertaining to alcohol, health and social welfare.²² Furthermore, “the purpose of [those] policies is to serve the interests of public health and social well-being through their impact on social and health determinants, such as drinking patterns, the drinking environment and the health services available to treat problematic drinkers”.²³

Unfortunately, in the Americas -and particularly in Mexico- alcohol-related harm has not yet been associated with comprehensive prevention and treatment policies. While there is a wide range of sophisticated political responses to address

20. Organización Panamericana de la Salud. *Alcohol y salud pública en las Américas: un caso para la acción*. OPS. Washington D.C., 2007, p. 23.

21. Babor T, Caetano P, Casswell S, Edwards G, Giesbrecht N, Graham K et al. *Alcohol: No Ordinary Commodity*. Oxford University Press, 2003 in Organización Panamericana de la Salud (2007). *Op. Cit.*

22. Longest, BB. *Health policymaking in the United States*. IL: Health Administration Press, Chicago, 1998 in Organización Panamericana de la Salud (2007). *Op. Cit.*

23. Edwards G et al. *Alcohol policy and the public good*. Oxford University Press, New York, 1994 in Organización Panamericana de la Salud (2007). *Op. Cit.*

the social and health consequences of harmful alcohol use, their implementation varies both geographically and in terms of timing, which poses an obstacle to the integration and comprehensiveness of efforts. Thus, while most countries have strategies that are compatible with the latest research findings, reality shows that, in practice, these findings are not always applicable.²⁴

In general terms, in the Americas there are around 32 different policies or strategies to address alcohol use, abuse and dependence.²⁵ These, in turn, can be grouped in nine major categories where States have focused their actions:

- Legal drinking age;
- Restrictions on alcoholic beverage availability;
- Restrictions on retail sale outside establishments;
- Prices and taxes;
- Drunk driving legislation;
- Screening and brief interventions for alcohol-related problems;
- Advertising and sponsoring;
- Alcohol-free environments, and
- Prevention, treatment and training of human resources.

The fact that these policies exist, however, does not necessarily mean they are fulfilling the objectives for which they were conceived. According to an expert panel called by

PAHO in 2005 to evaluate alcohol policies in the Americas,²⁶ there is a broad range of strategies that, while popular, do not meet the actual needs of the communities they apply to. That is the case of education and persuasion strategies that, despite their potential to increase knowledge and change certain attitudes among young people, do not produce sustained effects on drinking.

On the other hand, other less popular measures, such as increasing taxes and controlling alcohol production and distribution, proved more effective for reducing the availability of alcoholic beverages, especially among the youngest population sectors. The same study shows that laws that address risk behaviors, such as drunk driving, are more efficient for the region as a whole compared to other efforts that only focus on the substance.

While we do not intend to conduct an exhaustive analysis, it is worth mentioning that the most successful and cost-efficient policies identified have focused on establishing a legal drinking age; taxing alcohol sales; brief interventions for risk drivers, and programs imposing administrative sanctions for drunk driving based on blood alcohol levels. The worst policies identified, on the other hand, involved the promotion of alcohol-free activities and events; alcohol education programs in schools; alcohol education for college students; advertising in public

24. Organización Panamericana de la Salud, *Op Cit.*

25. Argentina, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Surinam, Trinidad and Tobago, the US, Uruguay and Venezuela.

26. Babor T, Caetano R. "Evidence-based alcohol policy in the Americas". *Rev Panam Salud Publica / Pan Am J Public Health* 2005; 18 (4/5):22. Longest, BB. *Health policymaking in the United States*. IL: Health Administration Press, Chicago, 1998

facilities, and taxi services as an alternative to reduce traffic accidents.

It is worth noting that the analysis of these measures cannot be dissociated from local contexts, the type of public institutions available to control alcohol supply and demand, consumption patterns and other epidemiological variables. Also, we cannot see these conclusions as final, unquestionable or absolute and, therefore, we should consider those factors that may increase or reduce the effect of such measures in each individual community.

Having said this, existing evidence shows that even those policies considered successful have flaws, and even the least effective ones, or those extremely expensive, can have positive effects. Examples of this situation include the establishment of a legal drinking age, the effectiveness of which will depend on the quality of law enforcement and surveillance mechanisms, and the widely criticized taxi services that, despite not having a proven impact on the reduction of traffic accidents, can help raise awareness among the population and reduce the number of drunk drivers.

