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The ethics of not taking a stand: dilemmas of drug and alcohol prevention in a consumer society—a case study

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Abstract

Advanced consumer societies face a dilemma in alcohol and other drug policy between individual freedom of choice and the need to prevent problems. As in many other areas of problem prevention and health promotion, the policy solution often emphasises the moral management of the self. This article argues, on the basis of a case study of a community-based alcohol and other drug prevention programme for young people in Finland, that the moral resources of public administration may not be sufficient for efficient prevention policies. The policies known to work, such as reduction of alcohol availability or restrictions on smoking, impinge on consumer choice, on market freedom and on lifestyle issues that are considered to be a private matter. As a result, public authorities tend to delegate responsibility downwards, from managers to field workers and from field workers to parents and schools. A consequence may be the use of policies that do not work but have popular appeal, such as zero tolerance instead of harm reduction programmes of illicit drugs. The emphasis on moral management of the self may lead to moral management of the other, which strongly disadvantages most youth and does not meet the needs of young persons in greatest need of help.
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The contemporary dilemma of problem prevention

A few decades ago, the Nordic states still tried to guide citizens to good manners. Through legislation, family assistance, educational programmes and instruction, the state took a normative stand on sexuality, women's employment, parenting, social manners and legitimate cultural taste. Particular attention was paid to the use of alcohol. In Norway, Sweden and Finland, state-owned alcohol monopolies attempted to direct the population towards what they considered to be civilised manners of drinking (Sulkunen, Tigerstedt, Sutton, & Warpenius, 2000). Drugs were not a major societal issue at this time.

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Today, the state has less authority to promote lifestyles. Many lifestyle choices are now considered to be a private matter, and as market freedom and consumer choice are dominant values in Nordic welfare states, as elsewhere, the traditional monopoly-based, alcohol-control strategy is being challenged. Yet, we also know a lot more about risks and harms related to alcohol use, and about efficient policies to prevent them (Babor et al., 2003). However, such policies imply infringement on free markets and consumer choice: price controls, rule enforcement on sales practices, and restrictions on availability and marketing (Room, 1999).

Illegal drugs further complicate the situation. Their control by the state is unquestioned, and drug use is highly disapproved of by the majority as it is not politically correct to be consumer oriented in terms of illegal substances. Nevertheless, harm reduction approaches, which emphasise public health, have been developed since the mid-1990s for 'hard drug users', greatly mobilised by the fear of an increasing

HIV/AIDS epidemic (Tammi, 2004). Harm reduction is seen as expensive, though, as it is funded by taxpayers.

The dilemma in problem prevention – the promotion of the public good versus market and individual freedom – is accentuated by increasing costs due to improved medical capacity to treat health problems. Prevention of problems is seen as an efficient way of cost containment but it entails the collaboration of the whole population (Petersen & Lupton, 1996; WHO, 1986). How to secure such collaboration turns out to be a central challenge in preventive alcohol and other drug policy. Several recent European Union and national alcohol and other drug programmes have responded to it by developing an approach that we call the *moral management of the self*. It entails coordinating and building partnerships between schools, parents, voluntary associations, officials and often even business firms in order to share responsibility, and to follow practices that are seen to promote healthy and low risk activities (WHO, 2000, 2001).

This article examines the ideological foundations, structural determinants and consequences of such an approach through a case study of a preventive drug policy programme, *Klaari*, organised around the turn of the millennium by the City of Helsinki, the capital of Finland. We argue that the approach reflects a wider *ethic of not taking a stand* on moral issues in contemporary society. We also argue that, despite the claims of its proponents, the approach is not completely neutral in terms of drug and alcohol policy, involving implicit biases in preventive social policy that disadvantage the weakest in society.

The article is based on an evaluation of the *Klaari* project conducted during its trial phase: 2000–2003. The research analysed the expectations and experiences of the project staff, of the Board of Directors, and of relevant collaborators and target groups. Its public image, organisation and working routines were also analysed. The evaluation was based on interviews and we also observed project meetings, visited some events and educational programmes, and analysed the project's plans and reports. The results were delivered to the participants in oral feedback and unpublished reports, which were discussed in special meetings with the researchers. The study thus was an intervention into the programme. The study had some effect on its working methods, agendas and future plans. However, its basic assumptions were not affected while the project was ongoing. When it became established as part of permanent city policy, it revised its strategy according to recommendations given by the research.