The practice of raising taxes also illustrates the importance of not overestimating the effectiveness of any given policy. In Mexico, for example, distilled beverages (*tequila*, *mezcal*) are subject to a 50% Special Tax on Production and Services (IEPS), in addition to 16% Value Added Tax (VAT)

and 28% Income Tax.²⁷ But this has not had a tangible effect on consumption. Worse still, the enforcement of this type of measures without appropriate supervision can actually encourage the emergence of criminal groups smuggling illegal alcohol and adulterating alcoholic beverages that will later be sold in bars and night clubs.

Another interesting example is that of regulations on alcoholic beverage advertising, where economic interests often prevail to the prejudice of public health. Thus, while the World Health Organization (WHO) has warned more than once of the health risks deriving from exposure to alcohol advertising, reality shows alcohol advertising campaigns are still legal in a large number of Latin American countries. In fact, in the last few years the alcoholic beverage industry began targeting young drinkers by launching a range of cheap products, such as sodas with alcohol, alcoholic energy drinks and premixed cocktails, with the only objective of increasing the market size.

But alcohol is not to blame. People should have access to mechanisms to protect their health in case they decide to drink. Unfortunately, this is not always the case in countries like Mexico, considering young people lack access to health and safety measures like those available in developed countries.²⁸

In conclusion, it is not about creating a catalog of good or bad policies, because we

27. It is worth noting that, while taxes in our country are higher than those in other Latin American countries, they are the lowest compared to those in member countries of the Organization for Economic Cooperation and Development (OECD).

28. World Health Organization (Ed). *Global Status Report: Alcohol & Young People 2001*. Geneva, 2001.

know there is often a good legislative or regulatory intention behind them. What is unforgivable, however, is the neglect and lack of coordination in the implementation of policies and programs, the long time it takes to recognize epidemiological realities and take actions to reverse them, and the arbitrary separation of policies in two areas that only undermine efforts. In this regard, the existing gap in alcohol policies has to do with the selective way in which we continue to refer to ‘drugs’ and underestimate the potential harm of alcohol.

OPPORTUNITIES TO IMPROVE MEXICO’S ALCOHOL POLICY

As already explained, Mexico’s alcohol policy is almost fully consistent with the regulation of the alcoholic beverage supply: supply, production; supply, distribution; supply, sale. What about the demand? It continues to grow. Despite significant achievements made in research on the harm produced by alcohol abuse, decades of poor interventions and systematic underestimation caused efforts to reduce the demand to stay within the boundaries of the medical-health approach. The same applies to the evolution of institutions specializing in addictions, if we consider the National Council Against Addictions (CONADIC) was only established in 1986 through a decree issued by Miguel de la Madrid, the President at the time.²⁹

Did the response simply arrive too late? Actually no, because efforts got here some 300 years too late, but the neglect was not accidental. And the political and programmatic reality of addictions has never adopted a progressive position. It is exactly the opposite. The evolution of theories in the field of drugs has almost always been accompanied by a series of setbacks in terms of individual liberties and the right to health that, far from encouraging the adoption of comprehensive approaches, allowed for the expansion of one-sided efforts, such as hardening control policies and the gradual militarization of control over supply.

It is precisely in this regard that government actions in the areas of addiction services, control and treatment are still in debt with society. By way of example, the Mexican Official Standard on Addiction Prevention, Treatment and Control³⁰ was only released in September 2000, when its enforcement opened up the possibility of regulating addiction prevention, treatment, research and training.

The narrow institutional vision with which local, state and federal authorities have addressed the phenomenon of drugs and drug addictions also reflects the predominantly pharmacological approach underlying most prevention and treatment efforts. So far, there has been virtually no strategy with a real impact on the individual and collective aspects that define and characterize the problem of harmful

29. Diario Oficial de la Federación, July 8, 1986.

30. SSA. (Ed.). *Norma Oficial Mexicana para la Prevención, Tratamiento y Control de las Adicciones*. NOM-028-SSA2-1999. Diario Oficial de la Federación, Mexico, 1999-2000.

consumption, a situation that, without a doubt, interferes with the process of raising awareness of the set of social practices that favor the normality of addiction as an organizer of the social dynamics.

This conceptual and instrumental gap is even more significant when compared to the fast legislative evolution in the field of psychoactive substance control and the uninterrupted development of mechanisms to punish drug-related crimes. And there is no valid counterargument here because, unlike illegal drug use, the problems of alcohol abuse and dependence are not new.

But developing a comprehensive drug policy involves a much more complex task that goes beyond substances themselves and falls within the scope of human security and development. It is for this reason that we continue to insist on the fact that this is not about alcohol; it is about poverty, the lack of services, the lack of real employment opportunities, low education levels; the lack of political will and international manipulation. Is there hope? Yes, but we are running out of time.