Alcohol and drug policy under a neo-liberal mode of governance

Finland and the other Nordic societies have undergone rapid modernisation since the Second World War. Like many other Western European societies, they turned within three decades from agricultural to industrial, and then gradually to post-industrial, economies (Therborn, 1995: 75). Denmark joined the European Union (EU) in 1973, Sweden and Finland in 1995. Norway remains outside.

As in most Western European countries, the parliamentary political structures in the Nordic countries have been based on strong class-related social movements that today face difficulties in maintaining their anchorage. Paradoxically, they often fail not only to demonstrate their differences but also appear confused about what they have had in common: the ideals of techno-scientific progress, universal citizenship of individuals, and the national welfare state (Sulkunen, 1997). These ideals have not been exhausted but realised—to an extent that they have altered shape. Future technical progress cannot be based on mere physical appropriation of nature; it has to embrace the ecosystem in its entirety, humans included. The ideal of individual citizenship that welfare state ideologists dreamed about in the 1930s has become pervasive, and a new nostalgia about the blessings of community has reappeared beside it. Capitalism still needs the nation state, but its principles and structures of responsibility have been altered.

These ideals of modernisation have constituted the social bond that in the past kept the moral community together, despite class-based conflicts of interest. They have been the three pillars of 'the public good' that has been the ultimate value in policy debates on moral issues such as alcohol and other drug use. Today, the sense of 'the public good' has become abstract and thin, and the moral community has lost strength. Nikolas Rose has even asserted that the end of societies has arrived: defining the 'good' that public policies ought to advance, and agreeing on common terms for such a discussion, is no longer easy (Rose, 1999: 98–136). We prefer the expression 'saturated society' (Maffesoli, 1996; Sulkunen, 1997), meaning that the ideals of progress, individualism or the good of the nation no longer seem to be acceptable, valid justifications for government interference in private moral choices.

In this article, we focus on the transformed role of the third pillar, the national welfare state, which is more relevant to alcohol and other drug policy than the other two. Under the neo-liberal mode of governance (Dean, 1999), the line between matters of private lifestyle choice and public interest becomes problematic in a new way, which is reflected in the structures and practices of public institutions themselves. The doctrine of *management in public administration*, advocated by the Organisation for Economic Co-operation and Development (OECD) since the 1980s, emphasises devolved responsibility, local initiative, increased civic responsibility, competition, budgeting by results, and the use of private-sector service providers (OECD, 1995, 2002). Public management is seen as offering a flexible and effective alternative to old-fashioned bureaucracy (Clarke, Gewirtz, & McLaughlin, 2000; du Gay, 2000). It is expected to neutralise and resolve conflicts in domains where there are radical differences of opinion, among experts and among citizens (Newman, 2000).

In preventive social and health policy, public management stresses partnership, community development and co-

operation between different professions and administrative branches. The essence of this strategy, which, in the area of crime prevention, David Garland (2001) has called the *criminology of the self*, is to share responsibility. The role of public institutions in this new strategy is not bureaucratic control but the empowering of citizens and market actors in order to prevent problems. Its reverse side is the *criminology of the other*, which means limiting the citizenship rights of particular groups, dehumanising deviants and excluding them from normal society with long prison sentences, and maximising the visibility of penal consequences. Criminology of the other is usually applied to groups already marginalised or weak, such as substance users, ethnic minorities, persons with mental problems and sometimes simply the young or poor (Garland, 2001: 137).

In more general terms, the kind of preventive social policy that our case represents could be characterised as the *moral management of the self*, with the *moral management of the other* as its reverse side. The devolutionary rhetoric of new public management reflects the difficulties that officials and experts face in formulating policy positions on morally sensitive issues. We call this attitude the *ethic of not taking a stand*, of arguing that often the most ethical stand is not taking a stand at all. It is not limited to alcohol and other drug issues or lifestyles. Medical experts have reacted to technological advances in life control in a similar way. Genetic counsellors, for example, frequently understand that their role is to transfer 'information to those who request it and then leave those individuals alone to make the tragic choices based on that information' (Bosk, 1992: xix).

The Finnish context

Until the Second World War, the Finnish temperance movement was associated with progress, national integrity and individualism in the Weberian sense of the Protestant ethic. Its exceptional legitimacy was due to its integration with both the nationalist and labour movements, and thus it became one of the contributing factors to the moral integration of the nation. As is typical of countries where distilled spirits are the major form of beverage alcohol, drinking in Finnish culture has traditionally been associated with intoxication. The control system has reinforced the image of alcohol as a drug rather than an as ordinary commodity (Sulkunen et al., 2000).

In the 1990s, the alcohol scene changed significantly. Alcohol consumption, measured in absolute alcohol per capita per year, had increased from about two litres in 1968, to about six in the mid-1970s and to about nine in the mid-1990s. In order to comply with EU regulations, production and wholesale of alcohol was opened to free competition in 1995, with only retail sales remaining under state monopoly (Holder et al., 1998). Restaurant and bar licensing became gradually relaxed. What little there was left of the temperance movement had petered out some 10 years earlier, and there were no successors to its traditions (Warpenius & Sutton, 2000).

Compared to most Western European countries, drug use and related problems remained relatively marginal in Finland until the mid-1990s. From 1995 to 1999, the prevalence of 15-year-olds who had tried drugs increased from 5 to 10% (Ahlström, Metso, & Tuovinen, 2001). According to whole population surveys, the lifetime prevalence of drug use doubled between 1992 and 1998 (from 4.6 to 10.2%), and estimates of the prevalence of 'hard drug users' indicated that between 1995 and 1997 it had increased by 40% in the Helsinki area (Partanen et al., 1999). As a result of these developments, politicians, authorities and the media have expressed serious public concern about the drug issue. A recent population survey shows a continuing increase in drug use, especially in the recreational scenes of teenagers and young adults (Hakkarainen & Metso, 2003).

Klaari Helsinki: an example of new public management

The *Klaari* project began in the Northern City district of Helsinki in 1994 with a nurse experienced in the clinical management of alcoholism. At the beginning of 2000, with financial support from the Ministry of Social Affairs and Health, it expanded into a citywide alcohol and other drug prevention project aimed at youth. Each of the seven city districts employed a prevention worker.

After a trial period of 3 years, the project was established as a permanent substance prevention programme of the City of Helsinki. Initially, its organisation consisted of three project managers: the nurse as the head of the project, a marketing director and an educational director. The managers requested the support of a group of experts with varying backgrounds. The formal power lay in the hands of a Board of Directors appointed by the city administration, the police and the church. The budgetary responsibility belonged to the Social Services Department of the City of Helsinki.

The declared aim of the project was to coordinate the work of professionals and voluntary workers for the benefit of young people. It did not produce any educational programmes or materials of its own:

> Klaari is a network for coordinating the resources of professionals, voluntary associations, parents and the rest of the citizenry. Its aim is to create a safety net for young people to advance their well-being and to decrease their substance use. Its guiding principles are high quality, voluntary activity, partnership, self-confidence and belief in the future. The focus is primary prevention, occasionally also secondary prevention. (Plan of activities for 2002)

The working principles of *Klaari* are aligned with the EU drug strategy for 2002–2004, which highlights cooperation and shared responsibility in preventive work (Council of the European Union, 1999). This orientation is incorporated in

national drug strategies in Finland (e.g. Action Plan, 2003) and in the 2000 Drug Strategy for the City of Helsinki. In the same vein, the national alcohol and other prevention programmes highlight local initiative, multi-professional cooperation, citizen participation and voluntary partnership. Thus, *Klaari*'s organisational form as a project with its own management, a separate budget and private business partners, is in itself an example of current European thinking in public management.

Romantic rationalism

The project managers hold strong views on the causes of social problems in contemporary society, and have responded accordingly. Their rhetoric refers to 'our zeitgeist' and 'late modernity'. Their diagnosis is that Finnish society is work-intensive, pluralistic and fragmented by drastic social change. Parenting has become an extremely demanding responsibility but a lonely task. Life is seen to include a multitude of alternative values and possibilities but no common framework for making choices. The resulting confusion tends to burn out professional educators and parents who are unable to provide young people with security and support in order to develop into well-balanced, responsible adults. According to *Klaari*, all this isolation causes further malaise: social exclusion, disorders in adolescent development, mental health problems, crime and use of intoxicants. In the words of Project Manager A (interviewed 18/9/2000):

> And then there's this cultural change. No village community or grandparent support, or a safety net for you any more. Too much has disappeared too fast, and all that cultural avalanche on top of it! Adult contacts around children have disappeared ... The late modern world is so chaotic for the youngsters that no individual can cope with it. Parents have the main responsibility but cannot quite do it on their own. Cooperation thus is essential. Parents need special support in all this.