CONCLUSION: WHAT DO YOUNG PEOPLE PROPOSE?

So far, we have provided an overview of the most important characteristics of the institutional approach towards the drug phenomenon and its relationship with the

formulation of policies to treat alcohol use, abuse and dependency. We also addressed some of the determinants of the development of prevention and treatment infrastructure, and showed how its emergence was late and insufficient to generate an effective impact on the epidemiological reality. We then provided an overview of the construction of the predominant paradigm of drug dependence, and concluded this has been marked by the implementation and consolidation of control mechanisms with a disproportioned effect on illegal drug supply, neglecting other public health problems such as harmful alcohol consumption.

To this we should add, however, young people's contribution to the discussion based on experiences and good practices documented in other parts of the world. In general, the effective responses studied and observed in places as distant as South America, Europe, Australia and New Zealand are based on holistic principles aimed at supporting actions by the State and communities in a prevention/harm reduction/treatment continuum based on the individual and his context, and not on substances.

In particular, we would like to stress the importance of intervening in four specific areas of action, to wit:

1. The sensitive and active participation of members of the industry in order to inhibit the sale of alcohol to minors and

avoid intoxication among young people by making patrons of establishments where alcoholic beverages are sold and consumed aware of the importance of discouraging abuse of fast consumption liquors (shots) and promoting the consumption of non-alcoholic beverages and foods;

2. Improvements in the areas of health and security through the provision of safe consumption environments; harm reduction measures in recreational spaces; access to, and availability of, appropriate health care and encouraging good communication with the police.

3. The development of a 'drinking culture' and a sense of common responsibility by providing straight information on alcohol consumption and activities to build the skills required to face emerging situations. The idea is to supply consumers with the tools necessary to avoid excessive consumption and information on where and how to get help in case it is required;

4. Cooperation between police forces, the judicial system and communities, ensuring all parties are well trained on the use of alcohol, are sensitive to users' needs and participate in the search of solutions.

These principles, which provide the framework for actions and responses by all actors involved -government, civil society, businesses, service providers, relatives and users- contribute to the creation of

safer consumption environments, while promoting the adoption of healthy behaviors with respect to the use of alcohol.³¹

By relying on businesses and service providers as joint enforcers of the policy, the industry can promote compliance with the legislation in force and help build relationships with communities, their residents and consumption establishments, in addition to achieving a balance between consumption and awareness of the implications and impacts of alcohol poisoning among the population. All of this, in turn, will lead to a decline in drug-related violence, antisocial behaviors and crime, as well as a tendency to lower consumption among minors.

Other recommendations that, in our opinion, must be considered in the development and implementation of an effective, inclusive and relevant drug policy include: a) the adoption of a human rights approach with a generational perspective, b) young people's participation in the design, implementation, follow-up and evaluation of local and national strategies, and c) addiction prevention programs and increased actions to promote young people's comprehensive development, taking into consideration our education, employment and recreation needs, as well as the specific vulnerabilities that lead to drug use.

Finally, and based on all of the above, an alcohol policy with a public health

31. Barra, Aram (2011): *Hablemos de alcohol*. [Online] Available at: <http://arambarra.wordpress.com/2011/06/02/hablemos-de-alcohol/> Last accessed: January 10, 2012.

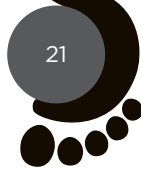
perspective should include complementary actions such as reinforcing institutions to make sure the law is enforced; the review of alcohol advertising regulation mechanisms; implementation of accident prevention measures such as Breathalyzer tests; education and training for health professionals, and development of treatment services integrated into the general health system.

We must bear in mind that none of these recommendations will work if we fail to promote, above all, a sense of responsibility among individuals and their freedom to exercise their rights and make decisions regarding their own bodies. After all, the State and society are there to protect the common good and guarantee, at all times, that men and women have equal access to information and services to protect their health.

Do you agree?

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NOTES

NOTES



Cut along the dotted line and roll the sheet into a tube, you will create a telescope with 1:1 magnification capacity. You are now ready to discover your world.

The background of the cover features a photograph of two individuals, likely indigenous, wearing traditional wide-brimmed hats and long, light-colored tunics. They are standing in a field of large agave plants. A large, solid yellow circle is superimposed over the center of the image, containing the text. At the bottom, there is a dark purple circular graphic that partially overlaps the yellow circle and the agave plants.

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