According to the managers, coordinated work among professionals and cooperation among parents will generate a new sense of community to replace the one that has been lost due to rapid social change. Their romantic nostalgia that idealises the past is combined with a belief in individuals' rationality. It is not 'evil people' but the system's demands and fragmenting consequences that block the road. Thus, the managers have confidence in people's own capacity to find solutions to their problems. As Project Manager B (interviewed 6/9/2000) states:

> Individuals are very much masters of their own destiny, and it's quite a lot that one can do about one's life. People have strength—when you just give them a chance to do something (...). You have to try to find solutions actively, for bigger and smaller things.

Romantic rationalism and an emphasis on the solutions rather than the causes of problems are central to the education programmes that the project employs. They include social skills training for parents, teachers and teenagers, as well as alcohol and other drug education. The favourite programme providers are the church, NGOs with anti-drug programmes, the police, family and child support organisations, the Finnish Red Cross and other health promotion and welfare agencies. *Klaari* had no quality assessment procedure for the programmes, nor was there any such procedure available outside. Their only possibility was to accept the programme providers' own word on quality, as the *Klaari* staff frequently denied having the necessary expertise in drug prevention to assess the programmes themselves. Communality and social responsibility were advanced by supporting parents' associations and other parental voluntary work. Multi-agency groups involving professionals were supported.

But what is the problem?

Like *Klaari*, many youth programmes in Finland have taken their models from American communitarianism and from the British 'third way' view of social policy, which highlight informal social control (Soine-Rajanummi & Saastamoinen, 2002: 157). Of course, there are many kinds of programmes, both abstract and concrete. Some lend their ear to youth while others disregard their views.

It is obvious that no model of prevention policy can produce a completely drug-free way of life. Although the official policy is 'no alcohol to persons under 18, and no illicit drugs at all', in practice the standpoint in regard to alcohol or other drugs is ambiguous. One member of the Board stated the problem as follows:

> ... total abstinence is not even our aim. In other words, as regards alcohol, our apparent aim is controlled use of alcohol and this aim has been found feasible. When it comes to narcotic drugs, sniffing glue, and all that, there is no clearly stated line, but personally I would like to see, if possible, zero tolerance as far as that stuff is concerned. That is, if our aim is regulation of one's own life, well-being, good life, etc., these apparently are value-judgements, and this kind of self-controlled use of alcohol can be a part of it. But if one uses, say, glue, then it is a question of a social problem. (Member A of the Board of Directors; interviewed 23/11/2000)

Zero tolerance in regard to illicit drugs is an attractive position, because it seems clear and simple. The underlying assumption is that drug use is, in all cases, a symptom of more profound malaise. The *Klaari* field workers are aware, however, that for many young people it is common to try drugs such as cannabis and ecstasy, and even to use them regularly. As with alcohol, illicit drugs are consumed in Finland as part of multifarious, changing user cultures (Salasuo

& Rantala, 2002). Risks are involved in them all but they vary, and their control is complex. Individual prevention workers may have strong opinions about drug use but they cannot put them forward in their capacity as official representatives of the city:

> I say an unconditional NO to all intoxicants (...) But if I express a direct opinion, I usually say that this is my personal opinion, not that of a social worker or city official. (Prevention Worker A; interviewed 31/1/2002)

Alcohol and tobacco also present difficult obstacles for prevention but for different reasons. Research findings about youth smoking and drinking have increased alarm about these problems (Rimpelä, Lintonen, Pere, Rainio, & Rimpelä, 2002), but in many cases youngsters' problems are due to the problem drinking of their parents rather than their own. Research has shown that only multi-component prevention has a realistic chance of producing effects; mere information about the risks of alcohol does not suffice. Preventive policies should therefore include restrictions on availability, and mobilising the media to support local initiatives to intervene in problems (Holder, 1998: 135–143). However, this requires much stronger political and moral resources than have been at the disposal of *Klaari*, which relies strongly on the romantic rationalism of individual self-regulation and the sharing of responsibility:

> Should we perhaps start from the idea that there would not be so very much state control. The control rather should lie in the family... (Project Manager B; interviewed 23/10/2000)

... and whose problem is it?

A sense of community is hard to create if people are not sufficiently motivated to work with each other. Abstract talk about preventing youth's malaise or about the erosion of communal ties is not sufficient to initiate action. As representatives of the city administration, the prevention workers can focus on only very limited, concrete problems on which most people in the area would agree, such as youth disturbances in a particular locality. More general plans for community action tend to turn into assaults against some particular group of people who are labelled as trouble-makers, as has been observed in earlier community studies (Holmila, 2002, p. 21).

People still live in communities, but these can be of very different kinds: family, workplace, leisure organisations, mass happenings, websites, peer groups, etc. To activate a wider *local* sense of community thus requires detailed knowledge about the social structures of existing communities in specific areas—and this takes time (Holmila, 1997: 208). As in most prevention programmes of this type, the average population in each Helsinki city district served by one prevention worker was close to 100,000. The programme workers were thus cherished extras in under-staffed social offices. In effect, most of their time was spent in contacts with other officials, not in face-to-face field work with the target population.

A key issue in communitarian approaches to preventive social work is how to define whose problems are to be addressed and who will be activated to deal with them. In this case, the focus is young people. Research evidence shows that their malaise indeed has increased, if one uses criminal behaviour as an indicator. However, this is not the case for the 'average' young person in Finland; it reports only on those who are already on the road toward social exclusion (Kivivuori, 2002: 60–62).

The departmental service system and the inter-departmental requirements of prevention meet in a special way in relation to corrective social work. In principle, problems should be prevented before they appear. On the other hand, it is often difficult to concentrate on problem-free youngsters without paying attention to problem youth. As Project Manager A (interviewed 6/9/2000) states:

> The parish, you see, does preventive work, as it keeps that night café, that anyone can enter, but then there is this lot around for whom one should organise something, so that the preventive work could go on undisturbed.

A central problem, however, is that one cannot pigeonhole problems so neatly in real life:

> Who is to tell who is at risk and who is not, when the world changes and the days are all different in a young person's life? Some day she might belong to our lot, another day not (...) I mean, life is not that simple. There can be very risky times now and then, the family might have a hard time and all that. (Project Manager B; interviewed 23/10/2000)

If drug problems are seen as symptoms of a general malaise, the road to their prevention should be via the advancement of welfare and the curtailment of poverty. However, the structural causes of exclusion, such as unemployment or gaps in the service system, are beyond political reach. The only solution that can be offered is partnership and the devolution of responsibility to 'all relevant agencies', which is fuelled by the view that problems in human life do not follow districts and departmental lines.

However, in *Klaari* the preferred solutions for parents – for example, parental education, human relations skills and supportive networks – reach mostly those who have greatest parenting interest in their children to begin with. Families that would need help and might still benefit from it are beyond reach (Raitasalo, 2003). Voluntary mutual-help groups such as Alcoholics Anonymous or single parents' clubs are often helpful, but the communitarian approach in *prevention* tends to exclude those that are in greatest need of support.

Drug-free youth for adults

One field worker was puzzled about situations in which a concerned parent comes to discuss his or her child's liberal attitude toward cannabis:

> I have thought of it myself, but the fact is that we have no shared view. If we work as part of the city, we surely ought be clearer on that, too (...) If a parent comes and asks, 'What shall I do now that my son says that cannabis is OK', what is our standpoint, or is it a personal matter? (Prevention Worker B; interviewed 25/10/2001)

Some governmental experts acknowledge that strict control of recreational drug use may bring labelling effects, unnecessary exclusion and other harms in its wake (State Committee, 2002). However, to accept this view is problematic for many officials. They fear appearing too liberal in the eyes of the public in the sense of accepting drug use despite its illegal status. Accordingly, there was much confusion about recreational drug use among the project staff. The managers' response was to enhance the abstract rhetoric of providing welfare with safety nets.

The problem did not vanish. Instead, it was simply passed down to the field workers. Since it was very difficult for the senior management to take a position on, for example, zero tolerance versus harm reduction approaches to the use of cannabis, solutions concerning information content were devolved—from the managers to the field workers, and from them all the way to information producers. However, when prevention workers deliver drug information programmes or lectures, whether they recognise it or not, they are taking a stand on drug issues and how to respond to them Rantala (forthcomming). In the words of Prevention Worker D (interviewed 1/2/2002):

> It was supposed that we have reviewed all the materials, so that we can tell what is good and of high quality. In principle we have the city drug prevention office for that purpose, but even they have not done that. No one has taken responsibility for the materials. I'm not saying it is our job, I just want to say that some people should think what is good material to be distributed at schools and so on.

Most of the drug programmes that *Klaari* supported and recommended were run by very anti-drug oriented NGOs, and were of the 'Just Say No' type. These kinds of programmes often lacked sensitivity to youth cultures. On the whole, *Klaari* itself is very adult oriented. Adults design the guidelines for prevention. Adults are mostly concerned about fighting illicit drugs, rather than about the smoking and drinking of minors. They are hardly concerned at all about the harm caused to young people by the smoking and drinking of adults. In addition, the tendency of many prevention programmes such as *Klaari* to rely on the problem definitions of the social and health professions rather than on those of youth work, results in activities promulgating an ideal of drug-free youth in order to please adults. The idea that the use of illicit drugs is not always a symptom of deprivation has only gradually lost ground to a more realistic view about youth drug cultures.

Discussion

Projects like *Klaari* in some respects act like social movements, although they are initiated and run by professionals and funded by public budgets. They possess an 'ideology' or a 'theory' about problems that suggests particular kinds of solutions. Great enthusiasm prevails at the initial stage and, like proper social movements, they strive for visibility in order to expand and gain acceptance, resources and power (Eyerman & Jamison, 1991).

Klaari succeeded in establishing itself as the permanent official alcohol and other drug prevention programme in Helsinki. Our interpretation is that this was possible because the project has, from the start, been consistent with the principles of the life-regulation policies typical in contemporary consumer societies. Three of these principles were particularly important for its success: (1) an emphasis on partnership and voluntary collaboration; (2) a reliance on individual and communitarian action instead of legislative or normative regulation, which might violate powerful interests; and (3) a rhetorical focus on youth instead of adults and on illicit drugs rather than on alcohol or tobacco.

In order to gain acceptance among partners and legitimacy among politicians and city officials, the managers were forced to adopt an indirect and abstract goal formulation. Empowerment through social and parental skills training, the provision of safety networks and the development of shared responsibility in a communitarian style constitute, in their ideology, an approach that we call the *moral management of the self*. Like Garland (2001) *criminology of the self*, it stresses individual competences and self-control, but excludes efforts to influence the environment or to improve the circumstances of the populations at risk from its agenda. It also refrains from taking a stand on the concrete issues related directly to drinking, smoking or using illicit drugs. Parents and professional educators are encouraged to define for themselves what they consider to be the most appropriate ways of dealing with adolescents' drinking or experimental drug use.

Moral management of the self implies moral management of the other as the reverse side of the coin. In our case study, the 'other' lurks in images of the deprived and marginalised drug user, of the noisy youthful drinking group behind the shopping mall—or even of young people per se. They were, in this case, almost completely excluded from the activities of the programme, only given the role of entertainers or conference assistants in the meetings, never the floor.

Anti-alcohol and anti-drug movements of the late 19th and early 20th century were integrated into social issues about progress, citizenship and nationhood. They claimed

and gained legitimacy for their cause through parliamentary institutions, to the extent that some succeeded in installing serious restrictions on alcohol production, sales and use in Finland, Sweden and many other Western countries (Sulkunen & Warpenius, 2000). Contemporary alcohol and other drug programmes in Europe are for the most part not legislative, nor do they aim at parliamentary victories. Instead of the future-oriented rhetoric of progress, they advocate nostalgia for the lost sense of community (cf. Rantala & Sulkunen, 2003). Nationhood hardly appears in their rhetoric at all, and individual citizenship has been transformed into a request for self-responsibility and social or parenting skills.

Conclusion

Our case study indicates that while a partnership-based approach to alcohol and other drug prevention that devolves responsibility reflects an attitude of not taking a stand in concrete moral issues, it does not necessarily justify a claim to complete moral neutrality in these areas. First, the priority given to illicit drugs represents a bias that reflects the legitimacy of drinking in the adult world but does not correspond to the relative severity of problems experienced by the young. Secondly, focusing on the young may be more strongly related to *moral management of the other* than to the overall damage caused by alcohol and other drugs in society. And thirdly, not taking a stand on drug issues automatically favours anti-drug activists with zero tolerance and penal approaches rather than more pragmatic harm-reduction methods. In the context of the legal drug, alcohol, it isolates the soft methods of prevention through community work from harder methods of market control and rule enforcement, which remain absent from its agenda.

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